Oregon Health Fund Board

Health Equities Committee Recommendations

Report to the Oregon Health Fund Board

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Committee Membership

Ella Booth, Chair
Associate Dean
OHSU School of Medicine

Joe Finkbonner, co-Vice Chair
Executive Director
Northwest Portland Indian Health Board

Tricia Tillman, co-Vice Chair
Health Equity Initiative Manager
Multnomah County Health Department

Michelle Berlin
Director, PATH *for women*
OHSU Center for Women's Health

Ed Blackburn
Deputy Director
Central City Concern

Bruce Bliatout
Program Manager
Multnomah County Health Department

John Duke
Director of Clinic & Health Services
Outside-In Homeless Youth Clinic

Scott Ekblad
Director
Oregon Office of Rural Health
OHSU

Honora Englander
Physician, Division of Hospital Medicine
OHSU

Yves Lefranc
Physician
Adventist Health Systems

Holden Leung
Executive Director
Asian Health and Service Center

Jackie Mercer
CEO
Native American Rehabilitation Association of the Northwest

Maria Michalczyk
Healthcare Interpreter Training Program Director, Nursing Continuing Education Coordinator
PCC/IHP

Melinda Muller
Physician
Legacy Health System

Laurie Powers
Professor of Social Work & Social Research
Interim Associate Dean for Research
Director of the Regional Research Institute
Portland State University
Regional Research Institute

Noelle Wiggins
Manager, Community Capacitation Center
Multnomah County Health Department

Committee Staff

Heidi Allen, MSW
Lead Staff, Health Equities Committee
Office for Oregon Health Policy & Research

Nathan Hielmaier, MPH
Policy Analyst
Office for Oregon Health Policy & Research

Oregon Health Fund Board — Health Equities Committee Recommendations

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Oregon Health Fund Board — Health Equities Committee Recommendations

I. Executive Summary

In June 2007, the Oregon Legislature passed the Healthy Oregon Act (Senate Bill 329, Chapter 697 Oregon Laws 2007). The Act called for the appointment of the seven-member Oregon Health Fund Board to develop a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The Healthy Oregon Act also established a set of committees to develop recommendations regarding what the reform plan will look like. While several elements of the Act contained references to equity and fairness, no specific mechanism for developing equity strategies was included in the legislation. The newly established Oregon Health Fund Board, in an effort to create that mechanism, created the Health Equities Committee. The Health Equities Committee became the sixth committee of the Oregon Health Fund Board and was chartered with developing multiple strategies to reduce health disparities in Oregon and to ensure that any health reform would specifically include elements to ensure that all Oregonians benefit equally from an improved and expanded health care system.

The Health Equities Charter (See Appendix A – Health Equities Committee Charter) directed the Committee to develop multicultural strategies for program outreach, eligibility, and enrollment procedures as well as to make policy recommendations for reducing health disparities through delivery system reform and the benefit design of the Oregon Health Fund program.

The Committee developed a series of recommendations aligned with the Board's priority areas, which the members believe will result in increased access to health care; an improved delivery system for Oregon's vulnerable populations; an affordable benefit package that meets the needs of Oregon's diverse communities; and healthier individuals, families, and communities.

Preventing Health Disparities before they Occur: Health Promotion and Chronic Disease Prevention and Management

Eliminating health disparities in chronic disease will have a profound economic impact on the state's health care system and will increase earnings over a lifetime as well as lower poverty rates, particularly for ethnic minorities.[1] The Committee recommends addressing the sustainability of the health care system by

[1] E.D. Crook and M. Peters, *Health Disparities in Chronic Diseases: Where the Money Is*, (The American Journal of Medical Sciences, 335(4):266-270, April 2008).

recognizing that the health of the individual begins at home and within the context of families, cultures, and communities (both locational and relational). Many chronic diseases have had a disproportional impact on communities of color.[2] Eliminating these disparities requires culturally-specific approaches to promoting health and preventing chronic disease.

Recommendation 1: Promote population-based approaches

The Health Equities Committee recommends an on-going, substantial investment in public health activities that will prevent disease and promote the health of Oregonians. Culturally-specific approaches to disease prevention and health promotion must be part of this investment.

Recommendation 2: Strengthen the relationship between health-focused Community-Based Organizations and the health care delivery system.

The Health Equities Committee recommends designing a contracting mechanism that will empower primary care clinics who primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services.

Recognizing that not every organization providing an integrated health home is focused on serving vulnerable populations, an alternative to renewable contracts should exist that will enable a provider to purchase community-based and/or culturally-specific services.

The Health Equities Committee recommends that high-value community-based health promotion, disease prevention, and chronic disease management services be eligible for direct reimbursement. Accountable Health Plans must reimburse a broader range of health professionals including, but not limited to, Community Health Workers, and a broader range of services including, but not limited to, peer-led disease management support groups in culturally-specific programs to maximize the health and function of individuals, families, and communities.

Recommendation 3: Develop programs to incentivize healthy personal decision-making

[2] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

The Health Equities Committee recommends that the state create a Wellness Account for individuals participating in the Oregon Health Fund program who receive a subsidy.

The state would deposit money in the Wellness Account based on completion of wellness activities. Monies accrued in the account could be used towards program cost-sharing expenses such as premiums and co-pays, or towards non-covered wellness activities, such as gym memberships or yoga classes. Financial incentives would encourage individuals to engage in activities that promote health, such as participating in a smoking-cessation program, getting recommended tests and procedures, and chronic disease management activities.

The Wellness Account is modeled after Enhanced Benefit Accounts (EBAs) that are currently being implemented in several state Medicaid programs.

Reducing Barriers to Health Care

Low-income individuals, who are disproportionately from communities of color, are more likely to be uninsured and to experience other barriers to accessing health care.[3] Reducing these barriers also impacts many other aspects of people's lives. In California, parents of children newly enrolled in the State Children's Health Insurance Program reported that their children performed better in school, felt better physically, and were able to get along better with their peers than they did before they had insurance.[4]

Recommendation 1: Implement universal eligibility

It is a long-held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise, and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.

Recognizing the political and fiscal implications of this recommendation, the Health Equities Committee believes the Oregon Health Fund Board should establish an 'Oregon Primary Care Benefit Plan', or alternatively a health care pool, within the Oregon Health Fund Program for non-qualified Oregon

[3] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report*. 2003–2006; Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: National Academy of Sciences, 2003).

[4] M. Seid, J.W. Varni, L. Cummings and M. Schonlau, *The Impact of Realized Access to Care in Health-Related Quality of Life in the California State Children's Health Insurance Program*, (Journal of Pediatrics, 149:354-61, September, 2006).

residents [legal immigrants who have been in the U.S. under 5 years, and individuals without documentation] who cannot afford to purchase health care without a subsidy. Financing for this portion of the program could be structured so that industries employing non-qualified Oregon residents are directed to contribute through the 'play or pay' requirement of the employer mandate based on the percentage of employees who would qualify for the Oregon Primary Care Benefit Plan.

Recommendation 2: Address citizenship documentation barrier

As consistent with current practices in the private marketplace, the Health Equities Committee recommends that citizenship documentation should not be a requirement to participate in the Oregon Health Fund program.

The Health Equities Committee further recommends investigating the possibility of obtaining a federal waiver to exempt Oregon from the citizenship documentation requirements imposed by the CMS through administrative rule, based on the Deficit Reduction Act of 2006.

Recommendation 3: Conduct targeted and aggressive outreach to multicultural communities

A media-only approach to outreach for the Oregon Health Fund program is not an adequate response to reducing disparities in health insurance status in Oregon.

The Health Equities Committee recommends a sustainable funding mechanism, with additional Medicaid matching funds, to support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial, ethnic, and language minority communities; individuals living in geographic isolation; and populations that encounter additional barriers such as individuals with cognitive, mental health or sensory disorders, physical disabilities, chemical dependency, and individuals experiencing homelessness.

100% enrollment of individuals who are eligible to participate in the Oregon Health Fund program is the object, and resources and interventions must be targeted towards this goal.

Recommendation 4: Implement affordable cost-sharing policies

The Health Equities Committee recommends equitable and fair sharing of health care costs.

Health insurance coverage with high deductibles and out-of-pocket costs disproportionately hurts low-income individuals' ability to obtain needed care, further contributing to health disparities. Equitable cost-sharing policies take into account and attempt to minimize the uneven impact that cost-sharing arrangements may have on health care access. Specific recommendations on how to promote equitable and fair sharing of health care costs are detailed on pages 26-27 of this report.

Improving the Quality of Care

There are several strategies that have been demonstrated to be effective at reducing the disparities of care that occur within the context of health care delivery.[5]

Recommendation 1: Promote integrated health homes

Elements of the integrated health home (also referred to as the "medical home") model that have been demonstrated to reduce health disparities must be encouraged in any medical service organization purporting delivery of an integrated health home. Examples of these successful approaches are on page 28 of this report.

For some populations, an integrated health home may be best provided outside of the traditional primary care service delivery system and a definition of integrated health home should not exclude organizations based on service-delivery type but should include coordination of care by a licensed medical provider.

The integrated health home needs to be viewed in the context of the social and education system, hospital and specialty care system, and public health system in a community.

Recommendation 2: Benefit package design should support the health of vulnerable populations by ensuring their health care needs are met and that care is affordable

Remove any financial barriers and increase reimbursement for preventive services, chronic disease management, patient education programs, and after-hours/walk-in primary care.

[5] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

The benefit program designed should improve access to and utilization of appropriate services in an integrated health home and support community-based organizations to assist in health promotion. The benefit program should also reward patients who actively participate in their own care, through incentives for patients who follow through with the medical treatment plan agreed upon with their health care providers. Encouraging patients to receive treatment for early disease in the less expensive outpatient setting, rather than waiting until disease progression requires extensive inpatient care will benefit both individuals and society. The state should also encourage providers to expand availability to patients (e.g. operating during evening and weekend hours). Patient education programs can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. For example, patient education programs have been found to be effective in reducing racial and ethnic disparities in pain control.

