

# Framework for Advancing Health Equity in State Medicaid Programs

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Much work remains to be done to fully realize health equity in the United States. Longstanding health and economic disparities heightened by the COVID-19 pandemic and the racial reckoning sparked by the murder of George Floyd and police shootings of Breonna Taylor, Jacob Blake, and too many others underscore how structural racism continues to permeate our nation. On April 8, 2021, the Centers for Disease Control and Prevention (CDC) recognized racism as a “serious threat to public health.”<sup>1</sup> By any measure—health or economic— American Indian and Alaska Native, Latinos, and Black populations have disproportionately borne the burdens of the pandemic, experiencing significantly higher rates of COVID-19 cases, hospitalizations, and deaths as compared to their share of the total population.<sup>2</sup> Inequitable access and treatment have strong and lasting negative impacts on the health and health care of people of different races, ethnicities, and sexual orientation, among other characteristics.

Advancing health equity is an essential way for State Medicaid Agencies (SMAs) to increase access to high-quality, affordable, whole-person patient-centered care for populations who have been historically and contemporarily marginalized. SMAs serve diverse populations that are disproportionately impacted by structural racism and experience disparities in health care access and outcomes. Advancing health equity is not only the right thing to do, but it will help states place their beneficiaries at the center of the care, which can lead to greater member satisfaction and engagement, increased use of preventive care, reduced utilization of unnecessary care, and more effective and efficient use of resources. More states are examining and considering adoption of comprehensive and practical approaches to advancing health equity.

In addition, the federal government has named health equity as one of its main priorities. On January 20, 2021, the Biden administration pledged to advance racial equity and support underserved communities through federal government programs.<sup>3</sup> In a similar manner, the Administrator of the Centers of Medicare and Medicaid Services (CMS), Chiquita Brooks-LaSure, defined the agency’s vision as one where “CMS serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes”<sup>4</sup>, and identified advancing health equity and addressing health disparities as the agency’s first strategic pillar. In the Fall of 2021, CMS released its Innovation Strategy and vision for the Innovation Center over the next 10 years and made a commitment to ensure health equity is embedded in every CMS Innovation model. Significantly, CMS recognized that “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”.<sup>5</sup> As part of next steps, CMS intends to launch “more Medicaid-focused models and/or modify existing models to include additional Medicaid beneficiaries”, “ensure all beneficiaries have access to providers engaged in care transformation by addressing implicit bias in model design, 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”.<sup>6</sup> Therefore, we believe CMS’ focus on health equity will translate into more opportunities and funding for states to develop and implement initiatives to advance health equity in their Medicaid programs in the coming year.

This brief presents NORC at the University of Chicago's Framework for Advancing Health Equity in State Medicaid Programs. This framework does not discount the importance of required systemic reforms to address racism, income, education, legal processes, housing, and workforce inequities, among other issues. Instead, this framework can serve as a tool for SMAs to develop a meaningful health equity strategy within their specific responsibilities and limitations.

## What is Health Equity?

Many organizations have their own definition of health equity. For example, the World Health Organization defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."<sup>7</sup>

