

# STATE HEALTH POLICY

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

This *State Health Policy Briefing* reflects on a January 2015 discussion of state and federal leaders convened by the National Academy for State Health Policy (NASHP) with the support of The Commonwealth Fund.

For the purposes of the meeting, health equity was defined as “assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need. Health disparities will be eliminated when health equity is achieved.”<sup>3</sup>

NATIONAL ACADEMY  
for STATE HEALTH POLICY

# Briefing

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## Building An Equitable Health Care Delivery System: Considerations For State And Federal Policymakers

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Health disparities persist in the United States,<sup>1</sup> with disadvantaged groups disproportionately bearing the burden of poor health outcomes and shortened lifespans.<sup>2</sup> This paper shows how state and federal policymakers can strengthen their efforts to achieve health equity by coordinating with one another to align payment models, create new partnerships, and build infrastructure and data systems to reduce health disparities.

According to the 2013 *CDC Health Disparities and Inequalities Report*, African American adults have a 50 percent greater likelihood of dying prematurely from cardiovascular disease than white adults. Infant mortality rates are twice as high for African Americans than for white infants, and infants are more likely to die in the Southern and Midwestern states than in other regions of the country.<sup>4</sup> Facts

such as these demonstrate the need to promote health equity across racial, ethnic, geographic, and socioeconomic lines.

While some state and federal equity efforts are underway, more remains to be done.

- Cross-agency cooperation in states, between federal agencies, and between state and federal leaders can amplify the impact of policies promoting health equity.
- State and federal policymakers can align health equity efforts, from payment incentives and data and infrastructure systems to strategies for community engagement.
- At the same time, policymakers need to guard against inadvertently exacerbating health disparities with policies that direct resources to some populations at the expense of others.

### DESIGNING PAYMENT AND DELIVERY MODELS TO ADVANCE HEALTH EQUITY

Providers and health systems are currently in a precarious situation: they are pulled toward transformative models with the potential to address health equity, such as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs), yet they are still largely paid for volume according to a fee-for-service model.

- Because fee-for-service models do not reward providers for keeping patients healthy or providing high-quality and coordinated care to those with complex needs, they provide little incentive to reduce health disparities in underserved populations.
- One meeting participant said, “The elephant in the room is that fee-for-service is a poor incentive that still dictates ... how things get done.”

**States can advance health equity by leveraging federal attention to the Triple Aim goals of improving care for individuals, improving the health of populations, and reducing the cost of care.**<sup>5</sup> Currently, federal-state partnerships such as Delivery System Reform Incentive Payment (DSRIP) programs within Medicaid 1115 waivers<sup>6</sup> (see the New

York State Snapshot, below), Adult Medicaid Quality Grants,<sup>7</sup> and Medicaid Health Homes<sup>8</sup> promote health equity by supporting state initiatives on prevention, care coordination, primary care, and care quality for populations burdened by health disparities. State and federal policymakers can also build programs with the flexibility needed to address the specific needs of underserved populations, such as the homeless, migrant workers, residents of public housing, and prison populations.

- The Medicaid Health Home State Plan Option, established by Section 2703 of the Affordable Care Act (ACA), allows states to establish health homes for enrollees with chronic conditions. **New York** is working to integrate its health homes with the criminal justice system: eligible individuals are identified before their discharge from a criminal justice facility and then receive coordinated, comprehensive care upon their transition into a health home.<sup>9</sup>
- The Comprehensive Primary Care (CPC) Initiative is a federal multi-payer program that aims to strengthen primary care through improved care management. **Oklahoma** reports early success with practices in its regional CPC project using embedded care managers to help improve health equity.<sup>10</sup>

### STATE SNAPSHOT

#### NEW YORK'S MEDICAID DSRIP PROGRAM

New York's Medicaid program has included a DSRIP program within its 1115 waiver to establish a network of Performing Provider Systems (PPSs) that receive incentive payments based on performance metrics for their attributed population. Attention to health equity is built into the DSRIP program through the Community Needs Assessments PPSs are required to perform. These assessments focus on health literacy and disparities in their high-risk populations. Medicaid transformation in New York also incorporates care management and health home initiatives, including the integration of health homes with the criminal justice system.

**Policymakers can leverage existing and future payment and delivery systems to advance health equity.** Ensuring health equity is embedded in existing priorities will also increase the sustainability of equity initiatives.

