

STATE POLICYMAKERS' GUIDE FOR  
ADVANCING HEALTH EQUITY THROUGH  
HEALTH REFORM IMPLEMENTATION

*Carrie Hanlon and Brittany Giles*

AUGUST 2012

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**Portland, Maine Office:**  
10 Free Street, 2nd Floor  
Portland, ME 04101  
Phone: [207] 874-6524

**Washington, DC Office:**  
1233 20th Street, NW, Suite 303  
Washington, DC 20036  
Phone: [202] 903-0101

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## EXECUTIVE SUMMARY

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Compared to other populations, racial and ethnic minorities suffer from poorer health status, health outcomes, health care quality, healthy lifestyle options and access to health care.<sup>1</sup> The Patient Protection and Affordable Care Act (ACA)<sup>2</sup> offers states multiple policy levers to improve the health status of and quality of care for racial and ethnic minority populations through broad delivery system reforms, targeted public health and community interventions and expanded health insurance coverage and access, as well as provisions specific to racial and ethnic minorities. This report draws from the experiences of teams of state officials in seven states that participated in the Health Equity Learning Collaborative, sponsored by the Aetna Foundation and administered by the National Academy for State Health Policy. It highlights select policy levers that can advance health equity, opportunities for state and federal agency collaborations to strengthen these efforts, and important lessons and considerations for advancing health equity.

This report first discusses select ACA provisions and policy levers in four broad categories that can be used to advance health equity for racial and ethnic minorities:

- Insurance coverage provisions, particularly the Medicaid expansion and development of insurance exchanges, to improve racial and ethnic minority populations' access to needed health care services, as well as culturally and linguistically competent eligibility and enrollment services.
- Health care delivery reform provisions related to the development and implementation of medical and health homes, federal opportunities to support delivery innovations, and support for developing a more diverse health care workforce.
- Provisions related to data collection and standardization to analyze health care access and utilization by race, ethnicity and language.
- Provisions to improve population health through community-based preventive health programs, support for public health infrastructure, safety-net capacity, and community health needs assessments to appropriately plan for health services in underserved communities and among populations of color.

Next, this report synthesizes the work of and recommendations from Arkansas, Connecticut, Hawaii, Minnesota, New Mexico, Ohio, and Virginia, the states that participated in the NASHP Health Equity Learning Collaborative. These states pursued a number of strategies to address racial and ethnic disparities in coverage or access to care and health care quality/delivery through implementation of health reform. With regard to coverage and access, the state teams integrated health equity into:

- Outreach and enrollment strategies to create and provide culturally sensitive educational materials to the public; incorporate health equity considerations into consumer assistance and outreach through navigator programs; and, develop data sharing agreements to analyze enrollment and prioritize areas for outreach and enrollment efforts; and
- Exchange planning by developing guidelines for collecting race/ethnicity/language (REL) data; analyzing health equity data and providing education for exchange planning and advisory board members; and ensuring diverse stakeholder representation on planning and advisory boards.

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In terms of addressing quality and health care delivery reform, participating states pursued:

- New provider training and expectations by developing cultural competency training and/or providing anti-oppression assessments for Medicaid providers, and facilitating managed care contract language changes to increase accountability to deliver culturally sensitive care and/or reduce health disparities; and
- Health and medical homes with an emphasis on health equity by conducting outreach to diverse communities to inform health home planning; medical home rollout in racially/ethnically diverse communities; developing and conducting cultural competency training for medical home providers; and pursuing federal support opportunities to improve payment and care delivery.

This report then offers important health equity considerations and themes from an in-person meeting of the Health Equity Learning Collaborative and federal officials. Key lessons from this meeting include: the value of federal data and tools in supporting participating states' efforts, the role of states in engaging communities and stakeholders in policy development, the importance of cross-agency collaboration to advancing health equity, and the need to frame health equity.

Overall, the following lessons emerged from the activities of Health Equity Learning Collaborative state teams:

- Advancing health equity does not depend solely on ACA implementation, but ACA provides a unique platform to catalyze state efforts.
- Language matters: quality improvement, population health, public health systems change, and patient-centeredness all have health equity components.
- State agencies would like more opportunities for peer-to-peer learning around issues of health equity.
- Participation in multi-state efforts helps legitimize efforts to advance health equity.
- Communities need to be partners in policy development and implementation.
- Data are power, and states continue to work to improve REL data collection to advance health equity.

Participating state teams identified and pursued a number of strategies to advance health equity through health reform implementation. The recent Supreme Court ruling enables the Health Equity Learning Collaborative states' improvement efforts to continue moving forward. With the ruling, all states now have critical decisions to make that can address disparities; the strategies of participating states offer examples of how policy makers can advance health equity using ACA and state-level policy levers.

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## INTRODUCTION

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Compared to other populations, racial and ethnic minorities suffer from poorer health status, health outcomes, health care quality, healthy lifestyle options and access to health care.<sup>3</sup> The Patient Protection and Affordable Care Act (ACA)<sup>4</sup> offers states multiple policy levers to improve the health status of and quality of care for racial and ethnic minority populations through broad delivery system reforms, targeted public health and community interventions, and expanded health insurance coverage and access, as well as provisions specific to racial and ethnic minorities. Since individuals from racial and ethnic minority communities are projected to comprise 54 percent of the U.S. population by 2050,<sup>5</sup> state health policymakers are in a prime position to utilize tools in the ACA to advance health equity—attainment of the highest level of health—for their most vulnerable minority populations.<sup>6</sup> From October 2011 through June 2012, teams from seven states participated in the Health Equity Learning Collaborative, which was supported by the Aetna Foundation and administered by the National Academy for State Health Policy (NASHP). Participating states engaged in technical assistance activities and peer-to-peer learning to plan and carry out coordinated approaches to advance health equity through ACA implementation. This report draws from the experiences of the Health Equity Learning Collaborative to highlight select ACA and state policy levers that can advance health equity, opportunities for state and federal agency collaborations to strengthen these efforts and important lessons and considerations for advancing health equity.

### Common Definitions

Achieving health equity for racial and ethnic minorities requires a working understanding of the factors influencing the health of these populations, some of which refer to factors beyond the scope of the health care system. Below are a few common definitions:<sup>7</sup>

- **Health equity:** Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with ongoing efforts to address avoidable inequalities and injustices, and eliminate disparities.
- **Health inequity:** A difference or disparity in health outcomes that is systematic, avoidable, and unjust.
- **Health inequality:** Difference, variation, and disparity in the health achievements of individuals and groups of people.
- **Health disparity:** A type of difference in health outcome that is closely linked with social or economic disadvantage.<sup>8</sup> Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability.
- **Social determinants of health:** The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.<sup>9</sup>



## STATE OPPORTUNITIES TO ADVANCE HEALTH EQUITY THROUGH HEALTH REFORM IMPLEMENTATION

This section explores provisions and policy levers in the ACA that can advance health equity for racial and ethnic minorities. These policy mechanisms fall under four broad categories: coverage, delivery system reform, data, and population health. Table 1 (below) provides an overview of key ACA provisions that explicitly reference care or access for racial or ethnic minority populations or are broader but can be used to advance health equity.