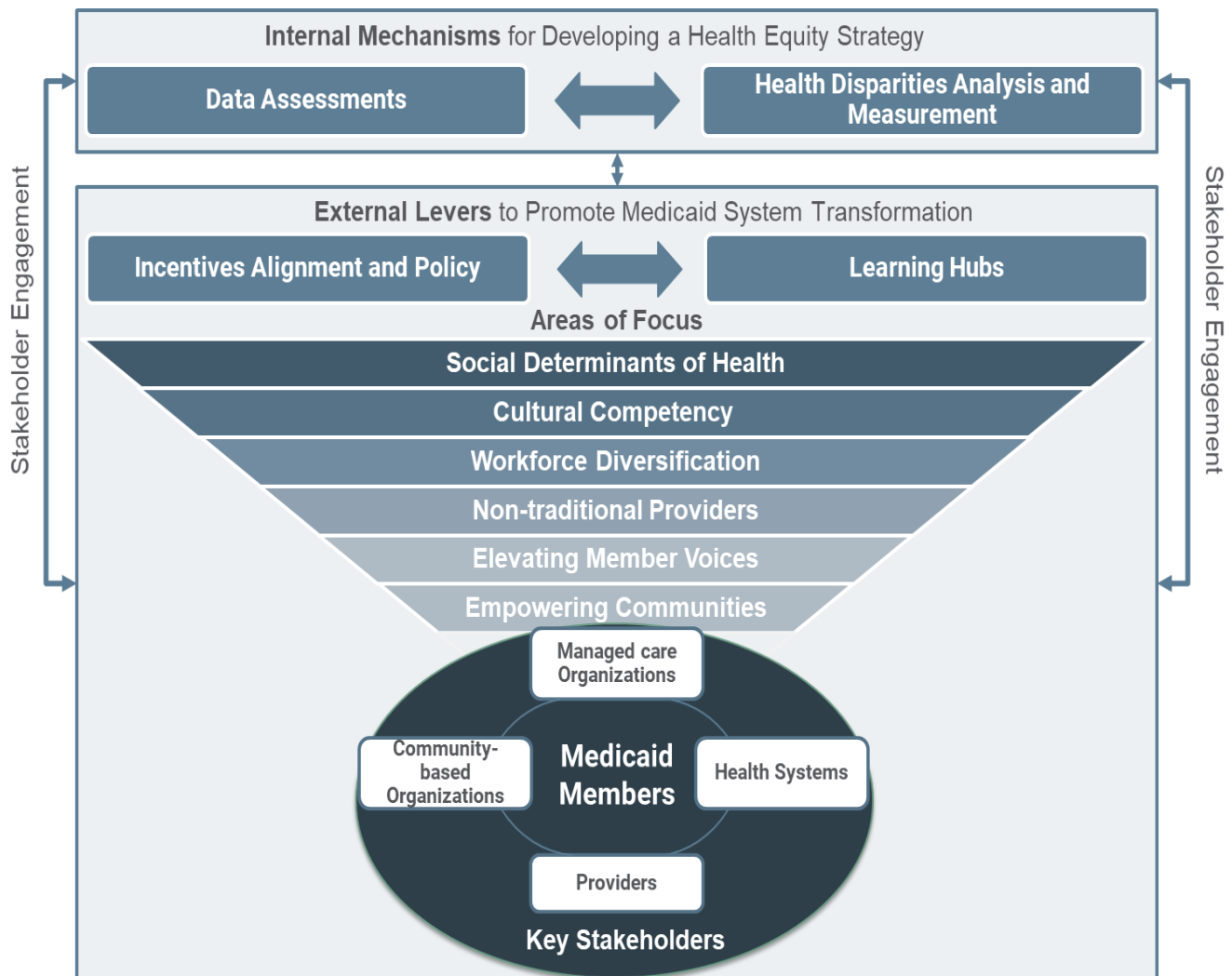
**For this brief, we use the Robert Wood Johnson Foundation's definition of health equity as both an outcome, "the elimination of social disparities in health and its determinants," and a process "of reducing health disparities and their determinants."<sup>8</sup>**

Advancing health equity is an ongoing journey and process marked by regularly assessing the extent to which health disparities are reduced or eliminated. The Kaiser Family Foundation defines health disparities as "differences in health and health care between groups that are closely linked with social, economic and/or environmental disadvantage. Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status and sexual orientation. Disparities in health and health care not only affect the groups facing disparities, but also limit the overall gains in quality of care and health for the broader population."<sup>9</sup>

## SMA Framework for Advancing Health Equity

The SMA Framework for Advancing Health Equity seeks to help and guide SMAs in creating a roadmap for advancing health equity in their state. While SMAs will have different starting points, all states can benefit from this framework regardless of their stage in the journey. The framework describes internal mechanisms that SMAs can use to develop a health equity strategy and external levers SMAs can leverage to encourage Medicaid system transformation toward health equity more broadly, all while ensuring engagement of various stakeholders in the process. The health equity framework also emphasizes the importance of stakeholder engagement across all facets of developing and implementing a health equity strategy. SMAs must engage with key stakeholders, including members, their families and representatives, advocates, health plans, health care providers and systems, CBOs, and others. Exhibit 1 summarizes the SMA Framework for Advancing Health Equity.

### Exhibit 1: Framework for Advancing Health Equity in State Medicaid Programs



**INTERNAL MECHANISMS FOR DEVELOPING A HEALTH EQUITY STRATEGY.** The framework includes two components within SMAs' locus of control and can be conducted internally to develop a health equity strategy: conducting a **data assessment** to determine if the state has high-quality member-level data on race, ethnicity, language (REL), gender identify, and sexual orientation; and developing a **health disparities analysis and measurement** strategy to identify and target areas for improvement.

#### **EXTERNAL LEVERS TO PROMOTE MEDICAID SYSTEM TRANSFORMATION TOWARD HEALTH EQUITY.**

The framework identifies areas that SMAs can influence to promote more alignment across various stakeholders serving Medicaid populations by defining **policies that align incentives** across SMAs, health plans, health systems, and community-based organizations (CBOs) to advance equity; and convening **learning hubs** as a mechanism for peer-to-peer learning of best practices for health plans and health systems. These incentives, policies, and learning hubs can center on the following key areas related to advancing health equity: social risk factors and social needs; cultural competency; workforce diversification; nontraditional providers; elevating member voices, and empowering communities.

