

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

Achieving health equity for the nation's racial and ethnic minority populations has become a priority at both the federal and state levels. State policymakers are in a prime position to utilize tools in the Affordable Care Act (ACA) to advance health equity for racial and ethnic minority populations. 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 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 *State Health Policy Briefing* is a summary of a report which examines the experiences of the Health Equity Learning Collaborative to highlight select ACA and state policy levers that can be used to advance health equity, opportunities for state and federal agency collaborations to strengthen these efforts, and important lessons and considerations for advancing health equity.

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Briefing

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State Policymakers' Guide for Advancing Health Equity Through Health Reform Implementation: 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.¹ The Patient Protection and Affordable Care Act (ACA)² 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. As addressing the health and health care needs of these populations has become an increasing concern at both the state and federal levels, 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.³

From October 2011 through June 2012, teams from 7 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 document summarizes a full report⁴ of the experiences of the Health Equity Learning Collaborative. It highlights 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.

STATE OPPORTUNITIES TO ADVANCE HEALTH EQUITY THROUGH HEALTH REFORM IMPLEMENTATION

There are several provisions and policy levers within the ACA that can be used to advance health equity for racial and ethnic minorities. Table 1 provides an overview of key ACA provisions that explicitly reference racial or ethnic minority populations, including:

- **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, and 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.

Figure 1: 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:⁵

- **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.⁶ 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 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.⁷

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"> Creates option to cover adults less than age 65 with incomes at or below 138% of the federal poverty level, including adults without custodial children From 2014-2016, offers states 100% FMAP (phasing down to 90% FMAP by 2020) for covering the newly eligible under the above option Sets new standards for simplifying health insurance eligibility and enrollment processes
	Insurance Exchanges (1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1324, 1411, 1412, 1413)	<ul style="list-style-type: none"> 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 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) Requires participating plans to provide certain health services (“essential health benefits”) for beneficiaries Requires participating plans to contract with providers that include community health centers and safety-net providers Requires exchange plans to develop consumer assistance Navigator programs that offer culturally and linguistically appropriate services
Quality and Delivery System Reform	Health Homes (2703)	<ul style="list-style-type: none"> Creates 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 condition⁸ Offers states 90% FMAP for 2 years for providing health home services (e.g., care management, care coordination, health promotion, referrals to community and social supports, and use of health information technology)⁹
	Center for Medicare and Medicaid Innovation (3021)	<ul style="list-style-type: none"> Creates a center designed to test health care payment and service delivery models that lower Medicare, Medicaid and CHIP spending, while maintaining or improving quality care¹⁰
	Accountable Care Organizations (ACOs) (3022, 10307)	<ul style="list-style-type: none"> Establishes the Medicare Shared Savings Program, 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
	Workforce Diversity (5402, 5404)	<ul style="list-style-type: none"> 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 settings¹¹
Data	Data Collection Standards (4302)	<ul style="list-style-type: none"> Requires all national population health surveys to include data on race, ethnicity, sex, primary language, and disability status¹² Requires data collected under a Medicaid or CHIP plan to meet the above standards Requires these data to be self-reported

Table 1: Select ACA Provisions that Can Advance Health Equity* (continued)

ACA Provision Topic and Section(s)		Brief Description
Population Health	Prevention and Public Health Fund (4002)	<ul style="list-style-type: none"> Establishes and allocates money for the Prevention and Public Health Fund to create a regular source of funding for programs addressing pressing public health priorities such as preventive health care and disease prevention
	Community Transformation Grants (4201)	<ul style="list-style-type: none"> Provides grants, supported by the Prevention and Public Health Fund, to help state and local agencies, nonprofit organizations, networks of community-based organizations, and Indian tribes engage communities in local chronic disease prevention strategies
	Community Health Centers and the Safety Net (5601, 10503, 2303) ¹³	<ul style="list-style-type: none"> Establishes the Health Center Program Expansion to expand operational capacity, improve existing facilities, and enhance health services Provides \$1.5 billion over the next five years to The National Health Service Corps to decrease primary care provider shortages in underserved communities Develops 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 Requires exchange health plans to contract with essential community providers (including safety net providers)¹⁴
	IRS Community Benefit (9007)	<ul style="list-style-type: none"> 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.

