Medicaid Medical Directors Network:
Perspectives on Health Disparities and State Strategies

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Overview and executive summary

Health disparities have been a global problem studied as early as 1840 in England. Edwin Chadwick conducted surveillance studies that demonstrated death differences among social classes in Liverpool, England. While the United States began to probe outcomes and patterns of health care delivered to defined populations, this body of work was not publicly attributed as an outcome of health disparities until 1984 when the U.S. Department of Human Services published the report, "Health, United States, 1983." This report revealed that while the overall health of the nation showed significant progress, major disparities existed in "the burden of death and illness experienced by blacks and other minority Americans as compared with the nation's population as a whole". Since 1983, health disparities have been researched to the present. Yet the nation is still grappling with how to effectively address them.

What we have learned is that population health outcomes are affected by more than traditional health care. In addition to health care, which needs to be high-quality and evidence-based, the federal government promotes the practice of reviewing all policies governing society. The purpose of the review is to identify and address inherent biases that promote health inequities resulting in sustained health disparities. This concept originated from the "Health in All Policies" (HiAP) framework, a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. This framework has been adopted by the Biden administration.

The impetus for this writing is to examine both long-studied health disparities and some of the solutions state Medicaid agencies are pursuing. Firm solutions to addressing health disparities exist, however, uptake of a number of solutions has been met with various barriers imposed by decisionmakers who have the authority to implement change. This paper reviews the levers Medicaid can use to address health disparities. These levers have been granted to state Medicaid agencies by federal authority. There are also strategies that can be employed by state Medicaid agencies in partnership with other state agencies and the communities Medicaid serves. The paper details a plethora of evidence-based solutions delayed in their implementation. It is the goal of this paper to highlight strategies that have been proven effective for consideration by Medicaid Directors, legislators, federal administrators, and other stakeholders. Such individuals may determine which strategies are viable, increase the uptake of proven plans of action, or initiate innovations that address health disparities in their own states.

Health disparities impact all Americans either directly or indirectly. The Kaiser Foundation Family study, "Disparities in Health and Health Care: 5 Key Questions and Answers," estimates that disparities amount to approximately $93 billion in excess medical care costs and $42 billion in lost productivity per year. Moreover, the study denotes additional economic losses due to premature deaths[1]. These costs are absorbed by all Americans through increased taxes, increased health premiums, and increased out-of-pocket health-related costs. Therefore, whether through a preventable drain on the nation's wealth and health systems or a failure to provide equitable health and opportunity to all, preventable health disparity is a public health crisis affecting all Americans.

Throughout the years, the federal government has provided strategies to states to promote health equity in the hope of decreasing health disparities. (Some of these strategies are later discussed in the paper). However, the United States continues to have a significant proportion of the population who experience health disparities. Barriers to progress include, but are not limited to, failure to address social determinants of health which contribute to preventable health disparities and a lack of implementation of evidence-based interventions.

About this Paper

This paper is informed by numerous discussions facilitated by the Medicaid Medical Director Network (MMDN). This paper reviews the levers Medicaid can use to address health disparities. It is intended to highlight strategies that have been proven effective for consideration by Medicaid Directors, legislators, federal administrators, and other stakeholders. It does not represent the position of any individual Medical Director or any one state, or its Medicaid agency. It serves to reflect the diversity of thought and opinion among MMDs on this subject. Every state is well-advised to consider its own unique population needs, geography, and challenges due to ever-changing environments.

The views expressed here do not necessarily reflect the views of AcademyHealth or any MMDN's supporting organizations.

While there remains considerable work to be done to remediate preventable health inequities, much has been learned about effective planning and actions targeted toward health inequity, thus disparities reduction. Success in states that achieved health disparities reduction was reliant upon data collection techniques that accurately identified sectors of the population experiencing inequities as well as disparities. Also, intentional efforts directed toward health disparities, community engagement in disparities reduction efforts, and identifying and working through legislative champions have contributed to improvements toward health equity and disparities reductions. To learn more, experiences of four states along their health equity journey can be found within the Appendix.

Introduction

The purpose of this writing is to propose effective solutions to progressively ameliorate and eventually eliminate avoidable health disparities. Section I discusses interventions taken by the federal government to address health equity and states' authority to address health equity. Section II covers federal partnerships that can be leveraged to progress health equity and reduce health disparities. Section III reviews innovations states have used to advance health equity through pilot programs, waivers, legislation, and/or other actions. Section IV provides an overview of suggested responses Medicaid agencies can initiate within their states to begin or continue work towards eliminating health disparities. To better understand Medicaid's role in addressing health disparities, however, it is important to briefly review the origins of health inequity and the resultant health disparities in the United States.

Background to health inequity and Medicaid

The societal concept of structural inequity is the foundation of all other disparities. The National Academy of Sciences, Engineering and Medicine, defines the concept: "Structural inequity is the personal, interpersonal, institutional, and systemic drivers—such as racism, sexism, classism, able-ism, xenophobia, and homophobia—that make those identities salient to the fair distribution of health opportunities and outcomes."[2] When considering health inequity, many continue to believe that medicine is apolitical and purely grounded in science; however, history and research reveal that medicine is inseparable from underlying laws, systems, and policies[3]. A conceptual example is the review of obesity programs in the United States. Studies find that the success of obesity programs targeted for people of color have been ineffective in demonstrating improvement and weight loss sustainability. A reason for this is that the structural barriers needed to promote and enhance weight loss are not addressed, e.g., a lack of green space and safe neighborhoods for walking to enhance physical activity. Structural barriers are consistent in many health conditions where disparities exist among different segments of the population.

Health equity, as published by the Office of Disease Prevention & Health Promotion (ODPHP) in Healthy People 2030, is the "attainment of the highest level of health for all people." Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities (ODPHP, 2021). Health inequity results in health disparities. Healthy People 2030 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" (ODPHP, 2021, Section 2, paragraph 1). Such disadvantages can be the result of systemic differences in the opportunities available to certain groups to achieve optimal health, leading to avoidable inequities in health outcomes (ODPHP, 2021, Section 2, paragraph 3). Health disparity is often linked with race; however, health disparities can negatively impact the health outcomes of any marginalized group of people including the disabled, females, or those whose geographic location, sexual orientation, and/or socioeconomic status differ from perceived norms.

Few efforts were taken to address structural inequities until the 1960s when movements to advance civil rights for marginalized groups were initiated. These movements include women's liberation, the Civil Rights Act of 1964, the Voting Rights Act of 1965, the Fair Housing Act, Title IX of the Education Amendments of 1972, and the Americans with Disabilities Act. Thus, disadvantaged populations began to gain traction for efforts toward equality. Specifically related to health, the Kerr-Mills Act (1960) provided a relatively simple, semi-automatic matching formula with no global cap that distributed health care payments based on the per capita income of each state. This Act served as the template for the passage of Medicaid legislation in 1965. However, although Medicaid has grown from a social program to a major insurer of Americans, many of the stigmas and biases associated with social programs have prevailed throughout the years. This linkage led to many states' medical assistance programs with budgets and resources that were not adequate to address inequity regarding health coverage compared to other health insurers, limited population access, and has resulted in lower priority when addressing quality of care.