### Areas of Focus for Encouraging Medicaid System Transformation toward Health Equity

- Adoption of strategies to address **health-related social needs**, including partnerships among health plans, health systems, providers, and CBOs.
- Delivering **culturally competent** and person-centric care.
- Creation of a **diverse workforce** that represents the backgrounds of the Medicaid population.
- Use of health navigators, doulas, peer-support specialists, and other **nontraditional providers** to promote member engagement with a goal of improving health outcomes while reducing health care spending growth.
- Empowering Medicaid members and **elevating member voices** by including members in decision-making processes.
- **Empowering communities** and CBOs to partner with the health care system to identify and address community needs.

## Internal Mechanisms for Developing a Health Equity Strategy

This section describes in more detail the steps SMAs can take internally to develop a health equity strategy. These steps include assessing gaps in member-level REL, gender identity, and sexual orientation data and conducting a health disparities analysis to prioritize populations or conditions based on baseline data.

### DATA ASSESSMENT

SMAs with accurate member-level data on REL, gender identity, and sexual orientation are in the best position to develop meaningful health equity initiatives. However, many states struggle to obtain data on REL for Medicaid members. For example, a Centers for Medicare & Medicaid Services (CMS) analysis found that, in 2018, "the majority of states (32) were missing more than 10% of race and ethnicity data; about 16 states were in the area of high concern missing between 10 to 50% of race and ethnicity information, and four states had unusable data"<sup>10</sup> as part of their Transformed Medicaid Statistical Information System (T-MSIS) Analytic File. Similarly, as part of race and ethnicity reporting requirements for health plans seeking Distinction in Multicultural Health Care, the National Committee for Quality Assurance (NCQA) reported receiving incomplete race and ethnicity data, 50% and 70%, respectively, from Medicaid health plans in 2018.<sup>11</sup> Without accurate member-level data on REL, gender identity, and sexual orientation, SMAs will experience challenges in developing meaningful health equity initiatives.

Generally, SMAs ask Medicaid applicants about REL during the application process. However, states can only require applicants to report information needed to determine Medicaid eligibility, per federal requirements. Given that REL are unneeded to determine Medicaid eligibility, SMAs often consider these fields optional and applicants can leave them blank.<sup>1</sup> After becoming Medicaid eligible, members interact with the health plan they are enrolled in or with their health care providers more often than with the SMA. Thus, opportunities exist for SMAs to improve their collection of REL data through internal data assessment mechanisms and by working with health plans and other partners. SMAs can improve REL and other data by:

- **Conducting internal assessments of data gaps.** SMAs can assess member demographic information to determine if it is accurate, comprehensive, and includes individual-level member data on REL, gender

<sup>1</sup> Per 42 CFR 435.907(e), SMAs "may only require an applicant to provide the information necessary to make an eligibility determination": 42 CFR § 435.907 - Application. LII / Legal Information Institute. Accessed March 31, 2021. <https://www.law.cornell.edu/cfr/text/42/435.907>

identity, and sexual orientation. If a significant percentage of this data is missing (more than 10%), states should take additional steps, like those described below, to improve the data's completeness.

- **Modifying Medicaid eligibility and renewal processes to encourage self-reporting of REL.** SMAs can consider modifying Medicaid eligibility applications online, on paper, and via phone to encourage reporting of REL. SMAs should also strive to partner with member advocates and community organizations to explain why the information is needed and to obtain feedback on what would be the best way to obtain REL information. After determining Medicaid eligibility, SMAs may only interact with members during the Medicaid eligibility renewal process. SMAs should also give consideration to modifying the Medicaid eligibility renewal processes to capture REL data from members. SMAs can also work with enrollment brokers and member services representatives to develop scripts for and encourage applicants to self-report REL during their interactions.<sup>12</sup>
- **Understanding how member data are stored and transferred to other data systems.** REL data is collected at the time individuals apply for Medicaid, and then, depending on the state, entered into the Medicaid eligibility information system or into the Medicaid Data Warehouse. SMAs can consider mapping how data are captured and stored in different data systems to assess if data have been modified inaccurately during the transfers. For example, Medicaid applicants may respond to race and ethnicity queries, but their responses for both fields could be combined inadvertently into a single field when stored in the Medicaid Data Warehouse. Other times, applicants may list multiple languages in the languages spoken at home field but the Medicaid eligibility system or the Medicaid Data Warehouse may only allow one language to be stored.
- **Assessing mechanisms for sharing demographic data with health plans.** SMAs can analyze the mechanisms used to share member demographic information with health plans. Sometimes, SMAs may share member-level information on REL, but health plans may not integrate this information into their own data systems. If SMAs are sharing member-level demographic data, states need to monitor health plans and use policy levers to ensure health plans are using demographic information to advance health equity.
- **Leveraging partnerships.** SMAs could also consider broadening partnerships to strengthen collection of REL and other data elements. Partnerships are formed and maintained over time when both parties have incentives that ensure they assign the appropriate level of staff and resources for success. Potential partnerships include:
  - **State public health departments'** vital records unit can help SMAs link Medicaid data with race and ethnicity information directly from birth records. This partnership would strengthen the relationship between both agencies and better align Medicaid's health equity strategy with the state's comprehensive health equity strategy for the entire population. In some states, statutes and/or restrictions can pose barriers to linking vital records with Medicaid enrollment data. However, with leadership support, SMAs can overcome these barriers to advance health equity since both agencies share the ultimate goal of advancing health equity for their state.<sup>13</sup>
  - **Medicaid health plans** can reach out to managed care members to obtain missing information on REL, mainly through initial enrollment calls, health risk assessments, or care management efforts. If states partner with health plans to get additional member demographic information, the state should develop the appropriate data mechanisms to collect that information from health plans and incorporate it into the state Medicaid data warehouse.
  - **Health information exchanges (HIEs)** can provide additional data on Medicaid members' addresses and contact information. HIEs may also collect REL and other data elements from participating health systems and share them with health plans and SMAs.
- **Developing new options to obtain data on gender identity and sexual orientation.** Gender identity and sexual orientation data are difficult to obtain. SMAs should consider partnering with trusted lesbian, gay, bi-sexual, transgender, queer (LGBTQ) advocates and representatives to engage this population