*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

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% of the federal poverty level or risk losing all federal Medicaid funding.¹⁵

THE NASHP STATE HEALTH EQUITY LEARNING COLLABORATIVE

In August 2011, NASHP solicited applications from states interested in participating in a Health Equity Learning Collaborative to receive assistance in simultaneously achieving health reform and health equity goals. State applications were assessed based on their ability to demonstrate commitment from Medicaid, public health, and minority health agencies to participate in a core project team; evidence of core team members' engagement in state health care reform efforts; evidence that the core team would establish feasible objectives for the eight-month project period; and evidence that participation would strengthen the states' (and inform other states') health equity and health reform agendas.

Based on the above criteria, NASHP selected Arkansas, Connecticut, Hawaii, Minnesota, New Mexico, Ohio, and Virginia to participate. Each state focused on three priorities during the eight-month technical assistance period of the Collaborative, 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.

Table 2: 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/advisory entities	✓	✓		✓					
Quality and Delivery System 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		✓	✓	✓		✓	✓	

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

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. States' actions to advance health equity relate to

health coverage and access, as well as quality of care and delivery system reform. Table 2 (above) provides an overview of states' actions in these areas.

STATE ACTION RELATED TO COVERAGE AND ACCESS

Participating states have taken steps to ensure that newly covered racial and ethnic minorities under the ACA Medicaid expansion and health insurance exchange have equitable

access to care. They are advancing health equity through exchange planning and leadership, consumer assistance and outreach, and by using data to inform insurance enrollment and service provisions.

- **Exchange planning and leadership.** Integrating health equity into insurance exchange planning first entails educating the 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. For example:
 - **Connecticut's** Office of Health Reform and Innovation is developing health equity training for its Health Insurance Exchange Board of Directors. 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.
 - **Minnesota's** Health Insurance Exchange Advisory Task Force devoted an entire meeting to the topic of health equity.¹⁶ Based on the information presented, the task force voted to commit to making each of its policy recommendations only after considering the impact on health disparities.
- **Consumer assistance and outreach in navigator programs.** **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. The Arkansas Insurance Department's Health Benefit Exchange Planning Division established a Consumer Advisory Committee and conducts consumer focus groups to develop outreach recommendations to reach diverse populations.
- **Data agreements and analysis to inform Medicaid enrollment and service provision.** Recently **Virginia's** health and Medicaid (Medical Assistance Services) departments entered into a data sharing agreement to evaluate and inform enrollment and service provision in *Plan First*, a family planning program within Medicaid. The health department analyzed *Plan First* data using geographic information systems (GIS) mapping and multi-level spatial analysis.¹⁷ With this information, Medicaid can more efficiently target *Plan First* outreach and program services to the communities with the most risk factors and highest need.

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

The following recommendations emerge 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

Participating states have also identified options for capitalizing on the health delivery reform and quality improvement components of ACA. This section highlights participating states' actions as part of health and medical homes, race/ethnicity/language data use, cultural competency training and managed care contract changes to integrate a health equity lens to ensure high-quality, equitable care for all.

- **Health and medical homes.** Like health homes authorized under ACA, the patient-centered medical home (PCMH) is an enhanced model of primary care that offers continuous, team-based, coordinated, high-quality, safe, and whole-person oriented care to patients, as well as a payment structure to support the necessary investments for this care by providers.¹⁸ 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. For example:
 - Collaboration between the **Ohio** Health Equity Learning Collaborative Team and the Ohio Office of Health Transformation led to the decision to target expansion of an existing PCMH model pilot in the state to health providers who primarily serve racial and ethnic minorities and underserved communities.¹⁹ The state

selected additional practices based on socioeconomic factors and racial and ethnic diversity.

