



## FOR DELIVERY & PAYMENT TRANSFORMATION

# Eight Recommendations for Federal Policy Priorities in 2021

Our country is at a critical juncture when policymakers will need to decide about how to improve our health care system, make meaningful investments in our public health infrastructure, and address social and economic drivers of health. In the new presidential term and the 117th Congress, it is imperative that we have bold, innovative leadership to steer us through one of the biggest health and economic crises in generations and embrace a path toward achieving greater health equity. Policy leaders who are committed to anti-racism and advancing racial equity-based changes in systems are essential to achieving greater health equity.

The federal Health Equity Task Force for Delivery and Payment Transformation brings together health equity and system transformation thought leaders from across the nation representing diverse communities. The Task Force leverages health system transformation efforts to develop and integrate policies that help to ensure that no one in our nation faces barriers to achieving optimal health because of who they are, where they live, what language they speak or how they identify. It uses a racial equity and intersectional approach to ensure that the multidimensional experiences and needs of the communities who are most often marginalized or harmed by systems, public policies and institutional practices are at the center of policymaking.

This moment calls for policymakers to step forward and tackle the longstanding systemic barriers to optimal health, including rooting out structural racism. Across all federal efforts, policymakers must identify and address racism as a public health issue – a step the American Public Health Association recently took.<sup>1</sup> Furthermore, addressing inequities in health and health

care must be an explicit, foundational goal of health policy. The *Health Equity and Accountability Act (HEAA)* is a blueprint for such policy.

In this brief, we present eight recommendations that offer concrete steps policymakers can take to address the the barriers that lead to such inequities. These recommendations are interrelated and focus on disrupting and remedying the inequitable distribution of power and resources, which cause harm, perpetuating and exacerbating health inequities.

### **RECOMMENDATION 1: Advance Equity-Focused Health System Transformation**

The U.S. health care system is designed to incentivize high volumes of clinically based care for sick people rather than to improve all people's health. It does so at exceedingly high cost and at low value for consumers. Despite spending far more on health care than similar industrialized countries, the U.S. ranks last in overall health outcomes compared to those countries on measures that matter for a healthy and successful life: quality, access to care and equity.<sup>2</sup> Efforts to realign

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the system toward improved overall health and wellbeing are proliferating and provide vehicles that must be tapped to ensure that they are centered on equity. Examples include Accountable Communities of Health, patient-centered medical homes, and accountable care organizations.

While these new payment and delivery models offer promise as a means to reorient the health care system toward achieving better health at lower cost, they can risk exacerbating existing inequities if a racial equity lens is not central to the design and implementation of such reforms.

To provide concrete ways to evaluate equity-centered health system transformations, the Task Force created a three-step rubric to assess whether a specific delivery and payment reform model explicitly focuses on remedying inequities.<sup>3</sup>

1. Is the model designed to reduce or eliminate inequities in health outcomes generally or in specific populations?
2. Does the risk adjustment effectively account for clinical and social risk within and across groups with documented health inequities, and does it safeguard against disincentives for payers and providers to take on more complex patients?
3. Does the model take into account underlying resource inequities for the individuals, communities, and providers who serve those communities?

**The Task Force encourages efforts to:**  
***Design and Implement Payment Systems That Sustain and Reward High-Quality, Equitable Health Care***

- » Develop a core equity measure set and require all payers and providers to report on those measures.
- » Incorporate health equity into quality measurements and performance-based payments, including paying providers for reducing disparities in health outcomes as part of a core payment reform package. States should replicate and build on initial “pay for equity” efforts with federal support and prioritization. And Medicare pay-for-performance programs should stratify measures (by race, ethnicity, and primary language at minimum) and move to incentivize the reduction of disparities across these measures.
- » Require and incentivize provider collection of patient social and behavioral risk data disaggregated by key demographic factors (described below) through Medicare, Medicaid, and commercial insurance value-based payment programs, with appropriate privacy and antidiscrimination protections.
- » Accurate collection of data on race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status is a critical but difficult step in implementing equity payment incentives in health care.
- » Amend the Center for Medicare and Medicaid Innovation’s (CMMI) statutory language to include a focus on improving health equity, in addition to reducing program expenditures.