Although health disparities directly impact marginalized populations, all Americans are impacted by health disparities. The inability of all to attain and maintain health impacts all Americans through taxation, federal laws and state health legislation. In addition to contributing to excess morbidity and mortality among racial/ethnic minority populations (~38.9% of the U.S. population)[4]; excess spending on health results in fewer available dollars for other needed commodities among all Americans. In 2020, the United States spent 19% of the country's expenditures on health consumption (up from 17% in 2019), whereas the next-highest comparable country (United Kingdom) devoted 13% of its GDP to health spending in

2022 (up from 10% in 2019)[5]. However, health care in the United States ranks lowest when compared to other developed countries on measures of access to care, administrative efficiency, equity, and healthcare outcomes[6]. A 2018 study by the William Keith Kellogg Foundation reports a potential economic gain of $135 billion per year if racial disparities in health were eliminated, including $93 billion in excess medical care costs and $42 billion in untapped productivity[7]. All Americans will benefit when structural inequalities responsible for health disparities are corrected.

Section I: Federal interventions targeted to address health equity

A number of the programs that support, or hinder, structural equity at the state level are designed, regulated, or administered at the federal level. In recognition of this, executive orders issued under the Biden Administration charged the Office of Management and Budget (OMB), in partnership with the heads of agencies, to identify effective methods for assessing whether agency policies and actions (e.g., programs, services, processes, and operations) equitably serve all eligible individuals and communities, particularly those who are currently and historically underserved by July 2021[8]. As part of this effort, federal agencies have been directed to consult with members of communities who have been historically underrepresented, underserved by or subject to discrimination regarding federal policies and programs, and to evaluate opportunities to increase coordination, communication, and engagement with community-based and civil rights organizations[9]. There are 18 federal agencies. Most are not directly responsible for health; however, the ability of all of our federal agencies to recognize their role in contributing to health equity is pivotal. For example, the Environmental Protection Agency, (EPA), while not directly responsible for the health of a community, has a responsibility to ensure that all are protected from poor air and other environmental factors that can affect one's health. While all agencies are currently accountable to perform the policy review described above, a few examples of agency partnerships that have been forged to address health equity are briefly described below.

The Equitable Data Work Group supports agencies to implement actions, consistent with applicable law and privacy interests, that expand and refine the data available to the Federal government to measure equity and capture the diversity of the American people.[10] Recognizing that many federal databases do not receive disaggregated data from states that assist in the identification and scope of disparities among marginalized groups, the administration has supported the development of the Data Equity Workgroup to better assist in advancing health equity.

Another example of federal agency promotion of health equity is the EPA. Within the auspices of the EPA, the Bipartisan Infrastructure Board has allocated billions of dollars to states, tribes, and territories for use intended for proactive lead line replacement programs with a particular focus on disadvantaged communities where the burden of adverse health consequences is significant.[11] These dollars may lead to less lead exposure and greater potential in learning among children living in disadvantaged communities. This section elucidates that health equity needs national support.

Section II: Federal partnerships and initiatives with states' use of universal authority through federal health policy

The Centers for Medicare & Medicaid Services (CMS) have undertaken initiatives to support health care quality improvement exclusive to Medicaid enrollees. CMS recognized "the full diversity of Medicaid beneficiaries is not reflected in many models to date", and that "Medicare-focused models have limited reach to Medicaid beneficiaries and safety net providers."[12] To this end, CMS intends to launch "more Medicaid-focused models and/or modify existing models to include additional Medicaid beneficiaries," and "ensure all beneficiaries have access to providers engaged in care transformation. These model designs are intended to address implicit bias, implementation, and evaluation," and to have "a more deliberate and consistent approach in quality measurement and evaluations to assess the impact of models on underserved populations and to close disparities in care and outcomes".

Moving toward this goal, CMS entered several multi-partner health disparity collaborations, including with other federal agencies, private and public sector entities, state partners and community-based organizations. To highlight the authority states possess to improve Medicaid effectiveness in meeting beneficiary needs, CMS issued a State Health Official letter to Medicaid Programs. The letter detailed alternatives that states may use to address housing, education, and food security. This information was offered with the goal of improving beneficiary health and reducing program costs.[13] Within the guidance provided, the following concepts were offered as reminders to state Medicaid officials engaged in planning improvement of their programs through addressing social determinants of health (SDoH):

1. Services must be based on individual assessment of need.
2. Medicaid is frequently, but not always, the payer of last resort. This means states need to assess other available public and private funding streams.
3. Utilization and payment must be consistent with efficiency, economy, and quality of care.
4. Services must be sufficient regarding amount, duration, and scope, to reasonably achieve their purposes.

CMS recommended states consider currently available authority methodologies and innovative strategies. Current strategies within the scope of states are:

1. State plan authority, including rehabilitative benefits, rural health clinics and federally qualified health centers, and case management.

2. Home-and Community-Based Services (HCBS) options, including 1915(c) waivers and 1915(i) and 1915(k) state plan options.
3. Section 1115 demonstrations, including addressing housing supports, home-delivered meals, and supported employment.
4. Section 1945 health homes.
5. Managed care programs, which states may encourage to use housing supports, home-delivered meals, and more.
6. Program of All-Inclusive Care for the Elderly (PACE).

Examples of several opportunities to create positive leverage for and among the states

National initiatives offer states and local communities a blueprint for identifying and implementing proven strategies to address, e.g., the Centers for Disease Control and Prevention's (CDC) "Health Impact in 5 Years (or HI-5 Initiative). The HI-5 initiative highlights non-clinical, community-wide approaches that have evidence reporting: 1) positive health impacts, 2) results within five years, and 3) cost effectiveness and/or cost savings over the lifetime of the population or earlier.[14] Within this initiative there are 14 evidence-based policies to improve population health. Two examples of these evidence-based initiatives are early childhood education programs and home improvement initiatives. The childhood education programs achieved a return on investment (ROI) that was higher when all benefit components, including earnings gains, were considered.[15] Home improvement loan and grant programs are intended to enable low-income homeowners to improve their living environment which inevitably has a positive impact upon health status.[16] Multiple systematic reviews and studies examining the evidence of the impact of home improvement interventions on health demonstrated improvement in health status, respiratory status, and mental health, and a reduction in primary care visits.[17] While state Medicaid agencies have no direct responsibility for education or housing, the impact these social determinants have upon health demand the attention of Medicaid agencies and state legislators to recognize the importance of addressing social factors as an integral component in population health improvement.