Support direct reimbursement for Community Health Workers (CHWs) for publicly-sponsored health programs.

Community Health Workers (CHWs), also known as promotores/as, Community Health Representatives (CHRs), lay health advisors, and outreach workers, among other names, are trained members of medically underserved communities who work to improve health outcomes. CHW programs have proven effective in teaching disease prevention, reducing barriers to care, improving patient-provider communication, and improving community health. Oregon can stimulate these programs by providing a variety of funding sources, including direct reimbursement. Establishing direct reimbursement may involve developing a certification system for CHWs. Any certification system should be designed and governed by CHWs and CHW advocates**.**

Analyze the cost-effectiveness and health equity benefits of alternative and complementary medicine including, but not limited to, traditional Chinese medicine for the inclusion of such health services in the benefit design of publicly-sponsored health programs

Ensure that Oregonians have access to affordable evidence-based alternative and complementary medicine.

Alternative and complementary medicine can reduce health disparities by providing culturally-specific approaches to improving health. These types of health services should also be vetted by the same standards as allopathic medicine and promoted in the commercial market of health care as allopathic medicine.

Recommendation 3: Ensure language access

Take advantage of growing technological capacity in Oregon by creating a state-wide pool of qualified, certified interpreters and organizations that may be able to utilize and build on technologies being developed for telemedicine or telehealth.

Seek federal matching funds for interpreter services through Medicaid. This helps ensure affordable interpreter services for providers who see Medicaid patients.

Use state regulation to impose mandates with funds to offset subsequent costs.

Recommendation 4: Address workforce issues

The Health Equities Committee focused their workforce recommendations on two domains. The first domain the committee felt should be addressed in health reform policy would aim to ensure an adequate workforce that reflects the diversity of Oregonians.

Expand educational institution capacity at health professional schools where more training opportunities are needed across the board from community college to university and postgraduate levels.

Increase financial aid in health professional schools for students needing more financial aid of the right kind (grants, scholarships, loan forgiveness).

Strengthen the pipeline to health profession schools; intervention needs to start early and focus on retention. Support mentoring program models that have been demonstrated to be effective in retaining students.

This includes convening all entities that are currently working on pipeline development issues so that efforts are coordinated, streamlined, and strategic in planning for the future needs of Oregon's population.

Improve the climate for diversity at individual health professional schools by mandating cultural (including sexual and gender minorities, persons with disabilities, and other vulnerable populations) and linguistic competence throughout the institution.

Utilize existing agencies to establish and report on diversity goals for health & hospital systems and health care training institutions to the Oregon Health Fund Board on a biennial basis.

Support Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.

The second domain of healthcare workforce the committee felt was crucial to eliminating health disparities is to ensure providers are trained to be culturally-sensitive healthcare practitioners.

Mandate a minimum level of educational credits for health care providers that must be earned in coursework specifically designed to increase cultural competence and/or awareness.

Recommendation 5: Expand data collection efforts

In Oregon there is such a dearth of data related to race, ethnicity, and primary language in health care that it is difficult to identify, let alone address, disparities in health care access, health care utilization, disease status, and/or quality of care. Where data exists, sources of are difficult to combine or compare due to differences in definitions and data collection protocols.

Recommendation: All health care providers and health plans participating in the Oregon Health Fund Program must be required to collect and report data on race, ethnicity, age-appropriate sexual orientation, gender, disability status, and primary language. These measures need to be included when assessing quality and ensuring transparency.

Recommendation 6: Implement initiatives to enhance quality

In its role as convener and collaborator, the Quality Institute should be responsible for:

- **Training provider organizations and health plans on protocols for collecting race, ethnicity, and primary language data based on the highest national standards. This will ensure consistency and comparability among data sources, increase cultural competency, and reduce provider discomfort with collecting this kind of information from patients.**
- **Developing a Health Disparities strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.**
- **Aligning resources to support quality healthcare across all demographic populations in Oregon.**

- **Disseminating meaningful and accurate information on health quality and utilization of healthcare resources in a manner that is accessible and understandable to individuals from a variety of cultural, ethnic, and educational backgrounds.**

Concluding Thoughts of the Health Equities Committee

The social determinants of health must be acknowledged in any explicit effort to reduce health disparities. Social determinants of health acknowledge that an individual's health is not solely understood by determining insurance status, by isolating the experience between patient and provider, nor can it be adequately addressed by focusing on individuals and individual responsibility. Health is more than health care. A review of population health factors determined that non-medical factors (genetic predispositions, social circumstances, environmental conditions, and behavioral patterns) are responsible for a large proportion of preventable mortality in the United States, perhaps 85-90 percent.[6,7]

In the acclaimed PBS documentary series, *Unnatural Causes: Is Inequality Making Us Sick*?, Dr. David Williams aptly frames the scope necessary to truly address health inequities through social policy when he argues: "Housing policy is health policy, educational policy is health policy, anti-violence policy is health policy, neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in our society has an impact on their health and is a health policy". Other states have acknowledged this by passing legislation giving members of the legislative body, or other policy-makers, an opportunity to request an assessment of how any proposed policy might impact the health of vulnerable populations. Health impact-assessment tools provide policy-makers with information to evaluate how education policy, housing policy, economic policy, land-use policy (as examples) might benefit or harm the health of individuals, families, or communities.[8]

The Health Equities Committee strongly encourages the Oregon Health Fund Board and other policy-makers to consider creating avenues for racial, ethnic, and cultural minorities to participate in an on-going effort to address health disparities in Oregon. These communities are the first to identify and understand the problems that affect them and will have the best ideas about how to address these problems effectively. Health care is experienced locally and

[6] Schroeder S, *We Can Do Better—Improving the Health of the American People*, (The New England Journal of Medicine, 357(12):1221-1228, September 20, 2007;).
[7] McGinnis JM, Williams-Russo P, and Knickman JR, *The case for more active policy attention to health promotion*, (Health Affairs, 21(2):78-93, March/April 2002).
[8] B. Smedley, B. Alvarez, R. Panares, C. Fish-Parcham, and S. Adland, *Identifying and Evaluating Equity Provisions in State Health Care Reform* (New York: The Commonwealth Fund, April 2008).

solutions for health care dilemmas must be addressed by engaging, supporting, and allowing the impacted communities to lead the way.

Finally, efforts to reduce health disparities can begin immediately, outside of health care reform, or as part of any staged implementation that involves expanding Medicaid. Appendix C describes Health Equities Committee recommendations that align with strategies that have been successfully implemented in other state Medicaid programs, or hold potential for improving Oregon's existing Medicaid program.

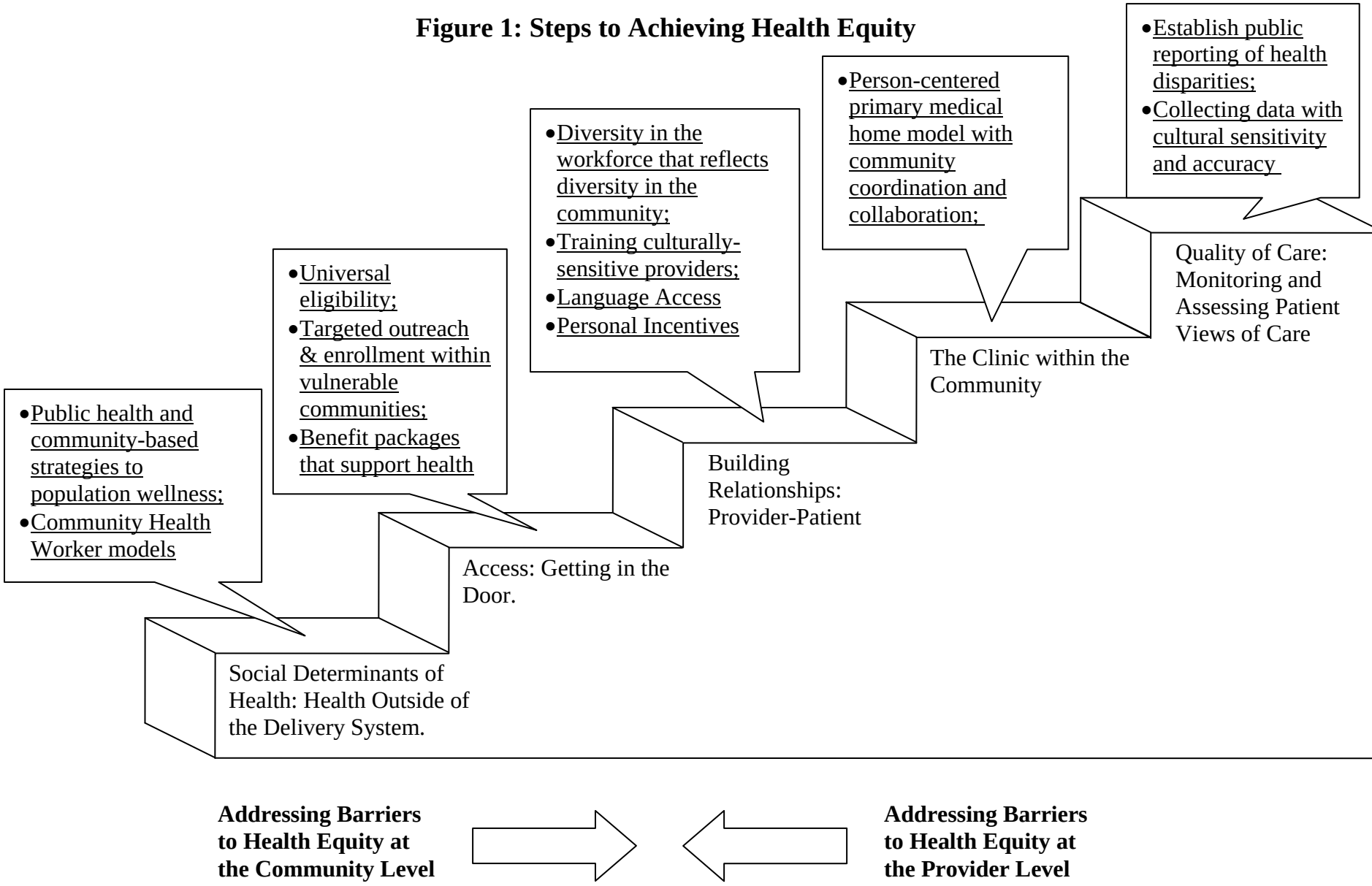
II. Conceptual Framework and Committee Process

Conceptual Framework
The Health Equities Committee used five broad concepts to inform and shape their approach to developing strategies that would reduce health disparities in Oregon (see Figure 1 on the following page). The first concept is often referred to as the social determinants of health, the second is providing access to the health care delivery system, the third is the concept of providing culturally competent health care, the fourth relates to the role of communities in shaping their own health and identifying solutions to problems within the community, and the fifth is monitoring the quality of care.