and identify how LGBTQ members can share sensitive information on sexual orientation and ensure the information is used only for improving care. Another option states could explore is developing their own questionnaire and conducting a survey to obtain information on members' gender identity and sexual orientation.

Additionally, we want to recognize that the federal government is instrumental in enacting needed changes to enhance the comprehensiveness and accuracy of race and ethnicity data in Medicaid. We do not focus on the federal recommendations in this paper, but we echo the recommendations of the Commonwealth Fund and NCQA about (a) the need for the OMB to redefine race and ethnicity categories reflect the cultural richness and diversity of the population; (b) to standardize race and ethnicity data collection efforts in federal programs; (c) to align incentives across different federal and state programs as well as local health departments to improve collection of race and ethnicity data; (c) to provide more technical assistance opportunities for states to enhance their data systems to capture race and ethnicity information; (d) to promote interoperability and the sharing of race and ethnicity information among states, local health departments, and their partners in the delivery of care; (d) to provide more education and materials on “the importance of asking an individual about their race and ethnicity, why it is important for the individual to answer the questions, and how will the information be used”, and (e) “including community voices in the development and dissemination of these materials”.<sup>14</sup>

## HEALTH DISPARITIES ANALYSIS AND MEASUREMENT

Meaningful health equity strategies are successfully implemented and sustained over time when results are documented through consistent measurement and systematically analyzed. Numerous studies show significant disparities in health outcomes along a variety of indicators. For example, the Agency for Healthcare Research and Quality (AHRQ)'s annual National Healthcare Quality and Disparities Report finds that some disparities lessened between 2000 and 2018, but others worsened, particularly among populations with low incomes and without health insurance. For nearly 40% of Black, Latinx, Asian, and American Indian and Alaska Native populations, health outcomes have worsened compared to white populations.<sup>15</sup>

To create a meaningful health equity strategy, SMAs should consider developing a health disparities analysis and measurement approach to set a baseline and identify health outcomes disparities. This approach includes the following elements:

- **Establishing priorities:** Sometimes, SMAs' Medicaid leadership team may prioritize populations for the health disparities analysis upfront. For example, some states may want to start by focusing on birth disparities given the disproportionate rate of preventable pregnancy-related complications for Black women<sup>16</sup> and deaths for Black infants.<sup>17</sup>

Otherwise SMAs can obtain input from different teams like their Managed Care, FFS, Quality, Care Management, and their Chief Medical Officer to identify populations or conditions to focus. The state should also produce a roadmap detailing a plan for expanding that analysis to other populations and conditions over time.

As part of this prioritization process, SMAs should include members, advocates, CBOs, health systems, and health plans to provide their feedback on the populations and/or conditions to focus and to obtain their support on the SMA's health equity approach.

- **Identifying measures:** SMAs should develop an understanding of measures that apply to the conditions and populations they have prioritized. A good starting point is compiling a list of the applicable measures that the SMA's internal team of quality advisors, (e.g., chief medical officers, data experts, and managed care and benefits experts) can use to evaluate and recommend measures for potential inclusion in the health disparities analysis.

### Measures Resources

- **CMS' Core Set measures for adults and children**
- **NCQA's HEDIS measures**
- **AHRQ's prevention quality indicators, inpatient quality indicators, patient safety indicators, and pediatric quality indicators**



The internal team can examine each proposed measure's specifications, including the denominator and numerator, and **recommend measures** to include in the health disparities analysis. Their recommendations should be based on the SMA's identification of the populations they can most meaningfully impact, the feasibility of each measure's calculation, the availability of data sources, and the adoption and use of measures among health plans and health systems, among other factors.