Creating standard measures

The lack of standardized, validated Social Determinants of Health (SDoH) measures is a major challenge in identifying and achieving measurable improvement in health equity. The CDC states, "Social determinants of health (SDOH) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes." In practice, SDoH refers to life circumstances that impact health adversely but are avoidable if all populations were afforded equitable opportunity for legal and social justice. Thus, SDoH includes, in many cases, avoidable and actionable circumstances.

Federal authority and support are essential to address the significant technical challenges related to SDoH data collection and sharing. The major difficulties identified by the Health Information and Management Systems Society in 2020 to collect SDoH are:

- Lack of standardization variables that define the social determinants of health and the appropriate screening tools to track these variables.
- Inconsistent data and measurement.
- Inadequate healthcare-based solutions for core problems such as access to care, poverty and food insecurity.

Many health practitioners can collect SDoH information but without consistent and standardized collection methodologies of SDoH, Medicaid programs are vulnerable to inaccuracies in assessing the prevalence of SDoH among Medicaid populations, in particular, historically under-resourced Medicaid populations. This lack of consistent measurement methodologies can lead to potential inaccuracies in both data-driven comparisons and outcomes analyses. CMS' influence in creating a standard template for use in SDoH data collection may assist in establishing a minimal set of SDoH required data. Collaboration between CMS and CDC could create a template for a minimal SDoH dataset. CMS, in partnership with the Office of the National Coordinator (ONC), can drive standardization regarding data collection efforts and analytic methodologies to assess measurement by all serving Medicaid, including but not limited to, health plans, health systems, and Electronic Medical Records (EMR) vendors. Moreover, there are few EMRs with actionable options related to a given SDoH. The ONC and CMS can take steps to ensure that EMR vendors enable not only identification of SDoH but implement orders and referrals related to a given SDoH. The federal government has limited ability at this point to affect purchasing of specific EMRs but does have the capability to promote or require reporting on SDoH elements that health systems and providers must have, thus driving the modifications that existing or new purchasers will demand.

As Spencer et al. have noted, "In the absence of uniform collecting and reporting methodologies, the capacity for state agencies, plans, and providers to share data and use SDoH to develop targeted strategies, guide care planning, and make referrals is limited".[18] Synchrony among electronic health systems allows agility in identifying state disparities. This information can be aggregated at the national level to enhance Medicaid programs' ability to identify state opportunities compared with their peers and to share intervention strategies that have proven effective throughout the beneficiary population or with specific marginalized Medicaid subpopulations.

As data collection with an SDoH minimal dataset evolves, existing tools such as PRAPARE or Health Leads Screening Toolkit can be used to expand the SDoH minimal dataset since these tools include information for the domains of economic stability, education, health and health care, neighborhood and built environments, and social community contexts.[19] CMS in partnership with the federal Office of Minority Health could work collaboratively to analyze state SDoH data and allow state end users to have confidence in the comparability of inter-and-intrastate data findings. Since many states lack the analytical systems and resources to perform this work themselves, federal partnership in the performance of data analyses may be of great benefit to states.

Facilitation of collective state data sharing action to address health disparities

In addition to the Equitable Data Work Group previously discussed, other data sharing initiatives have been undertaken to advance health equity. Within the Department of Health and Human Services (HHS), the CDC maintains databases that contain SDoH information. For example, the Compendium of Federal Datasets Addressing Health Disparities is a robust database containing multiple levels of governmental data that is intended to encourage intersectoral collaboration across federal agencies to better address health disparities. [20] The data within the Compendium serves as a resource to identify the relationship between socioeconomic factors, SDoH, and health equity. This new Compendium includes descriptions of over 250 databases from HHS and nine other Departments/federal partners, information on data sources relevant to opioid use/research, and information on datasets with more controlled access.[21] Among the intended users of the Compendium are health researchers, program evaluators, grant writers, health officials, and other public health officials. Data produced from the Compendium can be used to obtain evidence-based information to target interventions that improve health and wellness and identify opportunities for collaboration between these users and state Medicaid agencies. These interventions can ultimately lead to development of more effective programs, policies, and practices. An example of how the Equitable Data Work Group supports the research in health disparities is the support that CMS' OMH is providing for several investigators to gain access to CMS-restricted data for minority health research. These data facilitate health services research focused on, but not limited to, minoritized populations, including those based on race, ethnicity, language, sexual orientation, gender identity, and disability status. This information can be critical to state Medicaid agencies to most effectively identify and target health disparities among the Medicaid beneficiaries, and more specifically, among marginalized populations within Medicaid.

Health equity collaboratives

CMS and other federal agencies have supported several national collaboratives in health care. Specific to health equity, the Interdepartmental Health Equity Collaborative (IHEC) represents a national collaborative that is sponsored by any federal agency and OMH. The collaborative fosters a community of stakeholders engaged in addressing health disparities and SDoH by building capacity for equitable policies, programs, and practices, promoting strategic partnerships, and sharing relevant models for action.[22] As health disparities are frequently present among populations served by Medicaid, participation among state Medicaid agencies is appropriate, yet there are currently no state Medicaid agencies represented in this collaborative effort. Sharing the data developed by the data workgroup of the IHEC could be especially beneficial for state Medicaid programs since many of the federal agencies that have a role in creating policies that ensure health equity are represented in the workgroup.

Another example of a national collaborative is the Health Opportunity and Equity (HOPE) initiative. HOPE is an interactive data-driven initiative designed to help communities and states move from data collection to execution of initiatives targeted to address disparities. HOPE data identifies locations throughout the country where residents in individual states are doing well and where states can do more to help residents become healthier. In doing so, three important factors are noted that help state and federal leaders, advocates, and other stakeholders shape policies and practices: 1) identifying gaps in opportunity among people of different races and ethnicities; 2) targeting goals that are based on averages of top performing groups, and 3) reviewing the difference between the HOPE goal and the baseline rate of an indicator for a particular population. Using this data resource, states can crosswalk identified disparities with Medicaid policies and processes that are contributing to sustained disparities and work to revise or ameliorate such practices to advance the reduction of avoidable health disparities. Federally initiated collaboratives can help state Medicaid programs effectively target and implement interventions for disadvantaged populations impacted most by the identified disparities, learn from other states, create a collective data, implementation, and policy approach, and transform this knowledge into the strategies necessary to remediate identified disparities.