- › Require CMMI and state-level Medicaid or multi-payer payment reform initiatives to collect input from a diverse group of consumer advocates, community providers, and other key stakeholders when developing new value-based payment models, such as during the Request for Information and early design phase, the Technical Expert Panel application phase, and the evaluation design phase. This will help ensure that efforts to move toward value-based payment appropriately account for the health disparities experienced by BIPOC.
- › Establish payment and delivery models with CMMI authority that support and incentivize a focus on the social, emotional, behavioral and relational health of children, ideally as part of a high-performing pediatric medical home. These models must prioritize equitable health outcomes, particularly for Black, Indigenous, and people of color (BIPOC) children and families, and address inequities in reimbursement for community-based providers such as peer providers and community health workers (CHWs).

### ***Support Safety Net and Small Community Providers in Delivery System Reform***

- » Invest in the transition of diverse safety net and small community providers to value-based health care systems. These providers include behavioral health providers, family care practices, advanced practice nurses, community health centers and urban Indian organizations. Delivery system reform and integrated provider financing involve significant new expenses for health care providers. These expenses can include hiring new staff, training

existing staff (particularly around community-based interventions), installing new information systems and training staff to use them, increasing overall business capacity to manage a value-based payment approach, and making physical modifications to clinical space.<sup>4</sup>

- » Require CMS to establish a targeted Medicaid waiver opportunity that supports equity-focused delivery system reform investments, with a goal of making small, targeted investments that are available to all states.
- » Provide upfront financial support and technical assistance to help health care organizations and providers make health equity-focused investments, such as supporting infrastructure, standardizing screening tools for social determinants of health (SDOH), referral and collaboration tools or scaling team-based care. Identify “hubs” such as schools and housing to facilitate trusted collaborations (see this Brookings series<sup>5</sup>).

### ***Build Robust, Well-Resourced Community Partnerships***

- » Provide funding and technical assistance to community-based organizations (CBOs) for managing vendor contracts and improving their information technology infrastructure for business development and administrative operations (such as building their capacity to bill insurers). This will enable CBOs to maximize their ability to coordinate with community members and health systems to provide services, track clients’ progress and seamlessly exchange relevant information with providers.
- » Strengthen requirements to invest in community-based interventions, for example, hospital

community benefit and aligning community health assessments across multiple entities to triangulate on community need, to invest in BIPOC communities, both through business practices and by engaging community residents.

### **Ensure a Transparent, Representative Evidence Base**

- » Require all publicly funded medical and public health researchers to report their results disaggregated by race, ethnicity, primary language, geographic location, socioeconomic status, gender identity, sexual orientation, age and ability status.
- » The Office of Management and Budget and the Census Bureau should develop protocols, in consultation with community members, data users and researchers, for using data disaggregation consistently throughout the collection, analysis, and reporting of racial and ethnic subgroup data.
- » Ensure that these protocols are applicable to data policy leaders at every agency, such as the Departments of Health and Human Services, Housing and Urban Development, Transportation, and Labor

### **Grow a Culturally and Linguistically Diverse Health Care Workforce That Drives Equity and Value**

Require education and training for all health care providers to focus on culturally centered, language-accessible care; standardized data collection; social determinants of health; the effects of structural racism and discrimination on health; cultural humility (a process of reflection about personal and cultural biases and sensitivity to the cultural issues of others) and implicit bias in the health care system.

Invest in and expand K-12 “pipeline” programs, such as the federally funded Health Career Opportunities Program (HCOP), and college and postgraduate support to ensure academic readiness and to provide multiple entryways into health care professions for more people from underrepresented groups.

### **RECOMMENDATION 2: Bolster Investments in the Public Health Infrastructure**

The coronavirus pandemic is devastating BIPOC communities, shining a light on systemic racism and widening existing inequities. In addition, the available data on the pandemic are undercounting its impact on communities of color, specifically Asian Americans (AAs), American Indians and Alaska Natives (AI/AN), and Native Hawaiian and Pacific Islander (NHPI) communities.<sup>6</sup>

Substantial funding for public health, including funding to develop and distribute culturally and linguistically appropriate materials for pandemic-related programs and opportunities, is critical to improving population health. The entire public health workforce, including the new capacity created in the community-based health workforce, should be brought to bear to create innovative, community-centered solutions. Community outreach must include proactive engagement of trusted leaders in shaping these efforts.