**TABLE 1: SELECT ACA PROVISIONS THAT CAN ADVANCE HEALTH EQUITY\***

ACA Provision Topic and Section(s)		Brief Description
Coverage and Access	Medicaid Expansion (1101, 1311, 1322, 1421, 1501, 1513, 2001, 2005, 10104)	<ul style="list-style-type: none"> <li>Creates option to cover adults under age 65 with incomes at or below 138% of the federal poverty level, including adults without custodial children</li> <li>From 2014-2016, offers states 100% FMAP (phasing down to 90% FMAP by 2020) for covering the newly eligible under the above option</li> <li>Sets new standards for simplifying health insurance eligibility and enrollment processes</li> </ul>
	Insurance Exchanges (1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1324, 1411, 1412, 1413)	<ul style="list-style-type: none"> <li>Beginning 2014, creates a marketplace for legal residents and small employers to shop for affordable private health insurance plans and make informed decisions about their plan options</li> <li>Offers sliding scale federal tax credits for individuals between 138% and 400% of the federal poverty line to purchase plans (or between 100% and 400% in states that do not expand Medicaid)</li> <li>Requires participating plans to provide certain health services (“essential health benefits”) for beneficiaries</li> <li>Requires participating plans to contract with providers that include community health centers and safety-net providers</li> <li>Requires exchange plans to develop consumer assistance Navigator programs that offer culturally and linguistically appropriate services</li> </ul>
Quality and Delivery System Reform	Health Homes (2703)	<ul style="list-style-type: none"> <li>Created State Plan Amendment option to serve Medicaid enrollees with 2 or more chronic conditions, 1 condition and the risk of developing another, or at least 1 serious and persistent mental health condition<sup>10</sup></li> <li>Offers states 90% FMAP for 2 years for providing health homes services (e.g., care management, care coordination, health promotion, referrals to community and social supports, and use of health information technology)<sup>11</sup></li> </ul>
	Center for Medicare and Medicaid Innovation (3021)	<ul style="list-style-type: none"> <li>Created a Center designed to test health care payment and service delivery models that lower Medicare, Medicaid and CHIP spending, while maintaining or improving quality care<sup>12</sup></li> </ul>
	Accountable Care Organizations (ACOs) (3022, 10307)	<ul style="list-style-type: none"> <li>Established the <b>Medicare Shared Savings Program</b>, through which networks of providers agree to serve as ACOs to coordinate the full continuum of care for beneficiaries for at least 3 years and be held accountable for care quality and cost</li> </ul>
	Workforce Diversity (5402, 5404)	<ul style="list-style-type: none"> <li>Provides support to increase diversity of primary care and long-term care providers, recruit and train community health workers to provide education and outreach to diverse communities, and develop strategies to provide culturally and linguistically appropriate services in health care settings.<sup>13</sup></li> </ul>

**TABLE 1: SELECT ACA PROVISIONS THAT CAN ADVANCE HEALTH EQUITY (CONTINUED)**

ACA Provision Topic and Section(s)		Brief Description
Data	Data Collection Standards (4302)	<ul style="list-style-type: none"> <li>Requires all national population health surveys to include data on race, ethnicity, sex, primary language, and disability status<sup>14</sup></li> <li>Requires data collected under a Medicaid or CHIP plan to meet these standards</li> <li>Requires these data to be self-reported</li> </ul>
Population Health	Prevention and Public Health Fund (4002)	<ul style="list-style-type: none"> <li>Established and allocated money for the <b>Prevention and Public Health Fund</b> to create a regular source of funding for programs addressing pressing public health priorities such as preventive health care and disease prevention.</li> </ul>
	Community Transformation Grants (4201)	<ul style="list-style-type: none"> <li>Supported by the Prevention and Public Health Fund, these grants are designed to help state and local agencies, nonprofit organizations, networks of community-based organizations, and Indian tribes engage communities in local chronic disease prevention strategies</li> </ul>
	Community Health Centers and the Safety Net (5601, 10503, 2303) <sup>15</sup>	<ul style="list-style-type: none"> <li>Established the <b>Health Center Program Expansion</b> to expand operational capacity, improve existing facilities, and enhance health services</li> <li>The <b>National Health Service Corps</b> will receive \$1.5 billion over the next five years to decrease primary care provider shortages in underserved communities</li> <li>Developed Community-Based Collaborative Care Networks to organize community health centers and other safety net providers to deliver coordinated care to vulnerable communities in targeted geographic areas</li> <li>Requires exchange health plans to contract with essential community providers (including safety net providers)<sup>16</sup></li> </ul>
	IRS Community Benefit (9007)	<ul style="list-style-type: none"> <li>Requires nonprofit hospitals to periodically conduct community health needs assessments that incorporate community feedback and implement strategies to address identified community health needs to receive exemption from federal taxes.</li> </ul>

\*A comprehensive list of provisions is available in the following document, from which this table was adapted: Andrulis D, Siddiqui N, Purtle J and Duchon L. *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*. Joint Center for Political and Economic Studies, July 2010. Available online: [http://www.jointcenter.org/hpi/sites/all/files/PatientProtection\\_PREP\\_0.pdf](http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf)

In June 2012, the United States Supreme Court upheld the constitutionality of the ACA, except for the mandate that states expand Medicaid eligibility to Americans under age 65 with incomes at or below 138 percent of the federal poverty level or run the risk of losing all federal Medicaid funding.<sup>17</sup>

## INSURANCE COVERAGE

Access to insurance coverage is an important determinant of positive health outcomes, and a lack of health insurance is associated with underutilization of preventative services and medical treatment among racial and ethnic minorities.<sup>18</sup> In 2010, about 33 percent of Hispanics and 23 percent of African Americans were uninsured, compared to only 14 percent of white Americans.<sup>19</sup> Through provisions to expand the Medicaid program and create health insurance exchanges (highlighted in Table 1), the ACA holds opportunities to increase health insurance coverage and access to health care for minority populations.

Specifically:

- States that choose to participate in the ACA Medicaid expansion will provide critical coverage to the uninsured, a group disproportionately comprised of racial and ethnic minorities.
- State Medicaid programs need to be prepared to provide education about the program, adequately communicate entitled health benefits and employ strategies to retain the newly eligible, all in culturally and linguistically appropriate ways.
- The ACA's emphasis on simplifying health insurance eligibility and enrollment processes will be especially important for states with hard to reach Limited English Proficiency (LEP) populations that often experience translational difficulties when seeking coverage.
- States have the flexibility to incorporate health disparities tracking measures and cultural competency requirements into their Medicaid managed care organizations, which will be an important consideration for Medicaid managed care programs that contract with community health and safety net providers, as 84 percent of federally qualified health centers provide clinical services to LEP populations each day.<sup>20</sup>
- Exchanges will provide a marketplace to shop for affordable private health insurance plans. The exchange population is expected to be more racially and ethnically diverse than privately insured populations, with 58 percent of enrollees being white, 11 percent black, and 25 percent Hispanic.<sup>21</sup>
- States may require their Qualified Health Plans (QHPs)—defined as health plans participating in the exchange marketplace—to provide services beyond those that are federally required to meet the specific needs of diverse populations and strategically choose plans that advance health equity.
- At the governance level, states have the opportunity to ensure participation of minority communities by prioritizing community representatives as members of exchange advisory boards and by facilitating opportunities for public education and comment on exchange policy developments.

## HEALTH CARE DELIVERY REFORM

Although coverage expansions created by the ACA hold significant opportunities for states to advance health equity, the ACA also addresses care coordination, payment reform, and delivery system innovation. The ACA can support states seeking to improve racial and ethnic minorities' health outcomes and their experiences within the health system. For example:

- Racial and ethnic minorities are disproportionately burdened by chronic disease and illness.<sup>22</sup> Established as a state option in ACA, health homes are designed to serve chronically ill Medicaid enrollees.<sup>23</sup> ACA specifically defines chronic conditions served by a health home as including a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and obesity.<sup>24</sup> The latter three conditions represent serious morbidity risk factors for minority populations.<sup>25</sup>
- Health homes have an emphasis on patient-centered care. All health home services must be offered by a health home provider arrangement chosen by beneficiaries. As states develop health home service delivery models, they can consider health home design elements to decrease health disparities and improve health outcomes for minority communities disproportionately burdened by chronic disease.