Value-based opportunities

On September 15, 2020, CMS issued guidance to advance the adoption of value-based care strategies across healthcare systems and align provider incentives across payers to state Medicaid directors. CMS provided authority for these value-based care arrangements to address SDoH and other disparities across the health care system. To this end, CMS' support for innovative Value-Based Purchasing (VBP) models can promote efforts to address health disparities. One such VBP initiative is the Accountable Health Community (AHC) Model. Some state Medicaid programs have begun to utilize this strategy to incentivize health systems and providers to improve health outcomes, while also providing high quality and more efficient care. For example, CMS' AHC model is a currently existing framework that allows states to better identify the role that SDoH plays in the proliferation of health disparities. In these AHC models, the clinical workforce is connected to community bridge organizations that screen, identify, refer, and perform follow-up of beneficiaries who have SDoH challenges that impede their health attainment journey. CMS funding for these models supports the infrastructure and staffing needs of the bridge organizations.

Diabetes has drawn the attention of CMS as a favorable medical condition for VBP. CMS has hospital-based VBP programs for diabetes as well as a merit-based incentive payment system (MIPS) for clinicians servicing Medicare beneficiaries. While Medicare-insureds are the target population, state Medicaid directors can utilize the CMS guidance resource for developing VBP programs to work with their Managed Care Organization (MCO) and other health partners to develop VBP programs for Medicaid beneficiaries. One example of a state VBP program is the Louisiana VBP program. It requires MCOs to evaluate performance measures across race, geography, and disability parameters. Michigan requires its MCOs to describe their VBP strategies' impacts upon plan-specific health equity measures and report on the effectiveness of evidence-based interventions across a variety of social determinant parameters. In addition to the clinical measures, the VBP measures can include culturally tailored indicators to assess the impact of culturally adept programs relative to improvement in diabetes clinical and self-management. Of particular interest is the difference, if any, between models that use community health workers versus other traditional health workers who have received cultural humility training.

Avoidable admissions and readmissions within 30 days of hospital discharge are more likely to occur in minoritized populations. States can use the CMS *Guide to Reducing Disparities in Readmissions* as a resource. This guide can be used to facilitate collaboration across Medicaid agencies and their health partners, including but not limited to MCOs, hospitals, and community health agencies. Collaboration can identify root causes for readmissions and conduct further analyses to detect trends in subpopulations that lead to readmission disparities.[23]

CMS and other federal agencies have provided several methods for states to use universal authority to address health inequities and improve health disparities. Now is the time for states to utilize this authority in collaboration with CMS to improve health disparities. However, recent evaluations of several CMS models have illustrated the limitations VBP models face if implicit biases are not addressed from the beginning of their design. These reflections on VBP models' past and potential future demonstrate the need for an equity lens to be applied to all interventions, no matter how well intentioned. For innovative initiatives that require actions not granted under universal authority, state Medicaid programs have options such as state plan amendments and pilot programs to deploy innovative ideas to address health disparities.

Section III: State innovations used to advance health equity through pilot programs, waivers, and/or other actions such as legislation

As is well known, Medicaid serves people with complex clinical, behavioral health, and social needs facing challenging and persistent health disparities. Throughout the tenure of Medicaid, these populations have experienced poorer health outcomes compared to other insured populations. For years, these poor health outcomes were attributed to poor quality of care and/or lack of patient adherence. Quality of care and patient adherence are instrumental in achieving desirable patient health outcomes. However, research has demonstrated that health inequities among disadvantaged populations significantly contribute to the development of health disparities.[24] Social determinants and health inequities such as disparities in education and adequate income are linked and compounded by many factors beyond the traditional scope of Medicaid programs. CMS regulations have traditionally restricted state Medicaid programs from funding efforts that support SDoH issues; for example, housing. This section reviews the expansion of current federal programs, individual state innovative efforts, specific state initiatives that address health disparities, and federal waiver demonstrations.

State intra-agency collaboration and partnerships

On January 7, 2021, CMS issued an official letter encouraging states to utilize the federal authority provided and state innovative methods to enhance health equity and reduce health disparities. To accomplish these objectives, all involved need an all-hands-on deck approach. That is, all state agencies providing goods and/or services necessary to obtain and maintain optimal health are required to be engaged. Many of the disparities originate due to lack of available resources. However, sharing information across all involved is required to assure accuracy in estimating and fulfilling needs. As a strategy to address the complexity of needs, some states have developed committees with multiple agencies to specifically address equity from a multifaceted perspective. Agencies traditionally not included in matters of health such as housing and small business have been summoned, as well. Some state agencies have also educated employees about equity goals to create a common understanding of the state's Medicaid's mission toward health equity. For example, the Office of Equity and Inclusion (OEI), formed by Virginia's Department of Medical Assistance Services (DMAS) in 2021, formalized various health equity initiatives taking place throughout the agency. Since its formation, OEI has undertaken a number of projects: improving member communications by operationalizing the agency's Language and Disability Access Plan, providing feedback on policies regarding accreditation standards developed by the National Committee for Quality Assurance (NCQA), and conducting training that addresses cultural competency and nondiscrimination.

Enhancing the ability of the health care workforce to meet the needs of disadvantaged populations

Supporting the health care workforce involves at least three elements: 1) educating the workforce on equity and their crucial role in addressing equality, 2) providing accessible resources from the state and community to assist in improving problems, and 3) providing reimbursement to agencies that create and sustain systems for specific high-priority initiatives. To educate the workforce for the tasks ahead, it is essential to identify champions from the practicing community to be integral partners in the effort. Academic institutions have roles in shaping a diverse workforce in institutional and community settings. Effective resources reviewed and approved by community health leaders are more likely to reflect culturally appropriate and community-focused comprehensive educational materials. These resources, once developed, require review and consensus of clinical accuracy as well as cultural appropriateness for the communities served. Evaluation of patient learning materials should be planned post-implementation to assess their impact on served communities serves and their overall utility. Collaboration of state Medicaid agencies with health professional education programs can be a strategy to prepare students for diversity and equity training. Students' exposure to such collaboration will raise their consciousness of their role to identify potential health disparities and SDoH limitations as they interact with patients.

Effective strategies to address health disparities also call for clinician involvement. Reimbursement strategies for the efforts clinicians employ to identify and address disparities need to be recognized as an important component of clinician effectiveness. Collaboration among Medicaid agencies, MCOs, and provider networks help to establish reimbursement strategies that support effective interventions needed to successfully address disparities. Many clinicians in practice (health systems as well as private practice) have little support for social interventions or referral to other resources needed to address social inequity. This lack of support often results in significant challenges for clinicians in screening for and addressing patient social issues, although they may be aware of barriers impacting the patient's health status. It is not unusual that a patient discloses to a clinician that the home electricity is turned off. This situation is serious for a patient taking insulin or other medications that require refrigeration. Ensuring that clinicians are aware of and have support to address SDoH barriers is an important component for success in addressing health disparities. It is also important for Medicaid agencies and MCOs to consider the work and expense incurred by the clinician to appropriately perform their role in addressing health disparities. Medicaid has a special challenge in assuring that health system partners are aware of their role to address health disparities and to fully support clinicians in this process.