Most SMAs rely on the CMS Core Sets, which include measures they are required to report on, and the NCQA Healthcare Effectiveness Data and Information Set (HEDIS) measures reported by health plans. It is important to note that 69% of Medicaid members are enrolled in a comprehensive risk-based managed care program, most of which use HEDIS measures.<sup>18</sup> Due to the importance of racial and ethnic equity in health, NCQA requested public comment during the first quarter of 2021 on introducing race and ethnicity stratification into a select number of HEDIS measures for data reported in 2022. Many states look to NCQA for guidance and align their quality programs to match NCQA changes. Therefore, starting next year, more SMAs are likely to follow NCQA's guidance and require the stratification of HEDIS measures by race and ethnicity.

- **Collecting baseline data:** After selecting measures, SMAs can determine how they will calculate baselines for the proposed measures and assess if they have sufficient data. For some measures, SMAs can calculate results directly from the data stored in the warehouse; others may require medical record information not available via claims. For example, if an SMA wants to improve birth outcomes and increase the number of babies born weighing more than 2,500 grams among Black mothers, they must have access to data about their members' race and babies' weight.

SMAs need to conduct an analysis to determine the feasibility of calculating baselines per measure and identify data-system changes that may be needed to calculate the measures. If the data are not readily available, the SMA would need to develop a plan to collect that information, for example through key partnerships with state public health departments, HIEs, etc. Afterwards, SMAs can prioritize the measures and potential data-system changes or partnerships needed to calculate baselines. As part of this process, SMAs can obtain input from different teams (e.g., the claims data, encounters, data warehouse, and quality teams; the chief medical officer; and the benefits and managed care teams) to ensure potential implementation and operational issues are identified and discussed and a corrective action plan outlined. The goal of this process is for SMAs to develop a plan that outlines which baselines would be calculated first and a timeline for calculating baselines for additional measures.

Lastly, the state should calculate baseline data for the prioritized measures within their specified timeframe.

- **Conducting the health disparities analysis:** Once baselines for the prioritized measures are calculated, the SMA's internal team would define the **standard** for determining whether a disparity exists for a given condition and population. The internal team would look at baseline data for each measure and identify areas where there are significant differences in outcomes between members of different races, ethnicities, geographies, etc. SMAs would examine the findings from the health disparities analysis to identify the conditions or populations with significant differences that should be part of the SMA's health equity strategy.<sup>ii</sup> To the extent possible, the SMA should aim to gather data from other states for comparison purposes. Once NCQA obtains stratified

### Michigan's Health Disparities Analysis

Michigan publishes its annual Health Equity Report with tables that compare certain indicators between different populations.<sup>19</sup>

<sup>ii</sup> The Center for Health Care Strategies, the Institute of Medicaid Innovation, and the University of Chicago have a more detailed paper explaining how states can identify disparities and select benchmarks for advancing health equity. Please see: DeMeester et al. - Using Data to Reduce Disparities and Improve Quali.pdf. Accessed March 31, 2021. [https://www.chcs.org/media/Using-Data-to-Reduce-Disparities-2021\\_Final.pdf](https://www.chcs.org/media/Using-Data-to-Reduce-Disparities-2021_Final.pdf)

results for HEDIS measures, states will have benchmarks to compare their progress on reducing health disparities with other states.

## External Levers for Encouraging Medicaid System Transformation toward Health Equity

Until this point, the framework has identified internal processes for SMAs to consider in developing a health equity strategy. This section focuses on broader Medicaid system transformation and change needed across health plans and health systems to advance health equity. While not directly within SMAs' control, SMAs can align incentives and policy, and establish learning hubs to foster needed change across health plans and health systems. As noted earlier, SMAs should engage with stakeholders like health plans, CBOs and advocacy organizations, health systems and providers, and members at every stage of this process. SMAs can work with these groups to agree on and define the incentive approach, including levers to incentivize reductions in disparities.

### ALIGNING INCENTIVES AND POLICY

SMAs have various contractual and policy levers at their disposal to incentivize health plans and health systems to advance health equity. These levers include the following:

- **Managed care procurement processes:** With few exceptions, states use a procurement process to select the health plans that participate in their Medicaid programs. Incorporating health equity experience and requirements into these procurements will ensure selected health plans prioritize and work on health equity. States like Ohio are requiring the creation of a health equity director position, implementation of culturally and linguistically appropriate service (CLAS) standards, trainings on health equity, and reporting of certain HEDIS measures by REL in Medicaid managed care procurements.<sup>20</sup> Similarly, Hawaii requires health plans to develop an social determinants of health (SDOH) transformation plan to address health disparities, develop a cultural competency plan, and stratify measures by REL.
- **Managed care contract requirements and standards:** SMAs use contracts with health plans to define health equity requirements. For example, they can introduce minimum standards for participating health plans, such as ensuring they have NCQA's Distinction in Multicultural Health Care.<sup>21</sup> SMAs can also consider setting additional requirements for collecting and sharing member-level REL, gender identity, and sexual orientation data with the member's health plan and treating providers in a manner compliant with the Health Insurance Portability and Accountability Act (HIPAA). In addition, SMAs can consider standards and requirements around provider networks and network adequacy, member advisory boards, progress toward meeting milestones for reducing disparities, establishing health equity and cultural competency plans, and conducting community health needs assessments (CHNAs), among others.
- **Value-based purchasing (VBP):** To achieve meaningful change, SMAs can hold health plans accountable by advancing health equity through existing or new VBP initiatives. To successfully utilize VBP as a lever to advance health equity, SMAs need to define:
  - The target reduction goal and timeline for achieving the reduction.
  - The incentive payment that the health plan and/or provider will receive based on attaining the target goal as compared to baseline. The incentive amount should be substantial enough for the health plans and providers to change behavior.<sup>iii</sup>

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<sup>iii</sup> The Health Care Payment Learning & Action Network has an Alternative Payment Model framework describing different types of VBP arrangements. Please see: McCarron - 2017 - Alternative Payment Model (APM) Framework.pdf. Accessed March 31, 2021. <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>



## Using Value-Based Purchasing to Advance Health Equity

- Wisconsin has had a pay-for-performance (P4P) program with a 2.5% withhold of Medicaid managed care capitation payments for many years. In 2020, Wisconsin Medicaid modified its P4P program to allocate 1% of the withhold to creation of a performance improvement project to reduce disparities in post-partum care.<sup>22</sup>
- As part of its coordinated care organizations, Oregon Medicaid has a measure to reduce emergency department utilization disparities among members with mental illness.<sup>23</sup>
- Minnesota requires its integrated health partnerships to "propose a health equity measure aimed to reduce health disparities" in certain areas.<sup>24</sup>
- Michigan has a P4P initiative for Medicaid health plans to reduce racial disparities in low birth weight.<sup>25</sup>

- **Public reporting:** SMAs can utilize public reporting as a lever to motivate health plans and health systems to engage in health equity efforts. Comparing and publicly reporting health plan performance on health equity dimensions could motivate health plans to engage in health equity efforts.
- **Auto-enrollment of members who do not select a health plan:** Most SMAs have processes in place to auto-enroll members—that is, assign members to a specific health plan when the member does not choose a plan during enrollment. SMAs could obtain stakeholder input and support to modify the algorithms used to auto-assign members into health plans to incorporate health equity scores and steer more members to higher scoring plans.

## LEARNING HUBS

SMAs should also consider working with a neutral convener to create learning hubs, which are innovation forums where health plans and health systems can share best practices and discuss strategies to advance health equity. The goal of the learning hubs is for SMAs, health plans, health systems, and other key stakeholders to work together to discuss challenges and lessons learned in the implementation of health equity initiatives. SMAs may need a third-party organization dedicated to advancing health equity or an organization committed to quality improvement that is trusted by all parties to spearhead change. For example, this could include partnerships with foundations, quality organizations, or other entities. The learning hub could also bring outside experts to share their experiences and identify the factors that they have found make health equity initiatives successful.

### Texas Learning Collaborative to Advance Health Equity

The Texas Managed Care Organization SDOH Learning Collaborative is a partnership between the Texas Health and Human Services Commission, which is the state's Medicaid agency, Episcopal Health Foundation, Texas Association of Health Plans, Texas Association of Community Health Plans, and the Center for Health Care Strategies (CHCS) to promote shared learning around addressing the social needs of Medicaid beneficiaries in the state.

## Areas of Focus for Aligning Incentives, Policy, and Learning Hubs

SMAs can use their policy levers to align incentives between SMAs, health plans, and health systems to make meaningful strides toward promoting broader Medicaid system transformation to advance health equity. Key areas of alignment include identifying social risk factors and addressing members' social needs through data, policies, and partnerships; promoting health plan and health system cultural competency and diversification of

workforce; encouraging Medicaid coverage and use of nontraditional providers like health navigators, doulas, and peer-support specialists; elevating member voices; and engaging communities and CBOs to identify and address member needs. The following section describes each area of focus in more detail.