- In **Ohio**, leaders worked across state agencies to incorporate health equity language into its Medicaid managed care contracts.<sup>11</sup>
- **Massachusetts** configured its Determination of Need (DON) process to require hospitals planning large capital projects or service changes to incorporate plans for primary and preventive care for the community into their applications.<sup>12</sup>
- Equity is also built into **Louisiana's** risk-bearing Medicaid managed care delivery model, rewarding managed care organizations (MCOs) that improve performance on metrics related to health disparities.<sup>13</sup>
- Some federal agencies are also working together to build equity components into grant applications, and the Centers for Medicare and Medicaid Services (CMS) incentives for meaningful use of electronic health records (EHRs) require providers to collect patient demographic data that can inform health equity work for providers and policymakers alike.

### **BUILDING NEW PARTNERSHIPS AND COMMUNITY-BASED APPROACHES TO EQUITABLE DELIVERY SYSTEMS**

While new payment and delivery models can be important levers for advancing health equity, successful implementation relies heavily on effective cross-sector coordination on the state and federal levels, as well as effective community-level planning and outreach. States can most effectively capitalize on new payment models when state Medicaid and public health agencies - as well as agencies addressing housing, education, and criminal justice - coordinate their services to promote health equity.

**Involving community and consumers in evolving care models can bring important voices to the table.** In order to design health equity initiatives responsive to the needs of disadvantaged consumers, policymakers first need to learn to communicate with them effectively about health systems transformation.

## STATE SNAPSHOT

### **OHIO'S MEDICAID MANAGED CARE CONTRACTS**

Ohio incorporated into its Medicaid Managed Care contracts language requiring all participating managed care plans (MCPs) to “participate in, and support, [the Ohio Office of Medical Assistance]’s efforts to eliminate health disparities in Ohio.” The language also requires MCPs to participate in a Health Equity Workgroup charged with establishing disparity measures, addressing the disparities revealed by the measures, and collecting data on disparities among health plan members. A state official said, “For the first time, we have health equity language embedded in managed care contracts.”

- One state official noted her state was actively listening to consumers’ experiences with the healthcare system to learn how those experiences can inform health equity efforts.
- Health information technology (HIT) can also help engage consumers: some groups affected by health disparities, for example, are heavy users of smartphone applications and other information technology, opening the door for innovative consumer-oriented HIT directed at those populations.<sup>14</sup>

Requirements to conduct community needs assessments also provide an opportunity to engage consumer and community voices in program development.

- For example, some **Maryland** hospitals and public health departments jointly developed a single community needs assessment to be used for multiple purposes after working together in cross-sector local improvement coalitions.<sup>15</sup>

Modifying health equity messaging for different audiences can also help engage a wider group of stakeholders in equity efforts. Some audiences, such as payers, may need to hear a business case for addressing health equity.

## LEVERAGING NEW INFRASTRUCTURE TO ADVANCE HEALTH EQUITY

Implementing new payment and delivery models to promote health equity requires the support of new infrastructure, including new systems for collecting and analyzing data and new strategies for supporting a changing workforce.

**Access to and use of high-quality data supports strategic, targeted action to reduce health disparities.** Guided by data, states can target resources to populations suffering from the greatest health disparities.

- Data showing that one state's poor health metrics were driven almost entirely by the health outcomes of one disadvantaged group allowed policymakers to target interventions to meet the needs of that group.
- Similarly, **Ohio** used geographic information system (GIS) maps incorporating vital statistics and market research data to identify hot spots for infant mortality and poor birth outcomes to address inequities in perinatal health.<sup>16</sup>

Even in states with strong data reporting, disparities among certain populations, such as the LGBTQ community<sup>17</sup> and people with disabilities, may not be adequately captured.

- One participant suggested that policymakers meet this challenge by envisioning what health equity would look like in their area and then designing data collection to measure progress toward a specific goal or set of goals.
- Another participant said that the most successful entities “think of data as a process, not a product.”

**Electronic health records (EHRs) and health information technology (HIT) systems provide opportunities to advance health equity.** Health equity efforts are embedded in some federal HIT initiatives, such as the standards for the meaningful use of electronic health records (EHRs). The federal EHR meaningful use standards require the capturing of data on race, ethnicity, preferred language, sex, and age--information that providers and state and federal policymakers could use to inform strategies to reduce disparities.<sup>18</sup>

- The Institute of Medicine has also recommended that federal meaningful use standards require the reporting of data on the social determinants of health, such as educational attainment and neighborhood median-household income, which would provide additional valuable information to further inform this work.<sup>19</sup>

**Policymakers can incorporate health equity into workforce development.** Expanding the use of community health workers (CHWs) holds promise for improving health equity.