Additionally, Medicaid programs need to consider the demonstrated effectiveness of non-traditional health care workers and consider support for their adequate reimbursement. Several randomized trials of the Penn Center for Community Health Workers' IMPaCT model, which employs Community Health Workers/Promotores (CHW/P) for high-risk patients, demonstrated improvements in chronic disease control and mental health status resulting in a two-to -one ROI made by payers (Health Leads, 2018). The University of New Mexico Health Sciences Center and Molina Healthcare of New Mexico worked with a nonprofit consortium of health care organizations to employ CHW/Ps to engage with high-cost beneficiaries. An evaluation showed reduced emergency department and inpatient utilization and substantial cost savings.[25] Analyses of numerous other studies in the United States and internationally demonstrate that employing CHW/Ps offers the potential to reduce care utilization and realize cost savings.[26] These workers include among others, health navigators, community navigators, and social workers who provide outreach, peer support, and coordination of services. These measures have resulted in greater trust among communities and a cultural synchrony of shared lived experiences. Metrics to demonstrate the effectiveness of non-traditional health workers are often not present but need to be. The ability to demonstrate the effectiveness of this category of worker may help garner state support for these necessary resources. Medicaid agencies working with their MCOs to reward and incentivize practitioner work for quality outcomes can include such metrics in their VBP strategies. A 2022 Medicaid and CHIP Payment and Access Commission (MACPAC) brief found that 21 states currently authorize Medicaid payment for a variety of CHW services and details a number of avenues states can take to implement or bolster the availability of CHWs and other non-traditional health care workers for Medicaid beneficiaries.

Data needed to understand health disparities

Medicaid agencies need to determine the data that is required to understand the health disparities among Medicaid beneficiaries. Specific focus needs to be on the drivers of disparity indices in general and marginalized populations in particular. A consensus among Medicaid programs regarding a suite of SDoH measures that identify potential disparities could be beneficial in providing a benchmark or "apples to apples" comparison of the impact of disparities among and within states. State Medicaid leaders may want to solicit the support of CMS for state collection of these metrics and stratification of data by Race/Ethnicity/Language (REL) criteria. In support of the collection of this data, Medicaid, in collaboration with CMS, may consider developing an educational resource for new beneficiaries as part of an information packet that explains the importance of collecting the REL information. The packet will explain how the information is used to better understand the needs of all populations served by the state's Medicaid program.

Currently, there are no standard measures for assessing performance toward improving health disparities. If these metrics were available, they could form a foundation for accountability and transparency in addressing health disparities.[27] As with most improvement efforts, quantitative and qualitative metrics are needed to provide a comprehensive view of "among whom" and potentially where in the state disparities are occurring. Medicaid agencies can also request CMS to work with the ONC to require interoperability of electronic medical record platforms with the ONC data structure interfaces. National interoperability of data structures enhances the effectiveness and efficiency of data collection and may help leverage federal support to states relative to disparity data analytics.

Evaluation of disparity interventions and implementation science

Collectively pursuing an overall focus on the environment, in both ecological and societal contexts, should focus efforts on where the disparities-impacted population lives, works, and communes.[28] Although there have been improvements in medical care and disease prevention, the slow progress in appreciably addressing health disparities may be attributed to the lack of integration of evidence related to the role of ecological and sociological contexts. Studies have demonstrated the impact of early childhood education programs upon improved health in childhood and transcended into healthier adulthood.[29] A 2008 study conducted in Washington State demonstrated that a home visiting program targeting low-income, first-time mothers resulted in a long-term net benefit savings of approximately $18,054 per participant. Diverse forms of housing initiatives have demonstrated improved health outcomes, less risky behaviors, and improved mental health, among other benefits. While many of the interventions are not within the scope of state Medicaid assistance programs, experience has demonstrated that effective, sustainable health disparity remedies are not possible without the consideration and inclusion of these social health determinants in the strategies to remedy health disparities. Thus, Medicaid agencies need to become advocates and wherever possible, active collaborators with other state agencies and community advocates for improvements that address social determinants of health. Supporting the uptake and dissemination of implementation strategies is critical to reduce disparity gaps. Although considered a nontraditional role for Medicaid, participation in the implementation phase of disparity initiatives is an important role for Medicaid programs going forward. Medicaid is a resource to ensure that the implementation phase of initiatives includes representative stakeholders of the population of focus and other stakeholders whose services, processes, or policies are integral to the disparity reduction. Kerkoff et al., offer four recommendations for the implementation phase of a study. Medicaid agencies can have a role in oversight or as an active participant to ensure these steps are included in implementation planning and/or actual implementation.[30]

1. Identify important stakeholders related to equity and establish roles for partners throughout the implementation process.
2. Include equity-related considerations when deciding which intervention(s) to implement and de-implement.
3. Evaluate the performance gap related to the intervention or program of interest in vulnerable populations.
4. Identify and prioritize barriers faced by vulnerable populations—including structural racism and power dynamics

Inclusion of these processes into the pre-implementation planning as well as the actual implementation intervention(s) helps to ensure generalized outcomes to the target population.

Section IV: Strategies to promote reductions in health inequities and disparities

Throughout this paper, strategies have been suggested that can be employed to reduce health inequities that could lead to the reduction of health disparities. This final section summarizes the strategies which have the potential to improve health care when individual states put them into practice.

Eligibility and enrollment

Medicaid eligibility and enrollment decrease barriers to healthcare access. However, the ability to sustain healthcare coverage can be adversely impacted by states' Medicaid coverage policies. State-directed benefit thresholds reviewed with a health equity lens may reveal implicit bias in eligibility rules. Addressing these policies could move states closer to eliminating disparities in health care access (e.g., states pursuing 12 months of postpartum coverage, post-delivery for women). Other stakeholders are seeking various durations of continuous enrollment for newborns/children, to promote infant-child wellness and school readiness.[31] Employing community-based culturally sensitive workers to explain enrollment and eligibility processes and benefits may also enhance enrollee comprehension of the program, assist in navigation of complex enrollment requirements, and prevent disparate systemic disenrollment. Additionally, flexibility of programs that support employment without risk of eligibility loss during periods of transition can foster independence and ensure continued access to care.