The Committee also felt it was essential to have a shared understanding between members of the term 'cultural competence' in order to work together towards policy recommendations that would seek this objective in health care. A search of Oregon statute revealed a definition that the Committee felt would meet this objective:

> **Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each (OAR 415-056-0005).**

Figure 1: Steps to Achieving Health Equity



Committee Process

The Health Equities Committee began their formal deliberations in November of 2007. The diversity of Oregon was represented by the sixteen members of the Health Equities Committee.

The Committee held a total of ten meetings, during which members developed a number of strategic policy recommendations that would move Oregon towards an equitable health care system. The Committee invited a number of guests to present on specific topic areas including:

- Current outreach efforts for the Oregon Health Plan by the Department of Medical Assistance Programs (DMAP) and the impact of the Deficit Reduction Act of 2007 (DRA) citizenship documentation requirements on enrollment: Jeanny Phillips and Karen House.
- Primary Care Renewal and Medical Homes: Craig Hostetler, Oregon Primary Care Association, and Dr. David Labby, CareOregon.
- Oregon Workforce Issues, Dr. Lisa Dodson, Oregon Health & Science University's Department of Family Medicine
- Language Access: Mara Youdelman, National Health Law Program
- Community Health Workers: Teresa Rios Campos, Capacitation Coordinator, Community Capacitation Center, Multnomah County Health Department
- Public Health: Dr. Grant Higginson, Katherine Bradley, and Joel Young Public Health Division, Oregon Department of Human Services
- Care Coordination: Dr. Mark Redding, Executive Director, Children's Community Health Access Project (CHAP) and Laura Brennan, PacificSource Foundation
- Safety Net: Members of the Safety Net Advisory Council

The Committee also benefited from public input during portions of each meeting from a variety of stakeholders and the public, including: Oregon Primary Care Association, National College of Natural Medicine, Palliative Care Physician's Roundtable, Archimedes Movement (Portland Chapter), Women with Disabilities Health Equity Coalition (WowDHEC), Oregon Healthcare Workforce Institute, and a Rosewood Family Health Center Medicaid Enrollment staff member.

Materials, presentations and recordings from the meetings are available from the Oregon Health Fund website at:
http://www.oregon.gov/OHPPR/HFB/Health_Equities_Committee.shtml

III. Preventing Disparities before They Occur

With the aging of the state population and the rising prevalence of chronic disease, health disparities have important implications for the state's health care system in the near future. The Committee recommends addressing sustainability of the health care system by recognizing that the health of the individual begins at home and within the context of families, cultures, and communities (both locational and relational). Many chronic diseases have had disproportional impacts on communities of color.[9] Eliminating these disparities require culturally-specific approaches to promoting health and preventing chronic disease.

Policy Recommendations on Preventing Health Disparities through Targeted and Culturally-Specific Programs of Health Promotion and Chronic Disease Prevention/ Management.

As identified by the Delivery System Committee of the Oregon Health Fund Board, there are few incentives in the current health care system to prevent disease and truly promote a healthy population. Even fully-capitated managed care organizations do not always see direct benefit from investing in prevention efforts that pay off in the long run because of movement in and out, and between, health care plans. The Oregon Health Fund program has the opportunity to save money with long-term prevention investments that improve the overall health of Oregonians as they move in and out of plans while remaining in the overall Health Fund Program.

i . Population-Based Approaches

Recommendation: The Health Equities Committee recommends an on-going, substantial investment in public health activities that will prevent disease, and promote the health of Oregonians. We believe that part of this investment should be directed towards using culturally-specific approaches to disease prevention and health promotion.

a. *Initiatives that target health disparities should be guided by members from the communities experiencing health disparities.*
    i. *The Quality Institute and the Public Health Department would provide data to support decision-making on establishing funding and program priorities.*
    ii. *Priorities will likely vary by region.*

[9] A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey* (New York: The Commonwealth Fund, June 2007).

iii. *Multiple granting approaches should be used:*
    1. *Planning grants should be made available for regional collaboratives to develop around a proposed intervention.*
    2. *Competing grants should be designed to encourage creativity and collaboration.*
    3. *Non-competitive continuation grants should be available to maintain funding support for programs that have demonstrated success at meeting the goals of the grant.*
    4. *Emerging Issue grants should be available for communities to develop strategies and interventions around newly identified problems impacting population health.*

b. *Regional collaboratives consisting of social service organizations, culturally-specific organizations, health care organizations, and other community partners and community-based organizations would apply for grants that address targeted disparities with community-driven and implemented approaches.*
    i. *Matching regional funds may be required.*
    ii. *Funding should be administered in a way that supports the necessary steps to achieving targeted outcomes, and the outcomes themselves. Data & evaluation support will be provided through partnership with Public Health.*
    iii. *Effective programs will be shared and problem-solving will be facilitated through convening regional collaborative leadership (in person or virtually) on a quarterly basis in learning collaboratives.*

Health focused, community-based organizations have been very successful in providing culturally-specific programs that promote health, prevent disease, and help manage chronic diseases. These programs are overly reliant on federal grant priorities and struggle with sustainability. Providing a truly integrated health care home for multicultural communities requires a stronger relationship between these organizations and primary care clinics that serve vulnerable populations.

ii. ***Strengthen the relationship between providers and culturally-specific Community-Based Organizations (CBO's)***

Recommendation: The Health Equities Committee recommends designing a contracting mechanism that will empower primary care clinics who primarily serve vulnerable populations to build financial agreements with health-focused community-based organizations that provide culturally-specific health promotion and disease management services.

Renewable contracts will be awarded to health care clinics that partner with culturally-specific social service organizations (including organizations that focus on Persons with Disabilities, GLBT populations, homeless youth or adults, and populations with low literacy and illiteracy) to provide an integrated health care home. Clinics that have established in-house capacity for culturally-specific approaches would not be required to contract out for services already being rendered.

- *a. Partnership must include contractual financial agreements.*
  - *i. Social service organizations will provide culturally-specific approaches to health promotion, self-management for chronic diseases, and disease prevention. These approaches may include:*
    1. *peer-to-peer health education programs*
    2. *Community Health Workers*
- b. *Contracts will be based on a rate, adjusted to reflect the needs of the population, for serving a specified number of individuals in that population.*
  - i. *Organizations will be accountable on measures of process and outcomes that will reflect realistic timelines of:*
    1. *preventing chronic disease*
    2. *promoting population health*
    3. *chronic care management*
    4. *attention to health literacy*
    5. *accessibility to patients*
- c. *Contracts can be administered directly through the Health Fund Program or through a managed care organization.*

Recognizing that not every organization providing an integrated health care home is focused on serving vulnerable populations, an alternative should exist to renewable contracts that will enable a provider to purchase community-based and/or culturally-specific services.

Recommendation: The Health Equities Committee recommends that high-value community-based health promotion, disease prevention, and chronic disease management services, be eligible for direct reimbursement.

Accountable health plans must reimburse a broader range of health professionals including, but not limited to, Community Health Workers, and a broader range of services including, but not limited to, peer-led disease management support groups in culturally specific programs to maximize the health and function of individuals, families and communities.

iii. Policy recommendations on providing incentives for healthy individual lifestyle choices

Recommendation: Individuals purchasing health care with the assistance of a state subsidy will be provided with a Wellness Account where the state will deposit cash incentives for behaviors that will promote the individual's health. Some examples include:

- Developing a wellness plan with provider
- Meeting weight loss goals established in partnership with a provider
- Participating in a smoking-cessation program
- Getting recommended tests and procedures
- Chronic disease management activities

The Wellness Account is modeled after Enhanced Benefit Accounts (EBAs) that are currently being implemented in several state Medicaid programs and are generally used to pay for covered Medicaid services. Enhanced Benefit Accounts pay for benefits provided in addition to a beneficiary's Medicaid coverage, as an incentive to engage in healthy behaviors.

Under an EBA, a process is established for verifying achievement or completion of the desired outcomes. Recipients or providers typically provide the verification. Once verified or established, recipients have access to account funds and these funds enable them to access additional services or products.