#### **The Task Force encourages efforts to:**

- » Fund the Racial and Ethnic Approaches to Community Health (REACH) program at \$76.95 million. This is the only CDC program that funds communities working to reduce racial and ethnic health disparities.
- » Fund the Office of Minority Health at HHS at \$65 million.

- » Protect and defend against additional cuts to the Prevention and Public Health Fund (PPHF), and ensure that funds are used for programs it was intended to assist. The PPHF has been cut by \$11.85 billion dollars from FY2013 through FY2027.
- » Fund and grow the community-based health workforce, including community health workers (CHWs), by partnering with existing community workforces to identify and implement ways to sustainably finance their services through Medicaid and CDC funding.

### **RECOMMENDATION 3: Uphold Civil Rights Protections for People with Disabilities, Transgender People, Women, and People with Limited English Proficiency**

Civil rights and their implementation and enforcement are determinants of racial and health equity.<sup>7</sup> Longstanding nondiscrimination laws, such as the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and Section 1557 of the ACA, prevent discrimination against several protected groups. However, states have yet to fulfill the promises of the ADA and continue to interfere with the civil liberties of people with disabilities, including by enacting barriers to accessing long-term services and supports (LTSS) in the community.<sup>8</sup> Administrative actions to roll back nondiscrimination protections, such as the removal of language access requirements and placing women at risk of being denied emergency contraceptives and prenatal care, only deepen health inequities.

#### **The Task Force encourages efforts to:**

- » Strengthen implementation of Section 1557 of the ACA, which prohibits discrimination based on race, color, national origin, sex, age and

disability, in health programs and activities that receive federal funding. In addition, require all federal agencies to comply fully with Section 1557 language access provisions, including increasing the availability of in-language ACA notices as provided in the 2016 Final Rule.

- » Prioritize opportunities for seniors and people with disabilities to receive home- and community-based services (HCBS) by providing targeted grants to states to increase HCBS.
- » Enact civil rights legislation like the *Disability Integration Act*, which prohibits government entities and insurance providers from denying community-based services (including LTSS) to people with disabilities.
- » Increase federal oversight of the creation and distribution of public health materials and information to ensure they are culturally and linguistically accessible for people who have limited English proficiency (LEP) and people with disabilities.

### **RECOMMENDATION 4: Advance LGBTQ+ Health Equity**

LGBTQ+ Americans face multiple inequities that lead to disparities in health and health care outcomes due to stigma, systemic trauma and hate.<sup>9</sup> These disparities, which are even greater for LGBTQ+ people of color, youth, and elders, include limited access to health coverage and care; higher rates of substance misuse; higher rates of mental health needs, and increased incidence of HIV, other sexually transmitted infections (STIs), and some cancers compared to the general population. Policymakers must address the recent rollback of anti-discrimination protections that further jeopardize health equity for LGBTQ+ people.

### **The Task Force encourages efforts to:**

- » Prohibit health programs or organizations that receive federal funds from discriminating based on race, color, national origin, age, disability, sex, sexual orientation, gender identity or presentation.
- » Withdraw the revised regulation under section 1557 of the Affordable Care Act (ACA) and reinstate the 2016 regulation. The revised regulation includes an ideologically based redefinition of sex discrimination that excludes discrimination based on gender identity and sexual orientation. This redefinition opens the door for health providers to refuse to treat people for any health condition based on people's gender identity or sexual orientation.
- » Improve data collection, particularly for federally funded surveys aimed at understanding health disparities experienced by LGBTQ+ people. In addition, improve collection of data on sexual orientation and gender identity (SOGI), for example, by passing the *LGBT Data Inclusion Act*.
- » Eliminate discriminatory and harmful practices, including ending categorical prohibitions for state Medicaid dollars to be used for services related to sex reassignment and barring the use of Medicaid funds for so-called conversion therapy. This includes passing the *Prohibition of Medicaid Funding for Conversion Therapy Act*.
- » Ensure that school-based sex education for all youth is inclusive of diverse sexual and gender identities and includes information on building healthy relationships, sexuality and sexual development, sexual orientation and gender identity, pregnancy prevention, and STIs and HIV.