Coverage determination strategies to enhance health inequity to improve health disparities

State Medicaid programs should also look at current policies to determine how they could be contributing to health disparities. For example, reviewing policy decisions related to coverage determinations with an equity lens may unmask decisions that have inherent biases contributing to health inequities and resultant health disparities. Following the Biden's administration's "health in all policies" concept, coverage determination policies can represent barriers that prohibit the coverage of adjunctive care or supports needed for health improvement. While acknowledging that Medicaid programs have regulations that limit coverage of adjunctive care needs, Medicaid agencies can use multiple levers like value-based and managed care contracting to provide needed benefits that are not directly covered by Medicaid. States can also use State Plan amendments and waivers as levers to accelerate adoption of innovation in coverage strategies to enhance equitable care to beneficiaries. CMS recently approved Missouri's state plan amendment that adds coverage of the routine patient costs associated with participation in clinical trials as outlined in Section 1905(gg) in the Social Security Act for the population currently served in Missouri's Alternative Benefit Plan (ABP). States can also use waivers as a methodology to accelerate innovative strategies that promote health equity and reduce disparities. Alabama, like many other states, used American Rescue Plan Act funding for expansion of telehealth services with the purpose of increasing access to care. Recognition that coverage determinations impact health equity, thus health disparities, is a critical factor towards health improvement for traditionally marginalized populations of the United States.

Data collection needs to reduce health disparities

As previously discussed, there are several shared resources available for states without dedicated resources to analyze data to identify disparities. However, it is of utmost importance for states to consistently and completely collect data that includes information regarding beneficiary demographics. In 2020, CMS classified 14 states' Medicaid race and ethnicity data as "high concern" because more than 20 percent of the data was missing. An additional five states with more than 50 percent of their data missing were classified as unusable.[32] States must have systems to allow the integration of demographic data with SDoH data. Several strategies can be used to collect SDoH data and are discussed above.

Measurement

The field of health equity metrics is in a fledgling phase of development. A recent review of health equity measurement revealed numerous potential approaches that may be adopted to objectively monitor health equity performance. However, to begin to assess the impact of interventions targeted to address health equity, a set of universally used measures is needed. As previously noted, such uniformity could assist in benchmarking to ensure "apples to apples" comparisons and dissemination of successful interventions for marginalized populations having similar characteristics. States have a variety of strategies that can be used to encourage practitioners, healthcare partners, and community-based organizations to assist in the collection of data for measurement. States can also avail themselves of federal tools—complete data regarding indices such as race, geographic indicators for residence, ethnicity, language, disability, sexual orientation, and gender identity. Additional federal tools include data collections on social factors like socioeconomic status, housing instability, and food insecurity. Federally based input is needed to obtain adequate information to identify affected marginalized populations who may be subject to inequities. Combined with health data, this information can identify health disparities and those populations most disadvantaged by inequities.

Payment methodologies

Adequate reimbursement is critical to the sustained participation of clinicians and health systems in identifying and addressing health inequities. Many Medicaid programs use VBP programs as a means to reward practitioners for the delivery of high-quality care. Health equity measures are increasingly being considered for inclusion as VBP measures. State programs have also used incentive programs to improve care and address disparities. Examples of some payment strategies include Oregon's Office of Minority Health identification of a "disparity measure" to evaluate emergency department utilization for mental illness for inclusion in its incentive program for coordinated care organizations.[33] In 2013, Minnesota operationalized the Integrated Health Partnerships model (IHP) which is an ACO model of care within the Medicaid Program. Participating practitioners receive population-based payments for care coordination and are required to design an intervention to address specific health care disparities observed in the IHP's population. For states exploring alternative payment strategies that encourage the provision of optimal care, including SDoH assessments, there is a resource guide, published by the Health Care Learning and Payment Network.

Conclusion

The historical origin of health inequity is complex and rooted in the infrastructure of the United States. Although effectively addressing health inequities and disparities has been a slow process, federal and state governments acknowledge the necessity of change. Medicaid must assume the role of lead collaborator across many state agencies to ensure the needs of beneficiaries are accurately considered across operations in other state agencies. To adequately understand the needs of beneficiaries, Medicaid agencies must ensure the collection of relevant data needed to identify marginalized groups who may be most impacted. This will allow focused interventions for the most disadvantaged populations. Critically, the populations directly impacted by the inequity must be given space and power to contribute to solutions.

This work is therefore a primer on the problem, history, available tools, and strategies that Medicaid agencies may consider when they address health inequities. The authors of this discussion have clearly argued that work to reduce health disparities is continual and all-encompassing. Every state agency has a role to address health inequities. While Medicaid is responsible for coverage of care, the complexities of care require many other "fixes" that are not seen as components of traditional health care. However, we have learned from almost 40 years of study that these social determinants of health must be addressed if inequities are to be eliminated and that elimination of health inequities benefits everyone.

Finally, the writers have included an appendix that features four states in various phases of measuring and addressing health inequities to narrow health disparities. The states presented in the appendix include Connecticut, Minnesota, Oregon, and Texas. These vignettes provide tangible examples of actual strategies and/or interventions that a diverse group of states have taken to tackle the formidable challenges of health disparities present in Medicaid agencies.

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About the Medicaid Medical Directors Network (MMDN)

The MMDN seeks to advance more equitable, high-quality, accessible healthcare for all Medicaid beneficiaries by providing a forum for senior clinical leaders to discuss their most pressing needs and evidence-based solutions. As the professional home of the MMDN, AcademyHealth maintains a strategic partnership with more than 40 state Medicaid Medical Directors (MMDs) – committed to participating in multi-state data projects on pressing policy topics, hosting yearly convenings, and leveraging their collective experience to bolster both state and national Medicaid program initiatives. With support from several partner organizations including the Agency for Healthcare Research and Quality (AHRQ), the Patient Centered Outcomes Research Institute (PCORI), and the Centers for Disease Control and Prevention (CDC), the MMDN is committed to synthesizing and disseminating relevant findings to policymakers in a timely and translatable manner.

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APPENDIX

Interviews with Connecticut, Texas, Minnesota, and Oregon: States evolutions on the journey toward improving health disparities

Connecticut: Early exploration in health disparities

In Connecticut, the Department of Public Health (DPH) has a primary role to address health disparities. It is noteworthy that Medicaid works collaboratively with DPH and other state agencies to help identify and reduce disparities. Medicaid is working with practitioners to include the collection of race, ethnicity, and language (REL) preferenceas a standard routine practice. This data will be linked with data from sister agencies to help identify disparities and to which subgroups the inequities are occurring. Administered by the Connecticut Department of Social Services (DSS), Medicaid has not made changes to Medicaid processes to reduce disparities. Rather, Medicaid has used a variety of mechanisms to promote health equity in attempts to reduce disparities. A Medicaid state plan amendment allowed extension of the postpartum period from 60 days to 12 months post-delivery to individuals who have incomes up to 263% of the federal poverty level (FPL). This postpartum extension applies to citizens and qualified non-citizens. A qualified non-citizen must meet one of the following criteria:

- U.S. permanent resident, with Permanent Resident Card (formerly known as an Alien Registration Receipt Card or “Green Card”)
- Conditional permanent resident (I-551C)
- Other eligible noncitizen with an Arrival-Departure Record (I-94) from the Department of Homeland Security showing any one of the following designations: “Refugee,” “Asylum Granted,” “Indefinite Parole,” “Humanitarian Parole,” or “Cuban-Haitian Entrant”
- A citizen of the Republic of Palau (PW), the Republic of the Marshall Islands (MH), or the Federated States of Micronesia (FM).