IV. Reducing Barriers to Care

Low-income individuals, who are disproportionately communities of color, are uninsured and experience other barriers to health care. A comparison of comparable populations in the U.S. and Canada, which has a universal health insurance, revealed extreme racial disparities such as unmet health needs, forgoing needed medications, and lower perceived quality of care.[10] These barriers perpetuate health disparities as advances in biomedical knowledge and technology increase between people of higher and lower socioeconomic status based on access to valuable information and services to prevent or treat illness.[11]

i. *Universal Eligibility*

Recommendation: It is a long-held Oregon value that all Oregon residents have equal opportunity to support their families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise

[10] K.E. Lasser, D.U. Himmelstein, and S. Woolhandler, *Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey* (American Journal of Public Health, 96(7):1-7, July, 2006).
[11] D. Mechanic, *Population Health: Challenges to Science and Society*, (The Millbank Quarterly, 85(3):533-559, 2007).

and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.

Although undocumented individuals demonstrate less use of health care than US-born citizens, overall costs in healthcare are high as a result of poor access to primary and preventive care. [12] High and rising rates of the uninsured population contribute to excess reliance on hospital emergency rooms and admission to the hospital for potentially preventable complications of chronic and acute conditions. Insurance gaps and benefit designs that discourage essential or preventive care contribute to higher longer-term costs of care and undermine quality by creating barriers to timely access to effective care.[13],[14]

The Oregon Center for Public Policy estimates that undocumented immigrants contribute annually to Oregon between $65 million and $90 million in state income taxes, property taxes, and excise taxes such as gas and cigarette taxes.[15]

Permanent documented immigrants are eligible for public coverage but are subject to restrictions and stipulations. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricted documented immigrants arriving after August 22, 1996 from federally-matched Medicaid coverage for the first five years in residence.

The Pew Hispanic Center estimated that Oregon's 2005 undocumented immigrant population was between 125,000 and 175,000.[16]

Recommendation: As is consistent with current practices in the private marketplace, no citizenship documentation requirements will be in place to participate in the Oregon Health Fund program.

In order for these two recommendations to be realized, the Committee felt that policy implementation options should be considered by the Oregon Health Fund Board.

For example, a preferred option from the Committee would be: *to establish an 'Oregon Primary Care Benefit Plan', or alternatively a health care pool, within the*

[12] A.N. Ortega; H. Fang; V.H. Perez; J.A. Rizzo; O. Carter-Pokras; S.P. Wallace; L. Gelberg, *Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos*, (Archives of Internal Medicine, 167(21):2354-2360, 2007).

[13] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York, The Commonwealth Fund, Apr. 2006).

[14] Schoen et al., Commission on a High Performance Health System, Why Not the Best? Results from a National Scorecard on U.S. Health System Performance, (New York, The Commonwealth Fund, Sept. 2006)

[15] Oregon Center for Public Policy, *Undocumented Workers Are Taxpayers, Too*, Apr. 2006

[16] Pew Hispanic Center, *Estimates of the Unauthorized Migrant Population for States Based on the March 2005 CPS*, Fact Sheet dated April 26, 2006.

Oregon Health Fund Program for non-qualified [legal immigrants who have been in the U.S. under 5 years, and individuals without documentation] Oregon residents who are unable to afford purchasing health care without a subsidy. Financing for this portion of the program could be structured so that industries employing non-qualified Oregon residents are directed to contribute through the "play or pay" requirement of the employer mandate.

The Committee recognizes that this option faces the following challenges:

- If revenue comes solely from businesses rather than community support—it may still prove to be economically infeasible;
- The administration of such a program may require limited state funds for implementation;
- Creating two entirely different programs based on eligibility creates equity issues;
- This program could be construed as implicit support for individuals who are not authorized U.S. residents; and,
- Businesses may oblige the "play or pay" requirement for "recognized" workforce and avoid "unrecognized" workforce unless the state actively identified individuals in the latter group.

However, the Committee also maintains this recommendation for the following reasons:

- The Oregon Health Fund Program would be "universal" in that all Oregon residents will be included;
- No specific federal waiver would be needed if federal funds are not being utilized;
- Both "cost-shift" from uncompensated care as well as public health concerns created by exclusion are addressed;
- Businesses that heavily rely on a largely immigrant workforce will be included in the employer mandate and would also directly benefit from participation;
- If the Oregon Primary Care Benefit Plan is within the Oregon Health Fund Program it would combine all value-based purchasing advantages; and,
- Because it is less voluntary in design for employers and would therefore possibly prove to be more economically sustainable.
- The state would continue to benefit from federal dollars that support the Citizen Alien Waived Emergency Medical (CAWEM) program, providing reimbursement for emergency hospitalization costs, including childbirth.

The alternative policy options the Committee considered:

Alternative 1: Non-qualified Oregon residents may purchase their own health coverage either through the private market or through the exchange and are ineligible for direct state contributions.

Challenges:

- Oregon Health Fund Program would not be "universal" in that low-income, non-qualified Oregon residents would be excluded;
- This option doesn't address the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- The "play or pay" amount from businesses employing non-qualified workers not provided to those workers.

Advantages:

- No specific federal waiver would be needed;
- Option takes 'hot button' issue of immigration off the table as something that may stymie or present a roadblock to bipartisan agreement for comprehensive plan; and,
- This option would be consistent with current public programs such as the Oregon Health Plan and the Family Health Insurance Assistance Program (which requires citizenship documentation).

Alternative 2: All Oregon residents are to be eligible regardless of federal qualifications for state contributions to low-income individuals through the Oregon Health Fund Program.

Challenges:

- No federal match would be available for these individuals and the program would be reliant on state contribution only;
- Inserts 'hot button' issue of immigration into the comprehensive plan that may stymie or present a roadblock to bipartisan agreement; and,
- Inconsistent with the Oregon Health Plan that requires citizenship documentation.

Advantages:

- Oregon Health Fund Program would be "universal" in that all Oregon residents included;
- Addresses both the "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- The "play or pay" amount from all businesses going to all workers regardless of federal qualification.

Alternative 3: Establish an 'Oregon Primary Care Benefit Plan' within the health insurance exchange alongside the Oregon Health Fund Program whereby foundations, providers, managed care groups, targeted employers, counties, cities and others may continually contribute funds, on a voluntary basis, that will be appropriated to provide subsidies to individuals that do not qualify for state contributions but are unable to afford purchasing health care without them.

Challenges:

- Not a guarantee of shared responsibility "play or pay" payment by businesses that employ non-qualified individuals;
- Voluntary basis of revenue source may provide an inadequate long-term economic feasibility, particularly if large industries such as hospitality and/or agricultural choose not to participate;
- If not financially viable, fewer people will be covered, violating universality due to enrollment caps;
- Creating two entirely different programs based on eligibility creates equity issues;
- State resources would be necessary for administrative costs due to eligibility determinations; and,
- Could be construed as implicit support for individuals who are not authorized U.S. residents.

Advantages:

- Comprehensive plan would be "universal" in that all Oregon residents eligible;
- No specific federal waiver would be needed and no foreseeable problems with federal match;
- This option avoids contentious immigration debate that could weigh down the comprehensive plan because new state dollars will not be appropriated for non-qualified individuals;
- This option would be consistent with the Oregon Health Plan (which requires citizenship documentation) for state contributions;
- Addresses both "cost-shift" from uncompensated care as well as public health concerns created by exclusion; and,
- This option allows a myriad of interested parties the opportunity to contribute to reduce the number of uninsured Oregonians

ii. ***Address Citizenship Documentation Barrier***

Recommendation: Health Equities Committee Policy Recommendations on Citizenship Documentation Requirements for Participation in OHP-like Programs

The Health Equities Committee recommends investigating the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2006.

Oregon would request returning to previous documentation methodology employed by the Department of Medical Assistance Programs. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.

iii. *Targeted and Aggressive Outreach*

Recommendation: A media-only approach to outreach for the Oregon Health Fund program is not an adequate response to reducing health disparities in health insurance status in Oregon.

A sustainable funding mechanism, with additional Medicaid matching funds, must support community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial, ethnic, language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency, and individuals experiencing homelessness.

a. *These community-based approaches should be collaborative rather than competitive among agencies that serve vulnerable populations.*
b. *The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations involved in outreach.*
c. *The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations specific to enrolling vulnerable populations.*

100% enrollment of individuals who are eligible to participate in the Oregon Health Fund program is the objective and resources and interventions must be targeted towards this goal.

iv. *Cost-Sharing*

Recommendation: Promote equitable and fair sharing of health care costs within the Benefit Design.

Health insurance coverage with high deductibles and out-of-pocket costs disproportionately hurt low-income individual's ability to obtain needed care, further contributing to health disparities. Equitable cost-sharing policies take into account and attempt to minimize the uneven impact that cost-sharing arrangements may have on health care access.

a. *Include public contributions for those with low incomes to purchase health insurance, sliding fee scales for premiums, and limits on copayments and other out-of-pocket costs so that people at the lowest income levels will face only nominal charges. Premiums are the preferred form of cost-sharing for public programs because people can regularly budget those costs.*
b. *Benefits should be extended to all Oregonians that protect against devastating financial losses and bankruptcy due to unforeseen catastrophic illness or injury.*
c. *Utilization and quality data should be regularly accessed to determine if cost-sharing policies are worsening or increasing health disparities. For example, cost sharing thresholds should be evaluated to determine when and if those thresholds become barriers to necessary care.*
d. *Design public programs for health care assistance that do not disenroll beneficiaries or deny primary care services to people who do not pay required cost-sharing costs but rather, maintain health coverage while taking action to collect debt. Oregon's experience with administratively disenrolling individuals from its Medicaid program who did not meet cost-sharing requirements led to massive loss of coverage with adverse affect. Results from the baseline Oregon Health Plan (OHP) cohort survey indicate that nearly one half (45%) of the OHP Standard population experienced disrupted or lost coverage in the first 10 months after the OHP redesign in 2003. OHP beneficiaries who lost coverage reported significantly worse health care as well as medication access and had significantly h*igher medical debt than those with stable coverage.[17]

V. Improving the Quality of Care

i. Integrated Health Home

Definition of Medical Home/Primary Care Home: A system of care that provides coordination of multiple, disparate elements of care for a patient. This does not assume that all care is provided within the walls of a clinic.