- States can look to the Center for Medicare and Medicaid Innovation as a means for exploring delivery system reform models to advance health equity for minority populations. For states that will experience a large influx of racial and ethnic minority Medicaid enrollees in 2014, taking advantage of the lessons learned from Center initiatives can help policymakers incentivize Medicaid innovation and program advances, as well as increase the participation of minorities in primary care services that reduce health disparities and advance health equity.
- Developing and supporting a diverse health care workforce will be essential for states to engage and retain minority populations in the health care system. Moreover, research suggests that racially and ethnically diverse practitioners are more likely to serve in underserved areas and treat uninsured or underinsured patients of color.<sup>26</sup>

Racial and ethnic minority populations also could greatly benefit from Accountable Care Organizations (ACOs), which are supported by ACA as a mechanism to incentivize providers to deliver quality-driven care that promotes cost-savings.

- CMS regulation directs ACOs to consider the needs of these populations in planning, developing, and sustaining these models.<sup>27</sup>
- Providers applying as an ACO must meet eight “patient-centeredness criteria,” which includes “a process for evaluating the health needs of the ACO’s assigned population, including consideration of diversity in its patient populations, and a plan to address the needs of its population.” Applying ACOs must describe this process for addressing patient diversity in their applications, as well as how the ACO would “consider diversity in [its] patient population.”<sup>28</sup>
- States must be aware of the geographic concentrations of ACOs, and ensure that ACOs are developed in geographically and income-diverse areas to ensure equal access for racial and ethnic minority communities.<sup>29</sup>
- CMS grants ACOs the flexibility to decide the most effective measures to address the health needs of their diverse populations, which may be an opportunity for states to monitor how ACOs are decreasing health disparities among minority Medicare populations.
- As a means to plan and address population health needs, CMS encourages ACOs to partner with states or local health departments that perform community health assessments.<sup>30</sup>

## DATA

Collecting timely, reliable, and standardized data on health care access and utilization by race, ethnicity and language can help states strategically assess and refine their health systems to eliminate health disparities and promote health equity. Building upon the Office of Management and Budget standards for race and ethnicity data collection, Section 4302 of the ACA requires that all national population health surveys include data on race, ethnicity, sex, primary language, and disability status.<sup>31</sup> Through this part of ACA:

- States are permitted to further granulate the minimum data standards if these measures are representative of a sample size of the target population.<sup>32</sup>
- States can work to standardize race/ethnicity/language (REL) data collection and reporting more broadly, e.g., as part of all-payer claims databases to assess cost, quality and access (see page 19 for more on all-payer claims databases). As a result, states will be better equipped to track health disparities, justify policy initiatives to advance health equity, and adopt payment reforms that use data-driven equity performance measures.

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## POPULATION HEALTH

Improving population health may require implementing strategies that address larger social determinants of health beyond the scope of the health care delivery system. Additionally, these strategies may address the underlying societal factors influencing health disparities among racial and ethnic minority populations. Several ACA provisions address disparities through community and population health interventions. For example:

- The ACA allocates funding to the Prevention and Public Health Fund to support public health initiatives at local, state, and federal levels. In FY2011, these funds were used to support community-based preventive health programs, clinical prevention services, building public health infrastructure, and public health research and data collection efforts.<sup>33</sup> States can incorporate REL data improvement and address public health issues disproportionately affecting minorities.
- Community Transformation Grants, supported by the Prevention and Public Health Fund, are an important resource for states and localities looking to explicitly address health disparities among racially and ethnically diverse populations. In 2011, the program awarded \$103 million in implementation grants to 61 state and local agencies, tribes and territories, and nonprofit organizations to support community health and wellness. These awardees will engage in activities to address community tobacco-free living, active lifestyles and healthy eating, and support high-quality clinical preventions. The program is expected to run for five years and impact approximately 120 million Americans.<sup>34</sup>
- An estimated 23 million individuals will remain uninsured after most of the laws' provisions are implemented. Of this group, approximately one-third will be immigrant populations ineligible for Medicaid or exchange programs, in addition to the quarter of individuals that will be eligible for Medicaid but unenrolled.<sup>35</sup> Community health centers will be an important point of access to care for uninsured and newly insured populations. Through coordinated approaches to supporting community health centers and system capacity, the ACA affords states opportunities to build a sustainable safety net and public health infrastructure to address the health care needs of racially and ethnically diverse populations.
- Beginning with taxable years after March 2012, the ACA requires nonprofit hospitals to periodically conduct community health needs assessments and implement strategies to address identified community health needs if the hospitals are to receive exemption from federal taxes. The community health needs assessments are to incorporate feedback from communities, which will include the underserved and populations of color as well as local health departments.<sup>36, 37</sup> Many local health departments not only have experience conducting these assessments, but also often work with state health departments to compile data for statewide public health reports, which often include REL data. States can help local health departments share REL and crucial disparities data with non-profit hospitals.

## THE NASHP STATE HEALTH EQUITY LEARNING COLLABORATIVE

Achieving health equity for the nation's racial and ethnic minority populations has become a priority at both the federal and state levels. However, states are in a unique position to develop and adapt health equity agendas that meet the specific needs of their communities. In fact, all 50 states have established a minority health or health equity office or entity.<sup>38</sup> Implementation of the ACA provides a vehicle for moving health disparities issues out of the silos of office of minority health and into the larger context of state

health policy. State policymakers have an opportunity to work across agencies, systems, and sectors to develop sustainable and comprehensive state-based approaches to advance health equity for their minority populations.

To help state policymakers maintain momentum towards achieving health equity in a complex implementation environment, NASHP, with funding from the Aetna Foundation, developed the State Health Equity Learning Collaborative for teams of state officials. The purpose of this Learning Collaborative was to provide concrete assistance to seven states through access to expert consultation, implementation resources, and networking with other state officials to support states in simultaneously achieving health reform and health equity goals. NASHP anticipated the following outcomes for participating states:

- **Implementation of the ACA with a conscious consideration of the impact of state policy decisions on diverse populations,** and the ability to identify opportunities to promote health equity as they carry out required ACA roles and policies.
- **Elevation of health equity agendas.** Historically, initiatives that promote health equity have been siloed and vulnerable to political and financial shifts. Incorporating health equity into the broader scope of health systems will focus greater attention on the needs of diverse populations.
- **Integration of health equity initiatives across state programs.** Improving the health of diverse populations is an objective of multiple state agencies and branches of government. To be successful and have the greatest impact, Medicaid, minority health, public health and other agencies should build sustainable partnerships and promote cross-cutting health equity agendas.

### State Selection Process

In August 2011, NASHP solicited a national request for applications for states interested in participating in the Health Equity Learning Collaborative. NASHP sought applications from states that had firmly committed to advancing health equity and wanted to leverage the opportunities presented in health care reform. State applications were assessed based on the following criteria:

- **Partnerships:** Commitment from Medicaid, public health, and minority health agencies to participate in a core project team, as well as engage other relevant state agencies and stakeholder organizations.
- **Relevant health reform activity:** Evidence of core team member engagement in state health care reform efforts.
- **Reasonable objectives:** Evidence that the core team will establish feasible objectives for the eight-month project period, particularly by building upon existing complementary efforts.
- **Potential impact of technical assistance:** Evidence that participation would strengthen the state's (and inform other states') health equity and health reform agendas.

Based on the above criteria, and after consulting with a NASHP project advisory committee comprised of national and federal health equity experts, NASHP selected Arkansas, Connecticut, Hawaii, Minnesota, New Mexico, Ohio, and Virginia to participate in the Health Equity Learning Collaborative.