DSS submitted an 1115 Demonstration Waiver to fully subsidize the remaining premium and out-of-pocket costs for individuals enrolled in the silver benchmark plan from a Qualified Health Plan (QHP) offered by Access Health, Connecticut’s marketplace health insurance program. Working with state legislatures, DSS secured funding for undocumented individuals for 12-month postpartum coverage as well as health coverage for non-qualifying undocumented children up to 12 years of age whose family income does not exceed 323% FPL.

Medicaid is an active participant in agencies that collaborate to address health disparities. The program participates in the Office of Health Strategy with DPH and the Transparency Council of Medicaid Cost and Quality. One of the primary purposes of this group is to ensure that the Advisory Board reflects the diverse breadth and scope of the members and providers who participate in HUSKY Health. The group includes individuals with technical expertise relevant to the Department’s cost and quality transparency strategy. Medicaid is involved in the development and implementation of equity measures. The Office of Health Strategy (OHS) has selected measures in its Core Measure Set that will report performance by REL. OHS developed this measure in partnership with the Quality Council, a stakeholder body of payers, providers, state agencies, and consumer representatives. OHS prioritized stratification of measures in the Core Measure Set that show evidence of disparities in performance by REL in Connecticut. These inequities are required to be stratified for reporting to the National Committee for Quality Assurance (NCQA).

Lessons Learned from Connecticut:

1. Long term collaboration with state agencies and legislatures is necessary to achieve successful strategies that address disparities.
2. Disaggregated data is necessary to unmask disparities that are not readily apparent.
3. Select equity measures, whenever possible, that satisfy multiple requirements and involve community representatives in the measure selection process.

Texas: A state in the early stages of SDoH indicators for Medicaid population improvement

Much of the work in Texas has been performed by its External Quality Review Organization (EQRO) pursuant to the state's submission of its plan to sustain health programs for vulnerable populations. The work began after federal payments from the Delivery System Reform Incentive Payment (DSRIP) program stopped in September 2021. In March 2021, the EQRO published The Assessment of Social Factors Impacting Health Care Quality in Texas Medicaid. The document details the correlation of the impact of social factors with health outcomes for beneficiaries enrolled in three Texas Medicaid Programs (children ages 19 or younger, pregnant women, adults with disabilities and/or adults greater than 65 years of age. The findings from the study are positioned to inform possible new program proposals, policy changes, and strategies for quality improvement related to SDoH. The major finding from the study was that SDoH factors were better predictors of numerator compliance for certain quality outcomes rather than demographic variables used alone.

However, in identifying the most vulnerable Medicaid populations for Covid intervention, the Texas Health and Human Services Commission used a combination of federal and state data including Texas Department of State Health Services (DSHS) COVID-19 dashboard, the U.S. Census Bureau, the Texas Demographic Center, the Texas Workforce Commission, the Centers for Disease Control, Prevention's Social Vulnerability Index (SVI), and County Health Rankings and Roadmaps (CHR). State Medicaid data was disaggregated by race, age, gender, and specific Medicaid programs. This self-reported information is captured from public benefit applications although not mandatory. Having this information helps to identify subpopulations among the vulnerable and aids in selecting the appropriate outreach to the most vulnerable relative to Covid services.

To date, Texas has not focused exclusively on disparities in Medicaid. However, in reforming the delivery system to better meet the needs of the served population, disparities are likely to be identified and interventions proposed for improvement. As this work progresses, it is the intent of Medicaid leadership to enhance the program's partnerships with community-based organizations.

Lessons to be learned from Texas:

1. Leverage requests from federal agencies such as CMS as opportunities to enhance the collection of data that can be used to identify subpopulations who are driving adverse outcomes which can be used to investigate health disparities.
2. Leverage available data from federal agencies and collect data that includes demographics such as age, race, language, and zip code. The receipt of state data with this information allows federal analysts to produce data that more accurately reflects subpopulation health vulnerabilities.

Minnesota: An Intentional Approach to Reduce Health Disparities

Minnesota has reported health disparities between Minnesotans insured through its Medicaid program and those on commercial or Medicare insurance since 2007. Since that time, the state has continued to evolve efforts toward understanding, identifying, and developing strategies to reduce health disparities. The Minnesota Department of Human Services (DHS, where the Medicaid agency resides) has worked with Minnesota Community Measurement to measure and report various quality metrics that have defined the health disparities experienced by Minnesotans on Medicaid. Health disparities are identified using an intersectional approach with the recognition that risk factors for health disparity have cumulative effects upon health status. This has included reports that look at the impact of Deep Poverty , incorporating Accounting for Social Risk Factors in Minnesota Health Care Program Payments and Building Racial Equity into the Walls of MN Medicaid: A focus on US-born Black Minnesotans. .Minnesota Medicaid collaborates with other state agencies and community-based entities to advance health equity. Some of the initiatives done to advance health equity include:

1. Initiated a pilot grant program, Integrated Care for High-Risk Pregnancies-(ICHRP), designed to identify African American and Native American pregnant people who are dealing with homelessness, hunger, untreated mental illness, substance use disorder, and exposure to institutional racism. ICHRP collaboratives are co-led by community members, serve both parents, support workforce and leadership development within the identified communities, and engage in broader education and advocacy for the health of pregnant people, positive parenting, and early childhood brain development by reducing stressors through provision of culturally specific services and resources such as housing referrals, behavioral health care, food, and community supports through specially trained community health workers and doulas. The Governor and MN legislature expanded funding for this program in 2021.
2. Launched an alternative payment/Accountable Care Organization (ACO) model called Integrated Health Partnerships (IHPs). Minnesota's first iteration saved the state an estimated $277 million for the five-year period from 2013 to 2017, with about $92 million of this amount returned to IHPs as shared savings. In 2018, MN launched IHP 2.0, which enhanced the arrangements to focus more overtly on social determinants of health, community partnerships, addressing health disparities, and expanding opportunities for participation in the program. These "Equity Interventions" have focused on areas like behavioral health access, maternal health, food insecurity, housing, and addressing multiple social risks through community resource hubs. IHP 2.0 has included 27 IHPs, covering about 430,000 beneficiaries with more than 500 different provider locations and more than 10,000 individual practitioners.
3. Incorporated language in MCO Requests for Proposals that explicitly asks about addressing social drivers of health, structural racism and specific health inequities like maternal and infant health, behavioral health and dental care
4. Including withhold language in MCO contracts around decreasing racial disparities in quality metrics
5. Proposing and implementing a first of its kind Medicaid Housing Stabilization Services benefit. Added through a 1915(i) Home and Community Based Services (HCBS) state plan amendment, this benefit helps adults with disabilities and seniors on Medicaid who are experiencing housing instability find and keep housing. Since its launch in July 2020 utilization has far outpaced estimates and has been notably higher among Black and American Indian enrollees compared to their representation among Medicaid enrollees.
6. Providing more culturally and linguistically appropriate non-traditional health workers to support and promote care coordination. Minnesota Medicaid benefits include coverage for Doulas, Community Health Workers and Community Paramedics
7. Improved access to the Non-Emergency Medical Transportation (NEMT) Medicaid benefit
8. Worked with other data sources within the Department of Human Services to impute Race and Ethnicity data for enrollees who were enrolled in other public programs. This improved the incomplete rate of race data among Minnesota Medicaid enrollees, going from 32% to 9% and for ethnicity data the incomplete rate went from 11% to 5%.