[17] *Carlson, Matthew J., DeVoe, Jennifer, Wright, Bill J. "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results From a Prospective Cohort Study of the Oregon Health Plan" Annals of Family Medicine 4(5): 391-398, 2006*

Recommendation: Elements of the Medical Home model that have been demonstrated to reduce health disparities must be encouraged in any medical service organization purporting delivery of a Medical Home include:

a. *Patient Centered Care focus*
    i. *Extended office hours: evenings and weekends*
    ii. *Alternative access to providers such as telephone consultations and email exchanges.*
    iii. *Automatic reminders of recommended visit schedule and appointment times.*
    iv. *Mental Health and Chemical Dependency Integration*
    v. *Emphasis on chronic disease management and preventive care*
    vi. *Coordination with community based social organizations, peer support networks and organizations that integrate social determinants of health into care including public health as appropriate*
b. *Population based care: The Medical Home should include systems to coordinate care of all patients in the practice outside of office visits.*

Recommendation: For some populations, a medical home may be best provided outside of the traditional primary care service delivery system and a definition of medical home should not exclude organizations based on service-delivery type but should include coordination of care by a licensed medical provider.

Recommendation: The Medical Home needs to be integrated and viewed in the context of the social and education system, hospital and specialty care system and public health system in a community.

ii. Benefit Package

Recommendation: Remove any financial barriers and increase reimbursement for preventive services, chronic disease management, patient education programs and after-hours/walk-in primary care.

The benefit program designed should improve access to and utilization of appropriate services in an integrated health home and support community-based organizations to assist in health promotion. The benefit program should also reward patients who actively participate in their own care, through incentives for patients who follow through with the medical treatment plan agreed upon with their health care provider. Encouraging patients to receive treatment for early disease in the less expensive outpatient setting, rather than waiting until disease progression requires extensive inpatient care will

benefit both individuals and society. The state should also encourage providers to expand availability to patients (e.g. operating during evening and weekend hours). Patient education programs can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. For example, patient education programs have been found to be effective in reducing racial and ethnic disparities in pain control.

Recommendation: Support direct reimbursement for Community Health Workers (CHWs) for publicly sponsored health programs.

Community Health Workers (CHWs), also known as promotores/as, Community Health Representatives (CHRs), lay health advisors, and outreach workers, among other names, are trained members of medically underserved communities who work to improve health outcomes. CHW programs have proven effective in teaching disease prevention, reducing barriers to care, improving patient-provider communication, and improving community health. Oregon can stimulate these programs by providing a variety of funding sources, including direct reimbursement. Establishing direct reimbursement may involve developing a certification system for CHWs. Any certification system should be designed and governed by CHWs and CHW advocates**.**

Recommendation: Retain and utilize the Oregon Health Resources Commission (HRC) to analyze the cost-effectiveness of medical technologies and health services. The HRC should analyze the cost-effectiveness and health equity benefits of alternative and complementary medicine including, but not limited to, traditional Chinese medicine for the inclusion of such health services in the benefit design of publicly sponsored health programs.

Many diverse communities in Oregon are not limited to allopathic medicine as the only form of treatment for illness. This is especially true for communities that have specific cultural sensitivity or preference for a type of alternative or complementary medicine that may reduce health disparities. At the same time, finite public resources should be spent on medical technologies and health services that are evidence-based.

Recommendation: Ensure that Oregonians have access to affordable evidence-based alternative and complementary medicine.

As noted above, alternative and complementary medicine can reduce health disparities by providing culturally specific approaches to improving health. These types of health services should also be vetted by the same standards as allopathic medicine and promoted in the commercial market of health care as allopathic medicine.

iii. Language Access

The explicit goal of the following Health Equities Committee recommendations are to ensure health care services that are respectful of, and responsive to, the cultural and linguistic needs of Oregonians.

Recommendation: Take advantage of growing technological capacity in Oregon by creating a state-wide pool of qualified, certified interpreters and organizations that may be able to utilize and build on technologies being developed for telemedicine or telehealth.

State-wide pool would include partnerships including but not limited to hospitals, clinics, language bank companies, video interpreter services, and community services, etc.

a. As an example, partners in the pool could pay according to their percentage of services used the prior year.

Recommendation: Coordinate with state-wide technology efforts, such as Telehealth, to build future infrastructure for the state-wide pool, including video remote interpreting for Deaf people.

Recommendation: In planning for interpreter services, include organizations specific to ASL interpreters (such as the Oregon Registry of Interpreters for the Deaf), and disability/Deaf organizations (such as the Women with Disabilities Health Equity Coalition, and the Oregon Association of the Deaf) to ensure inclusion of video remote interpreting for ASL signers.

Recommendation: Seek federal matching funds for interpreter services through Medicaid. This targets provider organizations that serve Medicaid patients by making interpreter services affordable.

Promote video remote interpreting (and other telehealth technologies) as a viable option for health care providers.

Through a state plan amendment, make interpreter services a covered service rather than an administrative service, thereby eliminating the disincentive for providers to see non-English speaking patients.

Recommendation: Use state regulation to impose mandates with funds to off-set subsequent costs:

Any plan that participates in the Oregon Health Fund Exchange must pay for interpreter services.

Recommendation: Create education partnerships so that more health professionals are also certified interpreters.

Oregon may be able to utilize existing partnerships through the Health Care Workforce Institute or other existing groups that work toward certification of interpreters.

As much as possible, interpretation must be included in the health professional's job description, protecting the employee's time and reflecting their dual roles.

Definitions based on the Healthcare Interpreter Oregon Administrative rules:

- "Limited English Proficient" (LEP) is a modifier used by the federal government to describe a person with limited English proficiency. "Person with limited English proficiency" means a person who, by reasons of place of birth or culture, speaks a language other than English and does not speak English with adequate ability to communicate effectively with a health care provider.
- "Health Care" means medical, surgical, or hospital care or any other remedial care recognized by state law, including mental health care.
- "Interpreter Services" is listening to a message of one language and providing an oral rendition of the same message in another language. An interpretation is to be complete and accurate and relay the meaning of the message from one language to the other, considering the context and the meaning of the whole phrase and not each word as if it were "standing alone" without context.
- "Health Care Interpreter" means a person who is employed as an interpreter working in health care who is readily able to communicate with a person with limited English proficiency and to accurately translate the written or oral statements of the person with limited English proficiency into English, and who is readily able to translate the written or oral statements of other persons into the language of the person with limited English proficiency. Health Care Interpreter further means any individual paid as an interpreter working in health services, including mental health. As used in this section, the term "employed" means anyone who performs or is utilized as a health care interpreter whether it be in an hourly or salaried position, contractor, volunteer, or intern

iv. Workforce

The following recommendations are designed to create an adequate workforce to meet the needs of the population, including those living in rural Oregon, and will reflect the diversity of Oregonians.

Recommendation: Expand educational institution capacity at health professional schools where more training opportunities are needed across the board from community college to university and postgraduate levels.

Oregon's health care provider shortage is also challenged by the population's growing diversity and the need to provide culturally and linguistically competent care.

Recommendation: Increase financial aid in health professional schools for students needing more financial aid of the right kind (grants, scholarships, loan forgiveness).

a. *Expand reduced tuition to Oregon residents pursuing careers at Oregon health care educational institutions with additional incentives for underrepresented populations.*
b. *Offer loan forgiveness for providers who practice in underserved areas in Oregon or with underserved populations in Oregon.*

Ultimately, our patients pay the price when there are insufficient providers from backgrounds similar to theirs. Geographic, economic, educational, and cultural factors, with their effects on patient mortality, underscore the critical need for providers from disadvantaged backgrounds and with superior cultural sensitivity training, to improve health care for the underserved throughout Oregon. They will then be able to serve those who are now underserved, improving access to care. In addition, these individuals will function as role models for youth within their communities.

Recommendation: Strengthen the pipeline to health profession schools; intervention needs to start early and focus on retention. Support mentoring program models that have been demonstrated to be effective in retaining students.

The Health Equities Committee feels strongly that educational and experiential support in pre-college, college and in health professional schools will enable more applicants from disadvantaged backgrounds to apply, gain admission and graduate into the health care workforce.

Recommendation: The previous recommendation must include convening all entities that are currently working on pipeline development issues so that efforts are coordinated, streamlined, and strategic in planning for the future needs of Oregon's population.

a. *The Oregon Health Care Work-Force Institute would be ideally suited for the role of convener.*
b. *Entities that should be convened include, but are not limited to, Allopathic and Naturopathic providers, dentists, mid-level providers, nurses, behavioral health professionals, allied and Community-Health Workers.*

Recommendation: Improve the climate for diversity at individual health professional schools by mandating cultural (including sexual and gender minorities, persons with disabilities, and other vulnerable populations) and linguistic competence throughout the institution.

This in turn will mean better patient satisfaction and medical compliance, with decreases in morbidity and mortality related to chronic diseases over time. Providing culturally competent services that maximize the health and function of the individual results in lower spending on health care, as well as increased income from a more productive workforce.

Recommendation: Utilize existing agencies to establish and report on diversity goals for health & hospital systems and health care training institutions to the Oregon Health Fund Board on a biennial basis.

Recommendation: Support Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.

<u>Creating a culturally-competent workforce</u>

The final Health Equities Committee recommendation concerning workforce is that Oregon must have a provider workforce that receives the education necessary to provide culturally-competent and culturally-aware health care.