## HEALTH-RELATED SOCIAL NEEDS<sup>26</sup>

Many articles describe the importance of identifying social risk factors and addressing health-related social needs to improve health outcomes and advance health equity, often through the lens of SDOH. For the CDC, “addressing SDOH is a primary approach to achieving health equity. SDOH such as poverty, unequal access to health care, lack of education, stigma, and racism are underlying contributing factors of health inequities.”<sup>27</sup>

SMA should consider the link between health disparities and SDOH when developing their health equity strategy. Black, American Indian and Alaska Natives, Asian, Latinx, and other populations experience more barriers to care than their white counterparts due to structural racism and other related social factors. In addition, inequities might exist in access to services that help address social needs across different populations. Thus, SMA should develop strategies in partnership with health plans, health systems, and CBOs to better identify the social needs of the Medicaid population and populations of color more specifically, including:

- Development of data-collection and data-sharing approaches to identify social risk factors and share important social needs data (e.g., housing and food insecurity, etc.).
- Development of a plan to effectively connect members to community resources to address social needs and to follow up on the success and outcomes of the connections (e.g., closed-loop referral platforms such as San Diego 211 or using HIEs to centralize referrals and follow-up).<sup>28</sup>
- Incentivizing health plans and health systems to partner with CBOs to either strengthen existing programs or develop new ones to address social needs within their communities, as identified in CHNAs.

### Examples of Partnerships Around Addressing Member Social Needs

The [Medicaid Managed Care Learning Hub](#) spotlights examples of successful strategies for addressing housing and food insecurity:

- [FOODRx](#)
- [Circle the City](#)

## CULTURAL COMPETENCE AND RESPONSIVENESS<sup>iv</sup>

Advancing health equity requires strong leadership support and commitment to changing an organization's culture to make it more responsive to the cultural, ethnic, and racial diversity of the individuals they serve. SMA can consider introducing the following changes to encourage a culture of equity within their contracted organizations and health systems:

<sup>iv</sup> The term “cultural competency” is limited in scope compared to concepts like “culturally responsive” and “cultural humility”. The definition of cultural competence used by the U.S. Department of Health and Human Services Office of Minority Health’s National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) is “care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals”. “Cultural responsiveness” is the ability to recognize and understand the role culture plays in health care and adapt care strategies to meet patients needs - <https://culturecareconnection.org/cultural-responsiveness/>

Below is a brief description of the limitations of culturally competent care vs. culturally humble care:

“Cultural humility” may be defined as a process of being aware of how people’s culture can impact their health behaviors and in turn using this awareness to cultivate sensitive approaches in treating patients. Unlike cultural competency, there is no specific end point to cultural humility. This concept is a continual process, one that requires self-reflection and self-critique. Developing cultural humility [...] is a prerequisite to cultural competency. It does so by forming a foundation for students to consider possible power imbalances that may arise between a doctor and patient when cultural differences may have an impact on the potential clinical outcome for the patient. Subsequently, the student may be encouraged to develop approaches and skills that could contribute to a harmonious dynamic of the doctor–patient relationship.” – Sunila J. Prasad, Pooja Nair, Karishma Gadhvi, Ishani Barai, Hiba Saleem Danish, and Aaron B. Philip, “Cultural Humility: Treating the Patient, Not the Illness”, *Medical Education Online*, 2016; 21: 10.3402/meo.v21.30908. Published online 2016 Feb 3. dhttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC4742464/

It is not within the scope of this brief to debate the benefits and limitations of each of these concepts. We are basically trying to provide tools for SMA to design and implement meaningful health equity initiatives. Therefore, we will rely on the concepts of “cultural competency” and “cultural responsiveness” because they are more widely accepted and utilized in the health care community.

- A commitment to cultural competence and cultural responsiveness and incentivizing adoption of the **CLAS standards**.<sup>29,v</sup>
- A requirement for their Managed Care partners to develop a comprehensive cultural competence plan to (a) assess how the organization meets members' needs, (b) identifies gaps and areas for improvement, and (c) proposes an implementation plan to address those gaps. For example, Florida currently requires health plans to conduct a cultural competency plan.<sup>30</sup>
- An incentive for health plans to obtain NCQA's Distinction in Multicultural Health Care.

## WORKFORCE DIVERSIFICATION

A pivotal strategy to advancing health equity within health plans and health systems is the hiring and promotion of a diverse workforce that resembles the makeup of the populations served. A more diverse workforce will bring different perspectives to an organization's decision-making process and ensure that the organization more closely attends to members' needs.<sup>vi</sup> To encourage workforce diversification, SMAs could:

- Introduce and closely monitor requirements that managed care provider networks have providers and staff who speak the multiple languages representative of its members, potentially through contractual requirements related to NCQA's Distinction in Multicultural Health Care.
- Partner with professional associations to promote entry and maintenance of racial and ethnic minority groups into the health care workforce in areas where there are provider shortages.