- » Fund research that prioritizes intersectional analyses of disparities in health and well-being outcomes for LGBTQ+ people, particularly transgender BIPOC communities, older LGBTQ+ populations, and LGBTQ+ people with disabilities.

### **RECOMMENDATION 5: Strengthen Investments in the Health and Well-Being of Children and Youth**

Policymakers must work to improve health outcomes for children, with a focus on eliminating racial and ethnic disparities from early childhood through adolescence. Strengthening investments in children also means strengthening investments in parents, caregivers, and families who engage with a variety of sectors that affect their health and well-being, including the health care, child welfare, housing and education systems. For example, structural racism in the form of residential segregation, discrimination in bank lending, discriminatory policing, and sentencing practices, limit parents' ability to provide healthy living conditions for their children.<sup>10</sup> Further, disparities exist between LGBTQ+ foster youth and their non-LGBTQ+ peers, which are compounded by intersecting factors like race, ethnicity, culture and language. This highlights the need for culturally responsive child welfare programs in particular.<sup>11</sup>

Due to all these factors, there is a great need to invest in and build the evidence for culturally responsive programs throughout these systems that meet the needs of BIPOC and LGBTQ+ children and families.

### **The Task Force encourages efforts to:**

- » Transform child welfare policies and practices to promote the healthy development of LGBTQ+ and [gender-expansive children and youth](#).

- » Scale up home visiting programs like those funded through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, in addition to requiring that home visiting programs are culturally responsive. MIECHV programs serve only about one-third of U.S. counties, and expanding these programs would broaden their reach to the communities that need it most.
- » Connect disparate federal systems, for example, by blending funds from various federal programs, to serve children and families more equitably. These federal programs include Medicaid, juvenile justice, public health (including Title V Maternal and Child Health Services Block Grant) child welfare, housing, and education. Transparent sharing of disaggregated data among systems in a manner consistent with privacy protections under Family Educational Rights and Privacy Act and the Health Insurance Portability and Accountability Act must be prioritized.
- » Reinststate the Department of Education’s guidance on school discipline, which enforces disparate impact liability and calls for investigation of disparities in school discipline.
- » Increase economic security for working families with children by expanding the Earned Income Tax Credit (EITC) and making the Child Tax Credit (CTC) fully refundable.
- » Develop multigenerational demonstration models, including child care demonstration models, that focus on children, families, and social determinants of health, including infrastructure support and provider training on whole-child care models.

## **RECOMMENDATION 6: Accelerate Behavioral Health Equity**

According to the American Psychological Association, “the inadequate provision of culturally and linguistically responsive mental health care in racial and ethnic minority communities demonstrates a clear need for encouraging collaboration and finding ways to close the gap in care.”<sup>12</sup> These inaequencies affect other diverse groups, including LGBTQ+ populations and people with disabilities, as well as across the lifespan from childhood to transition-age youth and adulthood.<sup>13</sup> They affect people with mental illness across levels of severity and those struggling with substance abuse (many of whom have co-occurring mental and physical health challenges). Moreover, community conditions such as community-level trauma and community disinvestment can contribute substantially to poor behavioral health outcomes.

### **The Task Force encourages efforts to:**

- » Expand access to high-quality, culturally appropriate social, emotional and behavioral health supports that also address the impact of trauma.
- » Ensure access to evidence-based and emerging best practices in assessment, intervention and recovery supports that are tailored to address the unique needs of BIPOC and other communities that are often marginalized.
- » Build a robust behavioral health system that creates opportunities for people with behavioral health needs to live successfully in the community, and that limits the use of acute and institutional care where not indicated (for example, in hospitals, jails and prisons).
- » Promote successful community reentry from carceral settings by pushing CMS to issue guidance

(as required in the SUPPORT Act) to allow states to reactivate Medicaid benefits for justice-involved individuals 30 days before release.

- » Ensure that federal grants (for example, SAMHSA block grants and State Opioid Response grants) require equitable access to services and supports for BIPOC and other communities that are often marginalized.
- » Prioritize trauma-informed care and the prevention and mitigation of adverse childhood and community experiences. These experiences are also overrepresented in the BIPOC communities and undersupported. Federal investment should track these inequities and incentivize increased access to high-quality services and supports for affected families.
- » Fulfill the promise of mental health parity, that is, ensure compliance with the *Mental Health Parity and Addiction Equity Act* (P.L. 110-343), in public and commercial health systems by enforcing full implementation of parity laws in all states.
- » Require federal funding agencies, such as HHS, to incorporate culturally and linguistically responsive guidelines into proposals for programs for BIPOC children, youth, and families with behavioral health needs.