Recommendation: Mandate a minimum level of educational credits for health care providers that must earned in coursework specifically designed to increase cultural competence and/or awareness.

a. *This can be part of initial licensure or as part of continuing education.*

v. Data Collection

In Oregon there is such a dearth of data related to race, ethnicity, and primary language in health care that it is difficult to identify, let alone address, disparities in health care access, health care utilization, disease status, and/or quality of care. Where data exists, sources of are difficult to combine or compare due to differences in definitions and data collection protocols.

Recommendation: All health care providers and health plans participating in the Oregon Health Fund Program must be required to collect and report data on race, ethnicity, age-appropriate sexual orientation, gender, disability status, and primary language. These measures need to be included when assessing quality and ensuring transparency.

In a recently issued report, *Identifying and Evaluating Equity Provisions in State Health Reform* (April 23rd, 2008), the Commonwealth Fund urges states to strongly consider publicly reporting access and quality data that has been stratified by demographic characteristics to promote public accountability, inform the consumer base, support state efforts to evaluate disparities in health and to intervene as indicated (pg. 6).

vi. Quality Initiatives

Recommendation: In its role as convener and collaborator, the Quality Institute should be responsible for:

- **Training provider organizations and health plans on protocols for collecting race, ethnicity, and primary language data based on the highest national standards. This will ensure consistency and comparability among data sources, increase cultural competency, and reduce provider discomfort with collecting this kind of information from patients.**
- **Developing a Health Disparities strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.**
- **Aligning resources to support quality healthcare across all demographic populations in Oregon.**
- **Disseminating meaningful and accurate information on health quality and utilization of healthcare resources in a manner that is accessible and understandable to individuals from a variety of cultural, ethnic, and educational backgrounds.**

VI. Conclusions

The social determinants of health must be acknowledged in any explicit effort to reduce health disparities. Social determinants of health acknowledge that an individual's health is not solely understood by determining insurance status, by isolating the experience between patient and provider, nor can it be adequately addressed by focusing on individuals and individual responsibility. Health is more than health care. A review of population health factors determined that non-medical factors (genetic predispositions, social circumstances, environmental conditions, and behavioral patterns) are responsible for a large proportion of preventable mortality in the United States, perhaps 85-90 percent.[18,19]
In the acclaimed PBS documentary series, *Unnatural Causes: Is Inequality Making Us Sick*?, Dr. David Williams aptly frames the scope necessary to truly address health inequities through social policy: "Housing policy is health policy, educational policy is health policy, anti-violence policy is health policy, neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in our society has an impact on their health and is a health policy". Other states have acknowledged this by passing legislation giving members of the legislative body, or other policy-makers, an opportunity to request an assessment of how any proposed policy might impact the health of vulnerable populations. Health impact-assessment tools provide policy-makers with information to evaluate how education policy, housing policy, economic policy, land-use policy (as examples) might benefit or harm the health of individuals, families, or communities.[20]

The Health Equities Committee strongly encourages the Oregon Health Fund Board and other policy-makers to consider creating avenues for racial, ethnic, and cultural minorities to participate in an on-going effort to address health disparities in Oregon. These communities are the first to identify and understand the problems that affect them and will have the best ideas about how to address these problems effectively. Health care is experienced locally and solutions for health care dilemmas must be addressed by engaging, supporting, and allowing the impacted communities to lead the way.

Finally, efforts to reduce health disparities can begin immediately, outside of health care reform, or as part of any staged implementation that involves expanding Medicaid. Appendix C describes Health Equities Committee recommendations that align with strategies that have been successfully

[18] Schroeder S, *We Can Do Better—Improving the Health of the American People*, (The New England Journal of Medicine, 357(12):1221-1228, September 20, 2007;).
[19] McGinnis JM, Williams-Russo P, and Knickman JR, *The case for more active policy attention to health promotion*, (Health Affairs, 21(2):78-93, March/April 2002).
[20] B. Smedley, B. Alvarez, R. Panares, C. Fish-Parcham, and S. Adland, *Identifying and Evaluating Equity Provisions in State Health Care Reform* (New York: The Commonwealth Fund, April 2008).

implemented in other state Medicaid programs, or hold potential for improving Oregon's existing Medicaid program.

APPENDIX A

OREGON HEALTH FUND BOARD
HEALTH EQUITIES COMMITTEE
Approved by OHFB

Objective

The Health Equities Committee is chartered with developing multicultural strategies for program eligibility and enrollment procedures as well as with making policy recommendations to reduce health disparities through delivery system reform and benefit design of the Oregon Health Fund program. The work of the Health Equities Committee will be submitted directly to the Oregon Health Fund Board (OHFB) as well as integrated into the work of other OHFB committees.

Scope

The Health Equities Committee will focus its study of strategies to reduce health disparities in Oregon, including but not limited to:

1. Providing the Eligibility & Enrollment Committee with recommendations concerning but not limited to:
    - Best practices for outreach in communities of color, homeless adults and youth, with individuals who live in geographic isolation, and with individuals who experience other barriers to enrollment.
    - Strategies to reduce disparities in insurance status by decreasing barriers to enrollment and streamlining enrollment policies & practices
2. Providing the Delivery Committee with recommendations concerning reducing health disparities in Oregon. Recommendations may include but are not limited to topics such as:
    - Elements of the Medical Home model that reduce health disparities and provide culturally competent care.
    - Financial incentive programs to reduce targeted health disparities and quality care through provider fee increases and value-based purchasing
    - A plan to increase collection of health-related data for people of color and other under-represented populations using techniques that are culturally sensitive and accurate.
    - Provider workforce issues such as recruitment of minority and rural providers, retention, and cultural-competence training.
    - Methods to empower and incentivize individuals to make healthy lifestyle choices.

- Methods to ensure competent linguistic access within the health care delivery system.

3. Providing the Benefits Committee with recommendations concerning benefit designs that support the health of women, minorities, and other vulnerable populations including but not limited to:
    - Benefits related to women's health and benefit designs that target women of childbearing age.
    - An emphasis on reducing health disparities in developing a benefit package of essential health services.
    - Ensuring an affordable benefit package that promotes the health of individuals who have physical or mental health disabilities.
    - Reimbursement options for health promotion activities that occur outside of the traditional health care delivery system.

Committee Membership

Name	Affiliation	City
Yves LeFranc, MD	Adventist Health Systems	Portland
Ella Booth, Ph.D.	Oregon Health & Science University (OHSU)	Portland
Honora Englander, MD	OHSU Division of Hospital Medicine	Portland
Scott Ekblad	Office of Rural Health, OHSU	Portland
Maria Michalczyk, RN, MA,	Healthcare Interpreter Training program, Portland Community College	Portland
Michelle Berlin, MD, MPH	Center of Excellence in Women's Health, OHSU	Portland
Tricia Tillman, MPH	Multnomah County Health Department	Portland
Noelle Wiggins	Multnomah County Health Department	Portland
John Duke, MBA	Outside-In Homeless Youth Clinic	Portland
Jackie Mercer	NARA	Portland
Ed Blackburn	Central City Concern	Portland
Bruce Bliatout, Ph.D.,	Multnomah County Health Department	Portland
Laurie Powers, Ph.D.	Portland State University, Regional Research Institute	Portland
Melinda Muller, MD	Legacy Health Systems	Portland
Joe Finkbonner	Northwest Portland Indian Health Board	Portland
Holden Leung, MSW	Asian Health and Service Center	Portland

Staff Resources

- Heidi Allen, (Lead Staff) OHREC Director and Medicaid Advisory Committee, OHPR – Heidi.Allen@state.or.us; 503-373-1608
- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1632

- Shawna Kennedy-Walters, Office Specialist, OHPR – Shawna.Kennedy-Walters@state.or.us; 503-373-1598

Timing

The Committee will provide its recommendation(s) to Oregon Health Fund Board and the Eligibility and Enrollment Committee no later than February 10th, 2008, recommendations to the Oregon Health Fund Board and Delivery Committee no later than April 1st, 2008, and recommendations to the Oregon Health Fund Board and Benefits Committee no later than April 30th, 2008. The Committee will continue to act as a resource to the Oregon Health Fund Board and the committees of the Board as needed throughout the 2008 policy planning process.

APPENDIX B

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	**Delivery System Committee**	**Eligibility & Enrollment Committee**	**Federal Laws Committee**	**Finance Committee**
Promote equitable and fair sharing of health care costs.	☒	☒	☒	☐	☒
Remove any financial barriers and increase reimbursement for preventive services, chronic disease management, patient education programs and after-hours/walk-in primary care.	☒	☒	☐	☐	☐
Support direct reimbursement for Community Health Workers (CHWs) for publicly sponsored health programs.	☒	☒	☐	☐	☐
Retain and utilize the Oregon Health Resources Commission (HRC) to analyze the cost-effectiveness of medical technologies and health services. The HRC should analyze the cost-effectiveness and health equity benefits of alternative and complementary medicine including, but not limited to, traditional Chinese medicine for the inclusion of such health services in the benefit design of publicly sponsored health programs.	☒	☒	☐	☐	☐
Ensure that Oregonians have access to affordable evidence-based alternative and complementary medicine.	☒	☐	☐	☐	☐
Take advantage of growing technological capacity in Oregon by creating a state-wide pool of qualified, certified interpreters and organizations	☐	☒	☐	☐	☐

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	**Delivery System Committee**	**Eligibility & Enrollment Committee**	**Federal Laws Committee**	**Finance Committee**
that may be able to utilize and build on technologies being developed for telemedicine or telehealth.					
Seek federal matching funds for interpreter services through Medicaid. This targets provider organizations that serve Medicaid patients by making interpreter services affordable.	☒	☐	☐	☒	☐
Individuals purchasing health care in Medicaid and with the assistance of a state contribution will be provided with a Wellness Account where the state will deposit cash incentives for behaviors that will promote the individual's health. Some examples include: • Developing a wellness plan with provider • Meeting weight loss goals established in partnership with a provider • Participating in a smoking-cessation program • Getting recommended tests and procedures • Chronic disease management activities	☒	☐	☐	☒	☐
Use state regulation to impose mandates with funds to off-set subsequent costs for interpreter services	☐	☒	☐	☐	☐
Create education partnerships so that more health professionals are also certified interpreters	☐	☒	☐	☐	☐
All health care providers and health plans	☐	☒	☐	☐	☐