- **Minnesota** developed and hosted a health equity educational session for medical home (known as “health care home”) providers as part of broad medical home provider training. The health equity workshop featured best practices in providing culturally competent care. It covered race/ethnicity/language data collection and use, and provision of patient and family-centered care for diverse populations.²⁰
- **Hawaii** integrated health equity into health and medical home planning through educational workshops and focus groups with racial and ethnic minorities. The workshops provided information about health care reform from a consumer perspective and described health and medical homes. The Hawaii Department of Health held focus groups with mental health consumers served by safety-net providers to solicit feedback about cultural needs and preferences for accessing health homes and ensuring quality service delivery.
- **REL data collection guidelines and recommendations.** Health Equity Learning Collaborative states all are invested in increasing the validity and use of race/ethnicity/language (REL) data to understand, assess, and improve quality of care for minorities. For example:
 - Through this project, **Minnesota** energized an existing REL data workgroup²¹ by giving it the task of creating a consensus recommendation on the standardized collection of REL data for state health reform activities. The workgroup will present its recommendations to two broad entities guiding the insurance exchange and overall health reform.
 - **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). June 2012 state legislation enables the Office to promulgate regulations for APCD data collection.²² Office staff wants to ensure that the APCD contains consistent REL data to inform policy recommendations that advance health equity.
- **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.²³ The 14 CLAS standards 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.
 - **Virginia** Medicaid updated its *Plan First* provider trainings to include information on CLAS. 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 have pursued strategies to recommend or require Medicaid managed care organizations (MCOs) to complete specific health equity responsibilities. They also are providing health equity information to Medicaid MCOs. For example:
 - **Ohio** Health Equity team members met with Medicaid (Department of Job and Family Services) managed care contract staff and proposed several changes to help advance health equity, e.g., that MCOs systematically collect self-identified REL patient data, and that a Medicaid Health Equity Workgroup be established to help MCOs implement solutions to decrease health disparities.²⁴
 - In summer 2012, **Virginia’s** Chief Deputy for Public Health is scheduled to present to the executive administrators from the state’s six contracted MCOs information regarding infant mortality and *Plan First* in the context of health equity. This provides an opportunity to reach key partners to address racial and ethnic disparities in infant mortality.

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 emerge:

- 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 MCOs and providers to address health disparities for high quality, patient-centered care; and
 - Use Medicaid health plan or provider trainings and convenings as an opportunity to share tools and resources about disparities and health equity and ensure provider cultural competence.
- **Cross-agency collaboration is key to advancing equity.** Team members from public health, minority health and Medicaid agencies emphasized the role of ongoing collaboration in moving forward policy recommendations and in raising awareness about health equity.
 - **Framing health equity as an issue of quality, cost and justice is important.** Doing so garners widespread interest and takes advantage of the most opportunities to advance change.

Overall lessons from 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.**
- **Language matters:** Quality improvement, population health, public health system 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 and use it to advance health equity.

LESSONS: SUSTAINING STATE EFFORTS TO ADVANCE HEALTH EQUITY

As 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 state and federal policy levers available to facilitate these efforts. State team members convened to reflect on their experiences in the Health Equity Learning Collaborative and to identify action steps and promising strategies for advancing health equity through health reform implementation. The themes from these meetings, as well as overall lessons from the Health Equity Learning Collaborative include:

Meeting themes:

- **Federal data and tools can inform and support state efforts.** States can include federal data and tools in educational workshops for policymakers guiding health reform implementation to provide comparative information and reinforce the importance of addressing racial and ethnic disparities in health status and health care.
- **States play a crucial role in engaging communities that is not possible at the federal level.** State policymakers can facilitate the process of raising community awareness and educating the public about health reform and health equity in ways the federal government cannot.

The Health Equity Learning Collaborative state teams 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 facilitates 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 that can address disparities; the strategies of participating states offer examples of how policymakers can advance health equity using ACA and state-level policy levers.

ENDNOTES

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NATIONAL ACADEMY for STATE HEALTH POLICY

About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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