- Because CHWs are often members of the communities they serve and share the culture and language of their clients, they may earn the community's trust more easily than other providers.
- Some research has shown that CHWs have the potential to improve health outcomes among racial and ethnic minority populations by providing culturally and linguistically appropriate health education and support.<sup>20</sup>

State policymakers concerned with providing robust health services to underserved populations can leverage recent federal guidance on the use of CHWs and other non-licensed service providers.

## STATE SNAPSHOT

### LOUISIANA'S PRE-TERM BIRTH REDUCTION INITIATIVE

In Louisiana, the risk of pre-term births varies dramatically by parish and is inversely correlated with the percentage of at-risk pregnant women receiving appropriate treatment with a progesterone medication known as 17P. Although Medicaid covers 17P, women in some parishes receive the treatment at a much lower rate than others. The Louisiana Department of Health and Hospitals worked with the Louisiana Hospital Association to reduce this disparity by facilitating the ordering of 17P through an online resource center. The Medicaid agency also incorporated a 17P treatment pay-for-performance measure into Medicaid managed care contracts to encourage the use of the treatment when necessary.

- In 2013, CMS issued guidance allowing state Medicaid programs to reimburse for preventive services recommended by licensed providers but performed by non-licensed providers.<sup>21</sup>
- While this opens the door to an expanded role for CHWs, questions remain about best practices for education and licensure requirements, as well as sustainable financing models.

Other state and federal workforce policies that could contribute to health equity include encouraging providers to practice to the top of their licensure and cultivating a diverse provider workforce through more flexible educational loan repayment incentives.

### MOVING FORWARD

Several key takeaways emerged from the January 2015 meeting.

- States can advance equity through payment and delivery reforms such as pay-for-performance, medical homes, health homes, managed care contracting, and accountable care organizations.
- State public health and Medicaid agencies can more closely align their equity efforts, aided by federal grants, contracts, and technical assistance.
- Federal agencies and state and federal policymakers can collaborate more to maximize the potential of delivery system reforms to advance health equity.
- State and federal policymakers can play a critical role as conveners to help disseminate local innovations addressing disparities to other state and federal leaders.
- State and federal evaluations of delivery and payment reforms can assess how policy changes

translate to better outcomes for all populations and whether the reforms close gaps among different subpopulations.

- Standardizing HIT standards and priorities where possible across states would assist the federal government in effectively working with HIT vendors to create a common system to support the needs of all states and providers.
- States need to collect the data necessary to understand health disparities, target equity efforts where needed, and assess the effectiveness of equity initiatives. However, states may need additional resources from the federal government to collect and analyze the needed data and disseminate findings.
- State and federal policymakers can provide leadership, support, and training to the healthcare workforce to help workers fully understand and participate in the transition to new delivery systems that prioritize health equity.

### CONCLUSION

Opportunities exist for federal and state policymakers to drive improvements in health equity by incorporating equity into new payment and delivery models and data systems. By leveraging federal payment reforms and working collaboratively with private sector and community stakeholders, state Medicaid and public health agencies can design programs and policies to target and measure changes in local and regional health disparities. Reducing health disparities nationwide will require surmounting barriers to cross-sector and cross-agency communication and better aligning state and federal policies.

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### ENDNOTES

1 Agency for Healthcare Research and Quality, *National Healthcare Disparities Report: 2013* (Rockville, MD: Agency for Healthcare Research and Quality, May 2014). Available at: <http://www.ahrq.gov/research/findings/nhqrdr/nhdr13/2013nhdr.pdf>.

2 U. S. Department of Health & Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care* (Washington, DC: U. S. Department of Health & Human Services, April 2011). Available at: [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf).

3 Camara Jones, CDC, 2011.

4 U. S. Centers for Disease Control and Prevention, “CDC Health Disparities and Inequalities Report — United States, 2013,” *Morbidity and Mortality Weekly Report Supplement*, Vol. 26, No. 3 (Atlanta: CDC, November 22, 2013).