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	Delivery System Committee	Eligibility & Enrollment Committee	Federal Laws Committee	Finance Committee
participating in the Oregon Health Fund Program must be required to collect and report data on race, ethnicity, age-appropriate sexual orientation, gender, disability status, and primary language. These measures need to be included when assessing quality and ensuring transparency.					
In its role as convener and collaborator, the Quality Institute should be responsible for:	☐	☒	☐	☐	☐
a) Training provider organizations and health plans on protocols for collecting race, ethnicity, and primary language data based on the highest national standards. This will ensure consistency and comparability among data sources, increase cultural competency, and reduce provider discomfort with collecting this kind of information from patients.					
b) Developing a Health Disparities strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities.					
c) Aligning resources to support quality health care across all demographic populations in Oregon.					
d) Disseminating meaningful and accurate information on health quality and utilization of health care resources in a manner that is accessible and understandable to individuals					

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	Delivery System Committee	Eligibility & Enrollment Committee	Federal Laws Committee	Finance Committee
from a variety of cultural, ethnic, and educational backgrounds.					
Expand educational institution capacity at health professional schools where more training opportunities are needed across the board from community college to university and postgraduate levels. Oregon's health care provider shortage is also challenged by the population's growing diversity and the need to provide culturally and linguistically competent care.	☐	☒	☐	☐	☐
Increase financial aid in health professional schools for students needing more financial aid of the right kind (grants, scholarships, loan forgiveness). Ultimately, our patients pay the price when there are insufficient providers from backgrounds similar to theirs. Geographic, economic, educational, and cultural factors, with their effects on patient mortality, underscore the critical need for providers from disadvantaged backgrounds and with superior cultural sensitivity training, to improve health care for the underserved throughout Oregon. They will then be able to serve those who are now underserved, improving access to care. In addition, these individuals will function as role models for youth in their communities.	☐	☒	☐	☐	☐
a) Expand reduced tuition to Oregon residents					

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	**Delivery System Committee**	**Eligibility & Enrollment Committee**	**Federal Laws Committee**	**Finance Committee**
pursuing careers at Oregon health care educational institutions with additional incentives for underrepresented populations. b) Offer loan forgiveness for providers who practice in underserved areas in Oregon or with underserved populations in Oregon.					
Strengthen the pipeline to health profession schools; intervention needs to start early and focus on retention. Support mentoring program models that have been demonstrated to be effective in retaining students. We feel strongly that educational and experiential support in pre-college, college and in health professional schools will enable more applicants from disadvantaged backgrounds to apply, gain admission and graduate into the health care workforce.	☐	☒	☐	☐	☐
Strengthening the pipeline of health professionals must include convening all entities that are currently working on pipeline development issues so that efforts are coordinated, streamlined, and strategic in planning for the future needs of Oregon's population. a) The Oregon Health Care Work-Force Institute would be ideally suited for the role of convener. b) Entities that should be convened include, but are not limited to, Allopathic and Naturopathic	☐	☒	☐	☐	☐

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	**Delivery System Committee**	**Eligibility & Enrollment Committee**	**Federal Laws Committee**	**Finance Committee**
providers, dentists, mid-level providers, nurses, behavioral health professionals, allied and Community-Health Workers.					
Improve the climate for diversity at individual health professional schools by mandating cultural (including sexual and gender minorities, persons with disabilities, and other vulnerable populations) and linguistic competence throughout the institution. This in turn will mean better patient satisfaction and medical compliance, with decreases in morbidity and mortality related to chronic diseases over time. Providing culturally competent services that maximize health and functionality results in lower spending on health care, as well as increased income from a more productive workforce.	☐	☒	☐	☐	☐
Utilize existing agencies to establish and report on diversity goals for health & hospital systems and health care training institutions to the Oregon Health Fund Board on a biennial basis.	☐	☒	☐	☐	☐
Support Community Health Worker programs that recruit and train members of underserved communities to provide culturally and linguistically competent health services within that community.	☐	☒	☐	☐	☐
Mandate a minimum level of educational credits for health care providers that must earned in	☐	☒	☐	☐	☐

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	Delivery System Committee	Eligibility & Enrollment Committee	Federal Laws Committee	Finance Committee
coursework specifically designed to increase cultural competence and/or awareness. (Note: this can be part of initial licensure or as part of continuing education in health professions.) Elements of the Medical Home model that have been demonstrated to reduce health disparities and must be encouraged in any medical service organization purporting delivery of a Medical Home include: a) Patient Centered Care focus b. Extended office hours: evenings and weekends c. Alternative access to providers such as telephone consultations and email exchanges. d. Automatic reminders of recommended visit schedule and appointment times. e. Mental Health and Chemical Dependency Integration f. Emphasis on chronic disease management and preventive care g. Coordination with community based social organizations, peer support networks and organizations that integrate social determinants of health into care including public health as appropriate b) Population based care: The Medical Home	☐	☒	☐	☐	☐

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	**Delivery System Committee**	**Eligibility & Enrollment Committee**	**Federal Laws Committee**	**Finance Committee**
should include systems to coordinate care of all patients in the practice outside of office visits. For some populations, a medical home may be best provided outside of the traditional primary care service delivery system and a definition of medical home should not exclude organizations based on service-delivery type but should include coordination of care by a licensed medical provider.	☐	☒	☐	☐	☐
The Medical Home needs to be integrated and viewed in the context of the social and education system, hospital and specialty care system and public health system in a community.	☐	☒	☐	☐	☐
There should be an on-going, substantial investment in public health activities that will prevent disease, and promote the health of Oregonians. We believe that part of this investment should be directed towards using culturally-specific approaches to disease prevention and health promotion.	☐	☒	☐	☐	☒
Public health initiatives that target health disparities should be guided by members from the communities experiencing health disparities.	☐	☒	☐	☐	☒
a) The Quality Institute and the Public Health Department would provide data to support decision-making on establishing funding and program priorities.					

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	**Delivery System Committee**	**Eligibility & Enrollment Committee**	**Federal Laws Committee**	**Finance Committee**
b) Priorities will likely vary by region. c) Multiple granting approaches should be used: i. Planning grants should be made available for regional collaboratives to develop around a proposed intervention. ii. Competing grants should be designed to encourage creativity and collaboration. iii. Non-competitive continuation grants should be available to maintain funding support for programs that have demonstrated success at meeting the goals of the grant. iv. Emerging Issue grants should be available for communities to develop strategies and interventions around newly identified problems impacting population health.					
Public health initiatives should be regional collaboratives consisting of social service organizations, culturally-specific organizations, health care organizations, and other community partners and community-based organizations would apply for grants that address targeted disparities with community-driven and implemented approaches. a) Matching regional funds may be required. b) Funding should be administered in a way that supports the necessary steps to achieving	☐	☒	☐	☐	☒

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	Delivery System Committee	Eligibility & Enrollment Committee	Federal Laws Committee	Finance Committee
targeted outcomes, and the outcomes themselves. Data & evaluation support will be provided through partnership with Public Health. c) Effective programs will be shared and problem-solving will be facilitated through convening regional collaborative leadership (in person or virtually) on a quarterly basis in learning collaboratives.					
Renewable contracts for public health initiatives must be awarded to health care clinics that partner with culturally-specific social service organizations (including organizations that focus on Persons with Disabilities, GLBT populations, homeless youth or adults, and populations with low literacy and illiteracy) to provide an integrated health care home. Clinics that have established in-house capacity for culturally-specific approaches would not be required to contract out for services already being rendered. a) Partnership must include contractual financial agreements. b) Social service organizations will provide culturally-specific approaches to health promotion, self-management for chronic diseases, and disease prevention. These approaches may include:	☐	☒	☐	☐	☒

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	**Delivery System Committee**	**Eligibility & Enrollment Committee**	**Federal Laws Committee**	**Finance Committee**
i. Peer-to-peer health education programs ii. Community Health Workers Contracts for public health initiatives must be based on a rate, adjusted to reflect the needs of the population, for serving a specified number of individuals in that population.	☐	☒	☐	☐	☒
a) Organizations will be accountable on measures of process and outcomes that will reflect realistic timelines of: i. preventing chronic disease ii. promoting population health iii. chronic care management iv. attention to health literacy v. accessibility to patients b) Contracts can be administered directly through the Health Fund Program or through a managed care organization.					
Accountable health plans must reimburse a broader range of health professional including, but not limited to, Community Health Workers, and a broader range of services including, but not limited to, peer-led disease management support groups in culturally specific programs to maximize the health and function of individuals, families and communities.	☐	☒	☐	☐	☒
It is a long held Oregon value that all Oregon residents have equal opportunity to support their	☐	☐	☒	☐	☒