Lessons Learned from Minnesota:

1. Medicaid agencies must invest in data and analyses to measure and reduce health disparities and perform intersectional views of data across race, indicators of poverty, and disabilities. This approach helps ensure that those most impacted by health disparities are not masked in aggregated data.

2. Engage and promote community participation in the process of identifying interventions and determining measures to assess intervention effectiveness. Using its many community-advisory committees, the expression "no decisions about us without us" is a living example of the success that can be achieved when partnerships are forged between health care bureaucracy and the communities served.

3. Take an intentional approach toward identifying and addressing health disparities. Such an approach may involve but is not limited to discussion of structural racism, a review of social and public health policy that impacts equitable distribution of resources, community measurement, and culturally appropriate health workers in the formal health system and the communities they serve.

Oregon: A State Approaching the End of Health Disparities, Target 2030

Oregon's primary strategy to address health disparities is data collection of race, ethnicity, language, and disability, information that has been gathered since 2013. In 2021, the Oregon legislators passed House Bill 1351 which requires the collection of sexual orientation and gender identity information and a mandate to build a system for the maintenance of this data. Such an endeavor seeks to align technology with people served. In addition, Oregon addresses health disparities employing the framework of Dr. Camara Jones, physician, epidemiologist, and anti-racism advocate who specializes in the effects of racism and social inequalities and their impact on health care. This framework ascribes to the practice of addressing the source(s) of inequity leading to disparity. Upon finding the source(s), steps can be taken to successfully eliminate health disparities. Oregon acknowledges that trust between disadvantaged populations and the Health Authority is a vital requirement to successfully resolve disparities. Oregon has worked to achieve this trust through non-traditional health care workers as part of the healthcare team. Language diversity has also been respected and accommodated. The Health Authority also learned that quantitative data is not enough to clearly understand the needs that the data may appear to indicate. Therefore, the Authority has supplemented formal data with qualitative data which provides additional and oftentimes clarifying information of quantitative data. Using all its data, the Oregon Health Authority, through its various Divisions, has implemented specific strategies to address health disparities, including but not limited to:

- Obtaining authority from CMS to use Medicaid dollars to create the Office of Equity and Inclusion (OEI) Community Investment Council to provide advice and community feedback regarding matters of health equity
- Strategic planning for OEI as a Division, including but not limited to community engagement strategy.
- Seeking proactive responses to changes at the regional, state, and national levels.
- Strategy and prioritization to assure statewide reach.
- Development of long-range mission and vision.
- Development of mechanisms to forward the concerns, priorities, and opportunities of respective communities, while ensuring that those who have a harder time being heard have equitable representation.
- Facilitation of meaningful two-way communication between OEI and Oregon's diverse communities.
- Articulation of the value of OEI's work to improve health equity and to eliminate inequities and health disparities.
- Building capacity, resilience, and momentum to move OEI's work forward most effectively.
- Provision of statewide leadership and innovation in health equity, including breaking down silos and working with OHA and across other sectors and agencies.
- Creation of pathways for continued and sustainable engagement with existing and emerging community leaders.
- Under the oversight of the Oregon Health Policy Board, the OHA worked to implement a new model of care, Coordinated Care Organizations (CCOs), which was authorized by SB 1580 of the Oregon legislature. CCOs are local networks of varied healthcare providers (physical health care, health addictions and mental health care) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs have one budget that grows at a fixed rate for mental, physical and dental care (future). CCOs are accountable for health outcomes of the populations they serve. These entities have flexibility within their budgets to provide services consistent with the Oregon Health Plan (OHP) medical benefits. The goal of the OHP is to meet the Triple Aim of better health, better care and lower costs for the populations being served. To track if goals are being achieved through the CCOs, an annual report, Health System Transformation Report, is produced that allows stakeholders and other interested parties to review the progress or lack thereof of the year's outcomes for the selected metrics which comprise a combination of State metrics, CMS core metrics, and COO metrics. The link to the 2020 report is provided for the convenience of the reader: **https://digital.osl.state.or.us/islandora/object/osl%3A977993/datastream/OBJ/view**. Of note, Medicaid funding was used to incentivize CCOs to meet culturally focused metrics.
- Focused on a health workforce that is representative of the communities served. In addition, OHA has worked to secure training and to improve reimbursement for non-traditional health workers. Strong use of the healthcare interpreter program offers:
- Diversity of the health care workforce in Oregon.
- Provision of high-quality health care interpretation to Oregon's growing diverse populations.
- Promotion of health equity.
- Assistance for health care interpreters to obtain training and qualification to perform health care interpretation
- Invested in the work of alleviating health disparities by hiring representatives from the communities served, obtaining appropriations for systems and resources (including qualified staff with lived experience) needed to support the work to solve issues of health disparities, and partnering with the community to decide what has been successful in solving problems that lead to health disparities.

Lessons Learned from Oregon:

1. Obtain commitment from state leaders for health system transformation and be deliberate about leveraging and involving community partnerships in the solutions for health disparities.
2. Invest in adequate data resources to collect information about culturally distinct groups and use quantitative and qualitative methods in analytical methods to learn about what is needed by the community experiencing disparities. Note: Oregon's OEI went from a few employees to over 100 employees. Health Related Services (HRS) spending more than doubled from 2019 to 2020 with $34,153,552 spent in 2020. The top three areas of 2020 CCO HRS spending were HIT ($7,756,901), COVID-19 ($7,578,071), and Housing ($4,944,757). **https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2020-CCO-HRS-Spending-Summary.pdf**
3. Provide information to stakeholders and other interested parties regarding the progress of meeting metric goals; establish reputable benchmarks for metrics; practice transparency with data and hold forums to review and discuss findings. Note: Since 2013, the cost of the CCO program statewide has grown at a rate of 3.4 percent per member per year. Before Oregon's transformation, the growth rate was at 5.4 percent, which means about $2.2 billion in costs were avoided over the last five years.
4. Develop and obtain consensus among all stakeholders regarding state universal definition and language relative to health equity and an understanding of the root of the inequity.

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