Selected states were expected to:

- **Form a core leadership team** of state officials from Medicaid, minority health, and public health agencies to facilitate inter-agency collaboration.

- **Develop a workplan and achieve reasonable progress towards workplan objectives** within three policy priority areas for advancing health equity through health reform implementation.

Based on health care reform implementation priorities identified by NASHP's Executive Committee and feedback from the project advisory committee, NASHP provided a list to selected states of areas (See Table 2) from which they identified three priorities as the focus of their efforts over the eight-month technical assistance period of the Health Equity Learning Collaborative.<sup>39</sup>

**TABLE 2: HEALTH EQUITY LEARNING COLLABORATIVE STATES' WORKPLAN PRIORITY AREAS**

	Policy Area	Sample Actions to Advance Health Equity
Coverage and Access	Be Strategic with Insurance Exchanges	<ul style="list-style-type: none"> <li>• Develop descriptions of plans and subsidies that are culturally and linguistically appropriate</li> <li>• Conduct targeted outreach to racial and ethnic minority communities to increase their awareness of insurance subsidies</li> </ul>
	Simplify and Integrate Eligibility Systems	<ul style="list-style-type: none"> <li>• Adopt tested outreach enrollment and retention strategies to maximize participation of underserved populations in Medicaid and Exchanges</li> <li>• Reduce documentation burden of citizen verification</li> <li>• Increase translation and interpretation services</li> </ul>
Quality and Delivery Reform	Emphasize Coordination of Care	<ul style="list-style-type: none"> <li>• Establish health homes in racial and ethnic minority communities targeted to people with multiple chronic conditions</li> <li>• Integrate delivery system of behavioral and physical health for Medicaid recipients through safety net providers</li> </ul>
	Promote Quality and Efficiency from the Health Care System	<ul style="list-style-type: none"> <li>• Adopt payment reform demonstrations to improve care for persons with chronic diseases and concentrate public resources for pilot programs in racial and ethnic minority communities</li> </ul>
	Improve Provider and Health System Capacity	<ul style="list-style-type: none"> <li>• Strengthen the ability of safety net provider to service persons newly eligible for Medicaid insurance benefits, many of whom will likely be ethnic minorities with chronic conditions</li> <li>• Develop federal grant proposals to support increased workforce diversity and expanded provider capacity in underserved areas</li> </ul>
Population Health	Engage the Public in Policy Development and Implementation	<ul style="list-style-type: none"> <li>• Develop strategies to empower racial and ethnic communities to weigh in on policy options before that are adopted and to provide feedback on how that are being implanted so they can be improved</li> </ul>
	Use Your Data	<ul style="list-style-type: none"> <li>• Develop strategies to analyze the myriad new data elements mandated for collection in order to identify and drive needed improvements in health equity</li> <li>• Use data to establish provider performance measures for reducing health disparities and chronic disease</li> </ul>
	Pursue Population Health Goals	<ul style="list-style-type: none"> <li>• Revitalize public health strategies that focus on disease prevention and health promotion</li> <li>• Develop federal grant proposals to access opportunities provided by the Prevention and Public Health Fund</li> <li>• Expand the supply and scope of community health workers</li> </ul>

States' priority areas were the basis for monthly expert technical assistance activities and ongoing peer-learning opportunities, which focused on the following six topics:

- Strategies to ensure participation of diverse populations in Medicaid and exchange plans
- Engaging racial and ethnic minority communities in policy development and implementation;
- Health and medical home design considerations for health equity;
- Medicaid managed care contract options for advancing health equity;
- Cultural competency training for providers and policy makers; and
- Data collection and use to advance health equity.

The project culminated with an in-person state-federal meeting, followed by a state-only meeting of Health Equity Learning Collaborative team members. This report focuses on the experiences of the participating states and their strategies to advance health equity through health reform as part of this project.



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## STATE ACTION TO ADVANCE HEALTH EQUITY USING SELECT ACA AND STATE POLICY LEVERS

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States participating in the Health Equity Learning Collaborative have used select ACA state policy levers to advance health equity by building on existing initiatives and partnerships. This section first describes states' action to advance health equity related to health coverage and access, and then highlights action related to quality of care and delivery system reform. Table 3 (next page) provides an overview of states' actions in these areas. As previously noted, the activities described here are those that were the focus of this particular learning collaborative and do not represent the totality of states' health equity or health reform efforts.

### STATE ACTION RELATED TO COVERAGE AND ACCESS

Participating states have undertaken a number of activities that capitalize on increased insurance coverage under the ACA. They are taking steps to ensure that newly covered racial and ethnic minorities under the ACA Medicaid expansion and health insurance exchange have equitable access to care. These states are working to advance health equity through:

- Insurance exchange planning and leadership;
- Consumer assistance and outreach in navigator programs; and
- Data sharing agreements and analyses to inform Medicaid program enrollment and service provision.

#### Exchange planning and leadership

As activity in Connecticut and Minnesota show, integrating health equity into insurance exchange planning first entails educating policymakers tasked with developing the exchange about the needs of diverse populations and ways that policymakers can pursue health equity as a goal of exchange implementation. From there, exchange leaders can weave health equity into each stage of planning.

##### *Connecticut*

Connecticut's Office of Health Reform and Innovation is developing health equity training for its Health Insurance Exchange Board of Directors. An outside expert will lead the training, however the Office will collaborate with other state agencies to incorporate internal expertise and resources on health disparities within the state. State health disparities data from the public health department will be shared during the training, as will information on health equity improvement efforts in other states. Additionally, the Office will provide health equity training to the Governor's Health Care Cabinet, which advises the Governor on implementation of federal health reform and development of an integrated health care system in the state.

##### *Minnesota*

Earlier this year, members of the Minnesota Health Insurance Exchange Advisory Task Force devoted an entire meeting to the topic of health equity.<sup>40</sup> The Medicaid and health commissioners shared data about health disparities in the state, social determinants of health in the state, and the financial implications of disparities. Consumers and consumer representatives provided concrete policy recommendations for addressing disparities through the exchange, such as adopting data collection standards to capture disparities and ensuring culturally appropriate consumer outreach.<sup>41</sup> Based on the information presented, the task force voted to commit to making each of its policy recommendations or decisions only after considering

**TABLE 3: STATE ACTION THROUGH THE HEALTH EQUITY LEARNING COLLABORATIVE TO ADVANCE HEALTH EQUITY USING SELECT ACA AND STATE POLICY LEVERS**

ACA-Related Focus Area and State Activity		AR	CT	HI	MN	NM	OH	VA	
Coverage and Access	Outreach and Enrollment								
	Create and provide culturally sensitive educational materials to the public	✓						✓	
	Incorporate health equity considerations into consumer assistance and outreach through navigator programs	✓							
	Develop data sharing agreements to analyze enrollment and prioritize areas for outreach and enrollment efforts							✓	
	Health Insurance/Benefit Exchange								
	Develop guidelines for collecting race/ethnicity/language data				✓				
	Provide health equity data and education for planning or advisory board members		✓		✓				
	Ensure diverse stakeholder representation on planning or advisory entities	✓	✓		✓				
Quality and Delivery Reform	Medicaid Provider Training and Expectations								
	Develop cultural competency training and/or provide anti-oppression assessments for Medicaid providers	✓					✓	✓	
	Facilitate managed care contract language changes to increase accountability to deliver culturally sensitive care and/or reduce health disparities					✓	✓		
	Health and Medical Homes								
	Conduct outreach to diverse communities about health homes to inform planning			✓	✓				
	Plan for medical home rollout in racially/ethnically diverse communities			✓			✓		
	Develop and conduct cultural competency training for medical home providers	✓			✓		✓		
	Pursue federal support opportunities to improve payment and care delivery			✓	✓				
Data	Race/Ethnicity/Language (REL) Data								
	Inventory Medicaid, public health and other agency databases to assess and improve collection of REL data	✓	✓	✓	✓		✓		
	Develop polices to govern REL data collection through all-payer claims databases		✓						
	Explore development of standardized and integrated metrics to analyze disparities data across state agencies		✓	✓	✓		✓	✓	

the policy's impact on health disparities. In this way, efforts to advance health equity are integrated into exchange planning. A critical precursor that made this action possible in Minnesota was having task force members—the voices with authority at the policy-making table—who represent communities and who themselves are racial or ethnic minorities