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	**Delivery System Committee**	**Eligibility & Enrollment Committee**	**Federal Laws Committee**	**Finance Committee**
families, pay taxes, and contribute to the State's economy. To maintain the health of that workforce, it is fair, wise and in the State's economic interest that the Oregon Health Fund program shall be available to all Oregon residents.					
As consistent with current practices in the private marketplace, no citizenship documentation requirements will be in place to participate in the Oregon Health Fund program.	☐	☐	☒	☐	☒
Investigate the possibility of obtaining a federal waiver exempting Oregon from the citizenship documentation requirements established by administrative rule, stemming from the Deficit Reduction Act of 2006.	☐	☐	☒	☒	☐
Request returning to previous documentation methodology employed by the Department of Medical Assistance Programs. Findings from a previous state audit demonstrated that this methodology was an effective mechanism for ensuring appropriate participation in Oregon Medicaid and Medicaid-expansion programs.	☐	☐	☒	☒	☐
A media-only approach to outreach for the Oregon Health Fund Board is not an adequate response to reducing health disparities in health insurance status in Oregon.	☐	☐	☒	☐	☐
A sustainable funding mechanism, with additional Medicaid matching funds, must support	☐	☐	☒	☐	☒

Health Equities Committee Recommendations	Oregon Health Fund Board				
	Benefits Committee	**Delivery System Committee**	**Eligibility & Enrollment Committee**	**Federal Laws Committee**	**Finance Committee**
community-based organizations in delivering culturally-specific and targeted outreach and direct application assistance to members of racial/ethnic/language minority communities, individuals living in geographic isolation, and populations that encounter additional barriers such as individuals with cognitive, mental health, deafness or sensory disorders, physical disabilities, chemical dependency or mental health condition, and individuals in homelessness.					
Community-based approaches to outreach should be collaborative rather than competitive among agencies that serve vulnerable populations.	☐	☐	☒	☐	☐
The Office of Multicultural Health and county health departments should have a key role in ensuring that barriers to outreach and enrollment are addressed at both the community and system level and that those efforts are continuous and coordinated between the Oregon Health Fund Program, Department of Medical Assistance Programs, and community-based organizations involved in outreach	☐	☐	☒	☐	☐
The Office for Oregon Health Policy & Research should evaluate the effectiveness of the county-based organizations specific to enrolling vulnerable populations.	☐	☐	☒	☐	☐

APPENDIX C

Outreach and Enrollment

Health Equities Recommendations	Implementation States	State Medicaid Examples
• Aggressive outreach with sustainable funding and multicultural community leadership	• CA, IL, GA, NJ, NH, NM, NY, TX, WA, WI	• The New Jersey Division of Medical Assistance and Health Services and the New York State Department of Health (DOH) contract with community-based organizations that represent various population groups for outreach. New Jersey translates materials including fact sheets into seven languages. New York uses facilitated enrollers to assist individuals in completing enrollment forms and in assembling documentation required for enrollment. • New York State DOH contracts with an enrollment broker for the State's Medicaid Managed Care program. The enrollment broker operates a statewide HelpLine and conducts education, outreach, and enrollment services on behalf of local social services districts in New York City and Long Island. Separate toll-free numbers are maintained for five languages. • The Texas Health and Human Services Commission award grants to support a promotores/as outreach model. Promotores/as, or community health workers, have been involved in outreach to Hispanic populations. The grants are testing models to support expanding promotores/as' roles to health education as well, and if successful, could eventually be incorporated into the Medicaid and SCHIP programs. • Texas launched a bilingual English and Spanish Web-based tool to help residents determine eligibility for more than 50 state assistance programs including Medicaid and a variety of medical assistance programs. State outreach efforts are conducted in primary languages spoken by ten percent of the population. • The Washington State Basic Health Plan program staff collaborate with the Medicaid program to conduct marketing and outreach through various community-based organizations (CBOs). Written materials, applications, and customer service, including telephone services, are provided in the five most utilized languages. CBOs and tribal entities that participate provide outreach, application assistance, advocacy, and access to services in a culturally appropriate manner. • The Wisconsin Bureau of Managed Health Care Programs holds Medicaid and SCHIP community forums quarterly. The state contracts with agencies that represent various racial and ethnic populations to conduct outreach.

Access for Immigrants

Health Equities Recommendations	Implementation States	State Medicaid Examples
• Expand access to non-qualified Oregon residents [legal residents that have been citizens for less than 5 years]	• CA, CT, DE, HI, Il, MA, ME, MD, MN, NY, PA, RI, TX, VA	• California, Illinois, Massachusetts, New Jersey, and New York provide the most comprehensive state-funded coverage to legal-immigrant pregnant women during the five-year bar. • California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nebraska, New York, Pennsylvania, Rhode Island, Texas, Virginia and Washington are currently using their own funds to provide assistance to at least some children during the five year bar.

Benefit Design

Health Equities Recommendations	Implementation States	State Medicaid Examples
• Provide coverage for services related to Community Health Workers and alternative medicine.	• AK, NM, NY	• The State of Alaska has recognized community health aides/practitioners as billable providers for Medicaid reimbursement. • New Mexico state Medicaid office to establish a billing code for the "Coordinated Systems of Care Community Access Program (CSC-CAPNM) Community Health Workers. • New York's Medicaid managed care plan Health Plus employs 35 Community Health Workers as part of their staff.
• Provide incentives for wellness and prevention.	• FL, ID, IN, KS, MI	• In Florida, the state deposits funds for Medicaid beneficiaries into account to reward healthy behaviors, such as weight management, smoking cessation, and diabetes management. These funds could be used for health care related expenses at a participating pharmacy and enabling them to access additional services or products identified by the Medicaid program. • Idaho has two programs: participants in the Wellness PHA must keep child wellness exams and immunizations up to date in order to earn points. The Behavioral PHA requires that beneficiaries sign a "personal responsibility contract" to receive points that is based on achieving specified goals that are verified by a state agency. • Indiana's Personal Wellness Responsibility (POWER) Accounts allow beneficiaries to up to $500 of unspent funds (of $1,100) may be returned to participants if preventive services are completed. • Kansas' Get Healthy accounts provide incentives to beneficiaries who are engaging in healthy behaviors. Funds are deposited in accounts to offset specific health care-related costs, such as co-payments, smoking cessation and weight loss programs.

Language and Communication Access

Health Equities Recommendations	Implementation States	State Medicaid Examples
• Seek federal matching funds for interpreter services through Medicaid for provider organizations that serve Medicaid patients by making interpreter services affordable, thereby eliminating the disincentive for providers to see non-English speaking patients.	• CA, DE, IL, MA, NJ, NH, TX, WA, WI	• California's SCHIP (Health Families Program) and Medicaid (Medical) programs require health plans to notify enrollees of free interpreter services of their choice. Subscribers must be informed of availability of linguistic services such as the right to interpreter services at no charge, translated materials, and complaint procedures. Plans must assess the cultural competence of their providers on a regular basis and maintain an information system capable of identifying and profiling cultural and linguistic specific patient data. • Delaware and Wisconsin Medicaid managed care contracts specify that health plans must comply with all existing Federal employment laws, including but not limited to Title VI. • Illinois Medicaid and SCHIP programs must translate written materials and provide free interpreters for beneficiaries. • Massachusetts Medicaid has incorporated all Culturally and Linguistically Appropriate Services (CLAS) standards in the areas of language access services into its managed care contracts. Multilingual providers and skilled medical interpreters must be available for the most commonly used languages in each region of the state. The state has identified a need for technical support for writing CLAS standards in language that is user-friendly for plans. • New Jersey requires health plans to document availability and access procedures for providers, telephone assistance, and interpreter services; provide 24 hour interpreter access; report on the linguistic capability of interpreters or bilingual staff; provide professional interpreters when needed; maintain a list of interpreters who are on call; and provide other linguistic services to enrollees if they exceed five percent of those enrolled in the health plan's Medicaid/NJ Family Care line of business or 200 enrollees in the health plan. • Washington requires written information to be provided in a form that can be understood by each individual enrollee. The requirement can be met by translating the material, providing it on tape, having an interpreter read the material in the enrollee's primary language, or providing the material in an alternative format.

Data and Quality

Health Equities Recommendations	Implementation States	State Medicaid Examples
• Collect and report data on race, ethnicity, age-appropriate sexual orientation, gender, disability status, and primary language. These measures need to be included when assessing quality and ensuring transparency. • Develop a health disparities strategy that utilizes data to identify disparities and assist communities with evaluating interventions to reduce disparities. • Disseminate meaningful and accurate information on health quality and utilization of healthcare resources in a manner that is accessible and understandable to individuals from a variety of cultural, ethnic, and educational backgrounds.	• CA, GA, MA, NJ, NY, PA, SC, WA, WI	• The California Department of Health Services and New Jersey Division of Medical Assistance and Health Services require health plans to conduct group needs assessments to identify health education and cultural and linguistic needs and resources. Both states conduct annual evaluation of services provided and proposed to meet this need. California plans must also assess and report on the linguistic capabilities of interpreters and employed and contracted staff. • Massachusetts health plans must maintain an updated database on providers, to the extent available, about race, ethnicity, and language of enrollees. • New York requires health plans to provide a list of participating providers, including their language capabilities, to enrollees and to take special language information into consideration in assignment of providers. • The Washington Medical Assistance Administration has incorporated National Committee for Quality Assurance (NCQA) standards language into its managed care contracts. Among the requirements, health plans must take into consideration assessed special and cultural needs and preferences of enrollees in creating its delivery systems of practitioners and must provide equal access when oral or written language is a barrier to care. Plans must also monitor performance using HEDIS (standardized performance measures) and CAHPS (a nationally standardized survey of patient experience). • The Wisconsin Bureau of Managed Health Care Programs requires health plans to permit enrollees to choose providers from among the network based on linguistic/cultural needs as well as geographic location. Health plans must permit enrollees to change primary providers based on ability to provide services in a culturally competent manner. Enrollees may submit grievances to the health plan and/or the state related to inability to obtain culturally appropriate care, and the. • Pennsylvania hospitals are required to report on hospital-acquired infections, medication errors, readmissions, patient-safety measures, and clinical improvements that include data on race and ethnicity. • California, Illinois, Massachusetts and Pennsylvania all require specific ratios of providers to plan enrollees.