5 The Institute for Healthcare Improvement developed the Triple Aim framework to encourage simultaneous approaches to improving the individual experience of care, improving the health of populations, and reducing the per capita cost of healthcare. More information is available at: <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx>.

6 See the September 2014 Kaiser Family Foundation publication, *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*, available at: <http://kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/>.

7 Many of the core measures addressed in this program focus on prevention: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-medicaid-quality-grants.html>.

8 Section 2703 of the Affordable Care Act created an option for states to form Medicaid health homes to better coordinate care for the Medicaid population with chronic conditions. For more information, see <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>.

9 National Association of Medicaid Directors, *New York’s Health Home Project Criminal Justice Pilot Program*. Available at: [http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/ny\\_case\\_study.pdf](http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/ny_case_study.pdf).

10 For more information, see CMS *Comprehensive Primary Care Initiative: Oklahoma: Greater Tulsa Region*, <http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Oklahoma.html>.

11 The Ohio Department of Medicaid, *Ohio Medical Assistance Provider Agreement for Managed Care Plan*, Appendix K (January 2015), p. 22 of 24. Available at <http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/SFY2015-ManagedCare-PA.pdf>.

12 See The Commonwealth of Massachusetts, *Determination of Need Factor 9: Community Health Initiatives*, available at <http://www.mass.gov/eohhs/docs/dph/health-planning/don/don-community-health-initiatives.pdf>.

13 See Louisiana Bayou Health Program, *MCO Proposal Submission and Evaluation Requirements*, p. 29-30. Available at: [http://www.dhh.louisiana.gov/assets/docs/Proposals2014/LHC/Appendix\\_A\\_Proposal\\_Table-of-Contents.pdf](http://www.dhh.louisiana.gov/assets/docs/Proposals2014/LHC/Appendix_A_Proposal_Table-of-Contents.pdf).

14 Office of the National Coordinator for Health Information Technology. “Advancing Health Equity in the Digital Age.” Retrieved February 3, 2015. Available at: <http://www.healthit.gov/buzz-blog/from-the-onc-desk/advancing-health-equity-digital-age/>.

15 For more information, see Maryland Department of Health and Mental Hygiene, State Health Improvement Process (SHIP) at <http://dhmh.maryland.gov/ship/SitePages/local-action.aspx>.

16 Association of State and Territorial Health Officials. “Ohio Department of Health Collaborates with Partners to Address Health Disparities Using Meaningful Use Data (2014).” Retrieved February 3, 2015. Available at: <http://www.astho.org/Health-Equity/OH-Meaningful-Use-and-SDOH-Story/>.

17 On one CDC website, the acronym “LGBTQ” stands for “lesbian, gay, bisexual, transgender, and questioning”: <http://www.cdc.gov/lgbthealth/youth-programs.htm>.

18 See CMS *Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures Measure 2 of 16*, November 2014. Available at [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2\\_HospitalCore\\_2\\_RecordDemographics.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_HospitalCore_2_RecordDemographics.pdf).

19 The Institute of Medicine, *Capturing Social and Behavioral Domains and Measures in Electronic Health Records, Phase Two* (Washington, D.C.: The National Academies Press, 2014), 15. Available at: <http://www.nap.edu/catalog/18951/capturing-social-and-behavioral-domains-and-measures-in-electronic-health-records>. In this document, the IOM recommends that federal agencies include eight social and behavioral domains in EHR meaningful use reporting: “educational attainment, financial resource strain, stress, depression, physical activity, social isolation, intimate partner violence (for women of reproductive age), and neighborhood median-household income” (15).

20 See Hurtado M, Spinner JR, Yang M, Evensen C, Windham A, Ortiz G, et al. “Knowledge and Behavioral Effects in Cardiovascular Health: Community Health Worker Health Disparities Initiative,” 2007–2010. *Prev Chronic Dis* 2014;11:130250. Available at: [http://www.cdc.gov/pcd/issues/2014/13\\_0250.htm](http://www.cdc.gov/pcd/issues/2014/13_0250.htm).

21 See Centers for Medicare & Medicaid Services final rule, *Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment* (CMS-2334-F), available at: <https://www.federalregister.gov/regulations/0938-AR04/medicaid-exchanges-and-children-s-health-insurance-programs-eligibility-appeals-and-other-provisions>. See also the *CMS Informational Bulletin* dated November 27, 2013: <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf>.

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The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers 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](http://www.nashp.org).

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