### **Consumer assistance and outreach in navigator programs**

Under the ACA, states have the option to run health insurance exchanges independently or in partnership with the federal government. In February 2012, Arkansas decided to pursue the option to a develop a federally-facilitated exchange (FFE), while maintaining state operation of core exchange functions such as consumer assistance planning and plan management.<sup>42</sup> Through this State Partnership model, Arkansas has the flexibility to design its navigator program in compliance with guidelines set forth in the ACA and support the certification and training of eligible individuals to serve as navigators.

#### *Arkansas*

Arkansas is using its navigator program to advance policy levers afforded by the exchange to address health equity through consumer engagement, outreach, and navigator program design. For example, the Arkansas Insurance Department and Insurance Department Health Benefits Exchange Partnership Division has engaged community-based organizations, consumer advocates, and community members in educational activities to communicate opportunities within the exchange to advance health equity. The state is also currently working on a “Train the Trainer” curriculum and resource toolbox for community organizers to facilitate communication of exchange policy developments between the state and potential exchange enrollees and solicit feedback through public comment on planned policy developments. Lessons learned from these community engagement activities will be shared with state policymakers designing exchange plans and the navigator program to address the needs of minority communities.

Additionally, the Arkansas Insurance Department's Health Benefit Exchange Planning Division, which oversees the development of the State Partnership model, established a Consumer Advisory Committee and conducts consumer focus groups to develop outreach recommendations to reach diverse populations. Through the navigator program, the state is looking to implement certification policies that will allow broad participation in the program. This will be an important consideration for outreach in rural areas and localities with high concentrations of individuals from racial and ethnic minority groups. Finally, Arkansas is working to develop cultural competency contract language to be included in RFPs for organizations applying to participate in the navigator grant program. Examples of provisions are as follows:

- To ensure selected Navigators are trusted sources of health care coverage information in the communities they choose to serve, that services are culturally and linguistically appropriate, and that information is relayed in a way that simplifies choices and considers the individual needs of each consumer and their families;
- To create a positive opinion of the exchange, its benefits, and the important role health insurance coverage can play in reducing health care disparities.
- To maximize coverage for the uninsured or underinsured in the exchange.

### **Data agreements and analysis to inform Medicaid enrollment and service provision**

As described below, Virginia is establishing a data sharing agreement to inform Medicaid enrollment and service provision.

## Virginia

Virginia has created a new mechanism for cross-agency collaboration to understand and address disparities in enrollment and outcomes. In the state, unintended pregnancy rates are highest among certain groups of women, such as women ages 18 to 24, women whose income is below the poverty line, and Black or Hispanic women.<sup>43</sup> *Plan First*, a family planning program within Medicaid, has targeted outreach efforts to areas with high infant mortality rates. Recently, the state's health and Medicaid (Medical Assistance Services) departments entered into a data sharing agreement to evaluate and inform *Plan First* enrollment and provision of services. The health department analyzed *Plan First* data using geographic information systems (GIS) mapping in conjunction with multi-level spatial analysis. GIS mapping and spatial analysis are tools that analyze and display geographically referenced (and other) data to describe the geographic relationships and patterns.<sup>44</sup>

Spatial analysis was used to identify communities where multiple risk factors, such as low income or Medicaid eligibility and short birth intervals, overlap. With this information, Medicaid can more efficiently target *Plan First* outreach, enrollment and program services to the communities with the most risk factors and highest need. Given general demographic information about the state's geographic areas, agency staff can surmise which localities are most racially and ethnically diverse and best enable them to address racial and ethnic disparities in infant mortality. Their next steps will be including race and ethnicity data in the analysis for a more accurate assessment of racial and ethnic differences in enrollment. Including this data from the outset strengthens the state's ability to assess disparities in risk factors and prioritize communities with populations of color facing disparities in outcomes.

### **Recommendations based on state actions to advance health equity through coverage and access strategies**

The following recommendations emerged from participating states' experiences advancing health equity through exchange planning, navigator programs, Medicaid and health agency data agreements and analysis, and health plan education about health equity:

- Foster collaboration between Medicaid agencies, health departments, and minority health agencies; the latter have existing educational resources, community networks, relevant race/ethnicity/language data, and quantitative analytic expertise that can help Medicaid agencies prioritize outreach and service provision efforts and allocation of resources to maximize return on investment.
- Ensure exchange-planning (and all other policy-making) entities have diverse membership and include community members who will likely participate as consumers in the exchange.

### **STATE ACTION RELATED TO QUALITY AND DELIVERY REFORM**

In addition to addressing equity in access through ACA and state policy levers, participating states have identified options for capitalizing on the health delivery reform and quality improvement components of ACA. States are taking steps to ensure that delivery reform initiatives integrate a health equity lens to ensure high-quality, equitable care for all. Participating states seek to advance health equity through:

- Health and medical homes;
- Race/ethnicity/language data guidelines and recommendations;
- Cultural competency training for Medicaid providers; and
- Medicaid managed care contracting and education.

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## Health and medical homes

Nationally there has been a proliferation of state legislation and initiatives to promote adoption of the patient-centered medical home (PCMH) care delivery model.<sup>45</sup> Like health homes authorized under ACA, the PCMH is an enhanced model of primary care that offers continuous, team-based, coordinated, high quality, safe, and whole-person oriented care to patients and a payment structure to support the necessary investments for this care by providers.<sup>46</sup> Both health and medical homes play an important role in transforming the delivery of patient-centered health care for racial and ethnic minorities. As examples from Ohio, Minnesota, and Hawaii show, participating states are advancing health equity by integrating the needs of diverse populations into health and medical home initiatives via site selection criteria, provider education, and community engagement in planning. Their work offers ideas how states can ensure health homes and medical homes meet the needs of diverse populations.

### *Ohio*

In Ohio, 2010 legislation (House Bill 198) established the Patient-Centered Medical Home Education Pilot Program, through which 44 practices affiliated with medical and nursing schools were selected to promote adoption of the patient-centered medical home (PCMH) model of primary care.<sup>47</sup> The pilot program offers tuition assistance to primary care career students, trains them in the PCMH model, and engages them in practical, on-the-ground PCMH experience.<sup>48</sup> Earlier this year, the state announced not only a financial commitment to support implementation of the existing project but also an expansion to six additional practices. Collaboration between the Ohio Health Equity Learning Collaborative Team and the Ohio Office of Health Transformation led to the decision to target the expansion to health providers who primarily serve racial and ethnic minorities and underserved communities.<sup>49</sup> The state selected additional practices based on socio-economic factors and racial and ethnic diversity. In addition, every practice that receives training dollars must support at least 15 percent uninsured or Medicaid-eligible patients. This effort to target populations who bear a disproportionate burden of diseases and poor health outcomes will provide faster return on investment through improved outcomes and health status and in cost savings. It also provides a way to help advance health equity. Through the Ohio Patient-Centered Primary Care Collaborative, the state's health department is facilitating the PCMH project expansion and will help inform statewide PCMH policy.