## USE OF NONTRADITIONAL PROVIDERS

Nontraditional providers, including community health workers (CHWs), promotores de salud, and health navigators, are instrumental in engaging with members. They typically reside in the neighborhoods where the people they serve live, speak the same language as the members they support, and have an in-depth understanding of issues members face.<sup>31</sup> SMAs should:

- Consider modifying **Medicaid-covered benefits** to ensure these nontraditional providers are included as Medicaid-certified provider types.
- Explore covering other nontraditional Medicaid providers; for example, covering doulas is an important strategy to significantly improve maternal and child health.<sup>32</sup>
- Consider covering peer-support specialists who have similar backgrounds and lived experience as the members they serve to address behavioral health and substance use disorder treatment needs.<sup>33</sup>

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<sup>v</sup> There is extensive literature that demonstrates the need for strong leadership support and commitment to advancing health equity among health care organizations. For example, please see: Chin MH. Advancing health equity in patient safety: a reckoning, challenge and opportunity. *BMJ Qual Saf*. Published online December 29, 2020:bmjqs-2020-012599. doi:[10.1136/bmjqs-2020-012599](https://doi.org/10.1136/bmjqs-2020-012599)

<sup>vi</sup> There are many articles that describe the benefits of hiring, retaining, and promoting a diverse workforce in health care settings. A more recent article: Diversity in Medicine has Measurable Benefits. Accessed March 31, 2021. <https://www.hopkinsmedicine.org/news/articles/diversity-in-medicine-has-measurable-benefits>

## ELEVATING MEMBER VOICES

There are renewed calls and a focused emphasis for SMAs, health plans, and health systems to become more person-centric and more closely listen to and act on their members' needs. Building the infrastructure to channel and empower members' voices is essential to combat disengagement from the health care system. Members' voices need to be elevated, heard, and they need to be treated as equal partners in health care organizations' decision-making processes. SMAs should encourage health plans to involve, seriously listen, and respond to members in their decision-making process through member advisory councils and other health plan decision-making bodies.

### Examples of Successful Member Engagement Strategies

The [Medicaid Managed Care Learning Hub](#) spotlights examples of successful member engagement strategies, including:

- [Commonwealth Care Alliance \(CCA\)](#)
- [Banner Health and the Arizona Health Care Cost Containment System \(AHCCCS\)](#)

## EMPOWERING COMMUNITIES

For any health equity strategy to be successful, health plans and health systems need to partner with CBOs to address the needs of the communities where their members live. To engage communities and better understand their needs, SMAs should consider:

- Requiring health plans and the health systems they contract with to conduct **CHNAs**. The 2010 federal Affordable Care Act required hospitals to develop CHNAs; however, in some cases, their development became a check-the-box exercise. If done well with input of the hospitals, health systems, and CBOs in specific communities, CHNAs will help health organizations genuinely engage with community stakeholders to understand their needs and design health equity initiatives to address those needs.
- Introducing requirements around health plans partnering with CBOs to address community needs. Partnerships among CBOs, health plans, and health systems will be critical to identifying community needs and for the health care organizations to support CBOs more effectively in the communities they serve, which are often strapped for resources.

### Examples of States with Community Participation Requirements

- **Michigan** requires Medicaid health plans to participate in community-led initiatives, which may include collaborating in community health needs assessments or community health improvement plans conducted by hospitals in their service area. The state also requires health plans to partner with CBOs to address socioeconomic and/or environmental issues in the areas they serve.<sup>34</sup>
- **Minnesota** asks health plans that want to participate in Medicaid about their involvement in the county public health community needs assessment and how they have supported activities related to the goals and objectives identified in those needs assessments through a request for proposals.

## Conclusion

The United States needs systemic changes to dismantle the structural racism causing severe and unacceptable health inequities. Ultimately, only a coordinated strategy to dismantle structural racism that includes other local, state, and federal government agencies such as education, workforce development, justice, environmental protection, and others, will lead to meaningful change. Nevertheless, each agency must first look inward and act. The SMA Framework for Advancing Health Equity can help SMAs chart the first steps on their journey by collecting accurate data to identify disparities and then aligning incentives and policies to foster coordination among stakeholders, including members and their advocates; CBOs; local, state, and federal policymakers; health plans; health systems; and others.

This framework encourages SMAs to establish a health equity strategy by first collecting and sharing members' REL, gender identify, and sexual orientation data with health plans and treating providers in compliance with HIPAA requirements. In addition, SMAs can conduct a health disparities analysis to identify disparities, develop a plan for addressing identified disparities, and measure progress in reducing or eliminating disparities. Furthermore, SMAs can use VBP and other contract mechanisms, policies, and learning hubs to encourage health plans and health systems to advance health equity in various key dimensions: meaningful interventions that address members' social needs; cultural competency; workforce diversity; use of nontraditional Medicaid providers; elevating members' voices; and understanding and responding to community needs.

While this framework is only a starting point in advancing health equity, it explains the complexity of the changes SMAs need to think through when developing a health equity strategy. By implementing these strategies, SMAs and other stakeholders can achieve incremental and positive steps toward putting health equity strategies into practice and reducing health disparities in targeted areas over time while promoting broader Medicaid system transformation through incentives, policy, and peer-to-peer learning.



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