### *Minnesota*

A second way participating states have integrated health equity into medical homes is via provider training. Earlier this year, Minnesota developed and hosted a health equity educational session for medical home (known as “health care home”) providers as part of broad provider training. The health equity workshop was hosted by health department staff and featured best practices in providing culturally competent care and included topics such as race/ethnicity/language data collection and use, and provision of patient – and family-centered care for diverse populations.<sup>50</sup> The workshop was not a one-time event, as health equity and cultural competence are now topics for consideration as future education sessions are planned among the state's health care homes learning collaborative.

### *Hawaii*

Hawaii has integrated health equity into health and medical home planning through educational workshops and focus groups with racial and ethnic minorities. Hawaii's decision to develop these workshops was influenced by Connecticut's finding of significant public learning curves about the concept and function of medical and health homes, as well as public understanding of the implications of health reform. Taking a lesson from Connecticut's experience, Hawaii decided to design community-based workshops to

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educate the public about key implications of health reform within communities. The 90-minute workshops provided information about health care reform from a consumer perspective and described health and medical homes.

Additionally, the Hawaii Department of Health held focus groups with mental health consumers served by community mental health centers and federally qualified health centers to solicit feedback about cultural needs and preferences for accessing health homes and ensuring quality service delivery, particularly care coordination among medical and behavioral health treatment providers. The state will share feedback from the workshops and focus groups with groups guiding health home and other project planning. Insights will continue to inform delivery system reform efforts. For example, the state is pursuing a Primary and Behavioral Health Care Integration (PBHCI) grant from the federal Substance Abuse and Mental Health Services Administration to facilitate implementation of the state's pilot Bi-Directional Integration of Behavioral Health/Primary Care Demonstration Project.<sup>51</sup>

### **REL data collection guidelines and recommendations**

Health Equity Learning Collaborative states are all invested in increasing the validity and use of race/ethnicity/language (REL) data to understand, assess, and improve quality of care for minorities. Working through respective state offices or entities devoted to health reform, both Minnesota and Connecticut have identified policy levers and opportunities for improving REL data guidelines and recommendations.

#### *Minnesota*

In 2010, as a result of state legislation,<sup>52</sup> the health and Medicaid (Human Services) departments in Minnesota conducted an inventory of REL health-related data they collect and consulted with a stakeholder workgroup to develop recommendations for improving REL data collection to ensure sufficient information to assess program outcomes and make policies to address health disparities.<sup>53</sup> The workgroup's data collection policy and communication recommendations were included in a 2011 report to the state legislature.<sup>54</sup> The workgroup recommended that it, or a similar entity, continue to meet. The Health Equity Learning Collaborative has energized the 40-member workgroup by giving it the concrete task of creating a consensus recommendation on the standardized collection of REL data for state health reform activities. Over the summer, the workgroup will present its recommendations to two broad entities guiding policymaking in the state: the Governor's Task Force on Health Reform (comprised of public and private sector representatives tasked with improving health and access, lowering costs, and addressing disparities) and the Health Insurance Exchange Task Force. The workgroup's recommendations include:<sup>55</sup>

- Health care organizations in Minnesota will collect data on race, ethnicity/tribal affiliation, and language, adhering to standards adopted by the state.
  - Additional data collection variables should represent factors that influence health, such as socioeconomic status and acculturation.
- A uniform coding structure should be developed to facilitate data exchange among health care organizations; and
- The workgroup will continue to define locally relevant categories for ethnicity and language and develop recommendations for the reporting and sharing of REL data with stakeholders.

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### *Connecticut*

In recognition that accurate and standardized data are crucial to identifying needs and prioritizing improvement, Connecticut's Office of Health Reform and Innovation (Office) is exploring options for collecting and utilizing REL from the state's all-payer claims database (APCD). Nine states have an APCD, and seven states, including Connecticut, are in the process of implementing one.<sup>56</sup> APCDs are a critical tool states use to generate comparable health care cost, quality and utilization information from all payers in a state. The data helps target areas for improvement by identifying variations; when public, the data also enable consumers and purchasers to compare cost and quality to make more informed decisions. As health care reform is implemented, APCDs will play an important role in the evaluation of key reform efforts seeking to address rising health care costs, increased access to care, and population health improvement.<sup>57</sup>

June 2012 legislation in Connecticut enables the Office to promulgate regulations for APCD data collection.<sup>58</sup> Office staff want to ensure that as the APCD is developed, it contains consistent REL data to inform health system improvement strategies and policy recommendations that address disparities and advance health equity. Connecticut has existing policies to draw from, specifically the public health department's data collection standards for race/ethnicity categories, which preceded the Affordable Care Act but are consistent with the Act's provisions related to REL data collection.<sup>59</sup> Office and public health staff are interested in exploring a statewide, cross-agency approach to improved REL data collection.

### **Cultural competency training for Medicaid providers**

In 2001, the U.S. Department of Health and Human Services' Office of Minority Health developed national standards for culturally and linguistically appropriate services (CLAS) in health care.<sup>60</sup> The 14 CLAS standards are relevant for all health care providers; they address culturally competent care, language access services, and organizational supports for cultural competence. Their purpose is to reduce disparities by helping organizations and providers respond to the cultural and linguistic needs of diverse populations. The standards include several guidelines as well as requirements for federal grantees.

### *Virginia*

As part of the Health Equity Learning Collaborative, Virginia has helped make CLAS standards information more available to family planning providers. As previously mentioned, Virginia Medicaid has a state plan amendment for a family planning program branded as *Plan First*. *Plan First* offers eligible men and women services to help prevent unplanned pregnancies.<sup>61</sup> Medicaid updated its *Plan First* provider trainings to include information on CLAS. When Medicaid conducted five face-to-face statewide trainings of family planning providers, it shared information from the health department's CLAS trainings to address and ensure cultural competency.<sup>62</sup> These trainings will ensure that as more consumers become eligible for services under the Medicaid expansion, their family planning providers will provide culturally appropriate and sensitive care.

### **Medicaid managed care contracting and education**

Participating states also have pursued strategies to recommend or require Medicaid managed care organizations (MCOs) to complete specific health equity responsibilities, which a number of states, including New Mexico and California currently do.<sup>63</sup> Additionally, states are providing health equity information to Medicaid MCOs. Through these strategies, the states hope to leverage coverage expansions to promote quality care and health equity.

### Ohio

Ohio has had mandatory managed care for Medicaid-eligible families and children since 2006; currently the state has contracts with seven MCOs. Ohio Medicaid (Department of Job and Family Services) reviews managed care plan contract (provider agreement) language a couple of times each year to determine if additional policies or clarifications are needed. The most recent review occurred in spring 2012. Ohio Health Equity team members met with contract staff and proposed the following of managed care organizations (MCOs):<sup>64</sup>

- Systematic collection of self-identified REL patient data;
- Better identification and management of groups known to experience health care disparities;
- Use of culturally appropriate materials by the workforce; and
- Establishment of and participation in a Medicaid Health Equity Workgroup that will regularly review managed care contracts, create and implement baseline data measures, and link MCOs to organizations that can help them develop culturally appropriate materials and implement effective solutions to decrease health disparities.

In addition to MCOs and Medicaid, the Health Equity Workgroup would include representatives of the health department and the Ohio Commission on Minority Health. The Medicaid agency is currently reviewing the recommended language; the team participating in this project hopes to have it finalized for implementation later this year to be effective with the next contract period (beginning January 2013).

### Virginia

This summer, Virginia's Chief Deputy for Public Health is scheduled to present to the Medicaid Managed Care Organization (MCO) Workgroup information regarding infant mortality and *Plan First* in the context of health equity. The workgroup is made up of executive administrators from the state's six contracted MCOs, and therefore provides an opportunity for the state to reach key partners to address racial and ethnic disparities in infant mortality. This presentation is another example of how public health and Medicaid agencies can collaborate to share information about existing racial and ethnic disparities in health status and health care and create opportunities to address them.

#### **Using Data to Engage Communities in Policy Development in New Mexico**

The New Mexico Department of Health has instituted a new model for health planning to create a common language across local, Tribal, regional and state policy. Referred to as *Turn the Curve*, this model for planning and decision-making provides a forum for the state and communities to work collaboratively to address mutually identified population health needs. As of May 2012, the Department had held four public *Turn the Curve* meetings across the state. Each meeting enabled marginalized community members to voice their most critical population health needs, provide a consensus vote on which health needs to address, and propose strategies to do so. The Department strategically used statewide disparities data to identify locations for the meetings as a way to empower disadvantaged community members to advocate for themselves in health policy and as part of the health system. The meetings resulted in a commitment to future collaborative work between the state and communities on data and policy improvement. Community feedback will inform the Department's 2013 Statewide Health Improvement Plan. New Mexico's use of disparities data to engage vulnerable communities in health and health policy planning is a strategy other states could use in a variety of topic areas to advance health equity.



**Recommendations based on state actions to advance health equity using quality and delivery system strategies**

Based on participating states' activities to advance health equity through quality improvement and delivery system reform strategies, the following recommendations emerged:

- Incorporate cultural competence, REL data and health equity considerations into health and medical homes through selection criteria, provider training, and/or consumer engagement;
- Where possible, establish standards for REL data collection and use in APCDs;
- Educate medical providers about cultural competency and link providers to existing resources that will help them deliver culturally-sensitive care;
- Use Medicaid purchasing and regulatory strategies to require or encourage managed care organizations and providers to address health disparities for high quality, patient-centered care; and
- Use Medicaid health plan or provider trainings and convenings to share tools and resources about disparities and health equity and ensure provider cultural competence.

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## SUSTAINING STATE EFFORTS TO ADVANCE HEALTH EQUITY

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**A**s a final step in this project, NASHP hosted an in-person meeting of state Health Equity Learning Collaborative team members and federal officials to provide a forum for sharing state and federal initiatives to advance health equity through health reform as well as the policy levers available at the state and federal levels to facilitate these efforts. The next day, state team members convened again to reflect on their experiences participating in the Collaborative and to identify action steps and promising state strategies for advancing health equity through health reform implementation. This section describes the themes that emerged from the meetings:

- Federal data and tools can inform and support state efforts;
- States play a crucial role in engaging communities that is not possible at the federal level;
- Cross-agency collaboration is key to advancing equity; and
- Framing health equity as an issue of quality, cost and justice is important in garnering widespread interest and taking advantage of the most opportunities to advance change.

### **FEDERAL DATA AND TOOLS TO SUPPORT STATE EFFORTS**

In addition to seeking out ACA grant opportunities, participating states have used other federal, non-ACA resources to support state-level action to advance health equity. Ohio's public health department, for example, regularly references data from the Agency for Healthcare Research and Quality (AHRQ)'s National Healthcare Disparities Reports and National Healthcare Quality Reports to provide a national context for the importance of improving health care quality and access, as well as to measure quality and access in Ohio relative to other states and the nation.<sup>65</sup> The AHRQ reports track measures to assess trends in health care quality (effectiveness, safety, timeliness, etc.) as well as access for vulnerable populations. To help other state agencies incorporate health equity into improvement and priority-setting efforts, the Ohio Commission on Minority Health cites as a template the goals and strategies recommended in the first *National Stakeholder Strategy for Achieving Health Equity*, published by the U.S. Department of Health and Human Services (HHS)' Office of Minority Health in 2011.<sup>66</sup> This type of information can be included in educational workshops for policymakers guiding health reform implementation to provide comparative information and establish or reinforce the importance of addressing racial and ethnic disparities in health status and health care.

Federal agencies are improving collaboration and weaving disparities reduction activities throughout their efforts, which likely will have a ripple effect in states. As a result of ACA, there are now (new) Offices of Minority Health in four HHS agencies: the Centers for Medicare & Medicaid Services (CMS); the Food and Drug Administration (FDA); the Health Resources and Services Administration (HRSA); and the Substance Abuse and Mental Health Services Administration (SAMHSA).<sup>67</sup> There also is a federal interagency group devoted to health equity, which includes the Departments of Justice, Labor and HHS.

During the meeting, states offered a few suggested federal actions or guidance that would support health equity efforts, including:

- Recommending or requiring health disparities metrics from state Medicaid agencies in order to draw federal matching funds for Medicaid;
- Providing guidance for how navigators will reach diverse and vulnerable populations through insurance exchanges and in Medicaid; and

- Referencing strategies to reduce racial and ethnic disparities (e.g., cultural competence, language assistance, outreach to or inclusion of diverse communities) in federal grants.

### **THE ROLE OF STATES IN FACILITATING COMMUNITY ENGAGEMENT**

Although states often look to federal agencies for guidance and leadership in health and health care reform, federal officials rely on states for assistance too. Meeting participants made clear that one critical piece of health reform that the federal government cannot do—community engagement and education—is an important part of advancing health equity. Federal agencies do not have the capacity (or experience) to reach out to local communities, and while local organizations and communities themselves have the most expertise and capacity in community engagement, state agencies are able to engage community members in policymaking and as part of stakeholder convening.

Several state minority health office officials noted that their offices' roles and responsibilities include community engagement; as such, they have existing networks of community leaders and representatives as well as mechanisms to engage communities (e.g., via newsletters or regular public meetings). State policymakers can facilitate the process of raising community awareness and educating the public about health reform and health equity. For example, the Arkansas State Health Equity Collaborative (ASHEC) is a coalition of stakeholders from multiple sectors who convene quarterly to examine issues of health equity within the state. Through the ASHEC, the state has been able to develop and distribute a monthly newsletter for the public highlighting information about health equity events and resources within the community, particularly as they relate to health reform.

Participating states emphasized the importance of a second level of engagement: engaging community members in the policy-making process, as evidenced in Minnesota's exchange planning. Community member insight and experience help shape the course of action to ensure programs and policies meet the needs of the public—those most directly affected by health and health care policy.

### **CROSS-AGENCY COLLABORATION**

During the in-person meeting, state team members from public health, minority health and Medicaid agencies emphasized the role of ongoing collaboration in moving forward policy recommendations and in raising internal and external awareness about health equity. Through regular meetings and communication, team members identified ways that they could help each other by pooling their respective expertise and drawing from existing resources. For example, a number of participating states used disparities data from public health departments to inform broader discussion of health reform policy (exchange development) and initiatives (medical homes), as well as Medicaid programs (enrollment, prioritization of outreach efforts). In Ohio, the collaboration of three high-level directors from the Minority Health Commission, Public Health Department and Medicaid agency was key to advancing recommendations for draft managed care contract language. This project provided the necessary forum for cross-agency collaboration to leverage internal expertise and resources to propose the language at the exact time of agency-wide review of contracts.

### **EQUITY AS A QUALITY, COST AND JUSTICE ISSUE**

Another theme that emerged from meeting discussion was the need to recognize that stakeholders come to the table to address health disparities for different reasons, using different terms, and it is important to “speak the language” of each. Whereas social justice and equality are key principles for minority health offices, efficiency and cost containment are paramount to Medicaid agencies. In times of budget cuts for public health and Medicaid, identification of potential cost savings (e.g., through improved preventive

care or avoided emergency department use) can be persuasive in making the case for investment in new strategies. Several state teams found that framing health equity as an issue of quality improvement helped garner interest and buy-in. For example, language pertaining to cultural competency or disparities reduction can fall under quality improvement responsibilities in managed care contracts or as part of medical home or ACO provider responsibilities.

State and federal agencies emphasized finding possibility and opportunity to advance health equity even when not explicitly referenced or required. At the federal level, the Center for Medicare and Medicaid Innovation (CMMI) has a statutory responsibility to address costs; there is no explicit reference to disparities reduction or advancing health equity in its mission or purpose. With the preponderance of evidence of the costs associated with disparities,<sup>68</sup> initiatives that seek to address disparities as part of cost containment efforts *would* fit with CMMI's mission. Interestingly, in July 2012, CMMI announced a new State Innovation Models (SIM) initiative to provide \$275 million in funding for selected states to test payment and service delivery models within the context of larger health system transformation. States that apply “are encouraged to include care models and interventions that aim to reduce health disparities and address the social, economic, and behavioral determinants of health.”<sup>69</sup>

## LESSONS

Several overarching lessons emerge from participating states' activities and experiences as part of the Health Equity Learning Collaborative:

- **Advancing health equity does not depend solely on ACA implementation, but ACA provides a unique platform to catalyze state efforts.** ACA's numerous provisions related to reduction of disparities in health and care offer rare opportunities to advance health equity. ACA has provided momentum in states where leadership is actively pursuing ACA-related grants and working to comply with the Act's provisions. At the same time, many of the policy levers participating states are leveraging—through regulation and purchasing, for example—are applicable regardless of the state's support for ACA.
- **Language matters: quality improvement, population health, public health systems change, and patient-centeredness all have health equity components.** Participating states' experience is that the work of advancing health equity requires collaboration among stakeholders and agency representatives who may seldom partner with each other, and who often speak in different terms because they operate in different environments. Defining and ensuring common understanding of terms such as health equity, health disparities, social determinants of health, and even community are a critical step. As one state official noted, it is equally important to understand the cultures of partners by identifying and finding a way to reflect back (and meet) their needs and priorities, be they economic, social, and/or moral. Policies and programs linked to quality improvement, population health, public health systems change, and patient-centeredness are just a few examples of opportunities to incorporate (and translate to) health equity.
- **State agencies would like more opportunities for peer-to-peer learning around issues of health equity.** Throughout this project, state teams have been encouraged to build collaborative partnerships across Medicaid, public health, and minority health agencies, as these offices share complementary goals. However, the momentum to collaborate on strategies to advance health equity can become difficult in the face of day-to-day commitments and competing priorities. State officials in this project expressed interest in continuing the relationships they formed through the Health Equity Learning Collaborative, and are eager to engage in similar opportunities to convene, especially in-person, around issues of health equity.
- **Participation in multi-state efforts helps legitimize efforts to advance health equity.** Prior to the start of this project, state teams participating in the learning collaborative were all in the process of addressing health equity in their states. However, several state team members agreed that developing a formal state team—one recognized as participating in a multi-state initiative—was an important step in legitimizing and furthering work to advance health equity in their states.
- **Communities need to be partners in policy development and implementation.** State teams repeatedly emphasized the need for an active community role in shaping, reviewing, recommending, and helping to implement health policy if it is to meet the needs of communities. Community-based organizations and consumer groups lead community engagement processes, but state officials can ensure community representatives and individual consumers (not just consumer advocates) are a part of health reform and other policy-making. Public health and minority health

departments often have existing networks and engagement strategies to assist sister state agencies.

- **Data are power, and states continue to work to improve data collection and use to advance health equity.** As one state official put it, “You cannot manage what you cannot measure.” Data analyses and tools such as GIS mapping can help identify populations and localities suffering from the greatest health disparities and inform prioritization of resources for navigators, health homes, and accountable care organizations. Participating states are at different stages of inventorying and analyzing REL data collection and use, and they are interested in using health equity measures and metrics to assess progress and create accountability for improvement. Other interests are sharing REL data between Medicaid and public health agencies, and incorporating data on social determinants of health into state disparities reports.

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## CONCLUSION

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The state teams participating in the Health Equity Learning Collaborative identified and pursued a number of strategies to advance health equity through health reform implementation. Through attention to issues of health care access, quality, efficiency, and population health and numerous provisions pertaining to disparities reduction, ACA provides momentum as well as resources to spur state and federal action in advancing health equity for racially, ethnically and linguistically diverse populations. The recent Supreme Court ruling enables the Health Equity Learning Collaborative states' improvement efforts to continue moving forward. With the ruling, all states now have critical decisions to make about the insurance exchange and Medicaid expansion, both of which are opportunities to address disparities in coverage. States can continue to advance change by leveraging their roles as regulators, purchasers, conveners, and data stewards. The strategies of the seven participating states offer examples of how policy makers can advance health equity using ACA and state-level policy levers. Participating states have integrated health equity into managed care contracts, provider trainings, medical home criteria, and data collection and sharing standards, all to ensure they meet the needs of diverse constituents, with the goal of improving health care quality and reducing costs.

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APPENDIX

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APPENDIX: HEALTH EQUITY LEARNING COLLABORATIVE  
IN-PERSON MEETING PARTICIPANTS

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**June 1, 2012, Washington, DC**

**Arkansas**

Marquita Little  
Assistant Director of Policy and Planning  
Arkansas Department of Human Services

Creshelle Nash  
Assistant Professor  
University of Arkansas for Medical Sciences

Michelle Smith  
Director, Office of Minority Health  
Arkansas Department of Health

**Connecticut**

Sylvia Gafford  
Executive Program Director  
Connecticut Department of Social Services

Margaret Hynes  
Senior Epidemiologist  
Connecticut Department of Public Health

Matthew Salner  
Policy Analyst  
State of Connecticut Office of Health Reform and  
Innovation

Raja Staggers-Hakim  
Executive Director  
Connecticut Commission on Health Equity

**Hawaii**

Christian (Kimo) Alameda  
Director, Office of Health Equity  
Hawaii Department of Health

David Sakamoto  
Deputy Director  
Hawaii Department of Health

Curtis Toma  
Medical Director  
Hawaii Medicaid

**Minnesota**

Jeanne Ayers  
Assistant Commissioner  
Minnesota Department of Health

Alfred Babington-Johnson  
President and CEO  
Stairstep Foundation

David Stroud  
Manager, Center for Health Statistics  
Minnesota Department of Health

Antonia Wilcoxon  
Disparities Reduction Consultant  
Minnesota Department of Human Services

**New Mexico**

Jeff Lara  
Region 4 Public Health Director  
New Mexico Department of Health

**Ohio**

Johnnie (Chip) Allen  
Director of Health Equity  
Ohio Department of Health

Angela Dawson  
Executive Director  
Ohio Commission on Minority Health

Carol Ware  
Senior Program Administrator  
Ohio Department of Job and Family Services

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**Virginia**

Ashley Harrell  
Supervisor, Division of Maternal and Child Health  
Virginia Department of Medical Assistance Services

Rebecca Mendoza  
Director, Division of Maternal and Child Health  
Virginia Department of Medical Assistance Services

Michael Royster  
Director, Office of Minority Health  
and Health Equity  
Virginia Department of Health

**Aetna**

Gillian Barclay  
Vice President  
Aetna Foundation

Melenie Magnotta  
Grants Manager  
Aetna Foundation

**NASHP**

Brittany Giles  
Research Assistant

Carrie Hanlon  
Program Manager

Diane Justice  
Senior Program Director

Amanda Richardson  
CDC Fellow

Jill Rosenthal  
Program Director

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