## **RECOMMENDATION 7: Address the Social and Economic Drivers of Health**

Social determinants of health (SDOH) – the conditions in which people live, learn, grow, work and play – drive health outcomes and health care costs.<sup>14</sup> Health inequities stem from inequalities in these determinants. We use three principles to guide our SDOH policy approach:

1. Policies that target unmet health-related social needs must be paired with more policies that address the upstream structural drivers, like racism, that created the conditions for those unmet health-related social needs at the community level.
2. Community coordination systems must work efficiently to connect people to health promotion and support services.
3. Policy solutions that target upstream determinants of health are only one part of a comprehensive health equity strategy.

### **The Task Force encourages efforts to:**

- » Create a formal White House Interagency Task Force focused on achieving health justice. The Task Force will coordinate work on core public health and environmental and economic justice issues across the White House and multiple major federal agencies, as well as across existing and new health, infrastructure, housing, and environmental funding streams. This work would have a short-term goal of producing and implementing our recommendations in 2021. The long-term goal of this work would involve overseeing a strong, broad program that makes substantial progress on the unacceptable inequities that drive population health disparities.
- » Fund the creation of the Social Determinants of Health Program within the CDC at \$50 million. This program would award grants to community-based organizations (CBOs) to conduct research on SDOH best practices, provide technical training and evaluation assistance, and/or disseminate those best practices.



- » Pass comprehensive paid sick leave and family leave policies that cover all workers, including part-time, contingent, and self-employed workers. These policies should be designed to avoid further exacerbating economic inequality and health inequities, particularly for women and people of color. The policies must also include language that ensures coverage for at least 12 weeks of leave, dedicated funding for outreach and education, portability, progressive wage replacement, and protection against discrimination and retaliation.
- » Reduce barriers to accessing the Earned Income Tax Credit, Supplemental Nutrition Program for Women, Infants and Children (WIC), and the Temporary Assistance for Needy Families (TANF) program, including the Tribal TANF program, to help families meet basic needs such as food, housing and child care.
- » Invest in evidence-based programs (i.e., the *Reverse Mass Incarceration Act*) that are designed to reduce incarceration rates and provide states and counties with financial incentives to reduce imprisonment, since mass incarceration is a major threat to health equity.
- » Reinvest funds from law enforcement budgets to address upstream determinants of health while prioritizing the communities that are most often harmed by unjust policing policies.

## **RECOMMENDATION 8: Ensure Equitable Access to Health Coverage**

The new Congress and administration must move toward a national and universal guarantee of health coverage, including mental and oral health, like every other advanced nation. It would be a grave

injustice to leave large segments of the population out of our health care system, including justice-involved populations, immigrants of any status, families with mixed immigration status, people who were granted Deferred Action for Childhood Arrivals (DACA) status, Pacific Islanders who entered the U.S. under the Compacts of Free Association (COFA),<sup>15</sup> people with Temporary Protected Status, and people without U.S. residency status.

### **The Task Force encourages efforts to:**

- » Eliminate all immigration-based barriers to care, including the discriminatory five-year waiting period for noncitizen access to Medicaid and the Children’s Health Insurance Program (CHIP).
- » Halt immediately the implementation of the Department of Homeland Security’s and Department of State’s public charge rules retroactive to February 24, 2020, and then withdraw those regulations.
- » Allow all immigrants, regardless of status, to obtain ACA coverage with financial support, in addition to restoring and increasing funding for outreach and enrollment for the ACA, Medicaid and Medicare.
- » Remove the exclusion of DACA recipients from enrolling in the health care marketplace and receiving subsidies, as well as any other exclusions for Medicaid and CHIP coverage.
- » Address the coverage gap experienced by people with incomes above Medicaid eligibility limits but below the poverty level, especially those in states that have not expanded Medicaid.
- » Reduce premiums and cost-sharing for low-income people who have coverage through the ACA marketplaces.

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- » Expand access to oral health coverage and care by adding oral health coverage to Medicare and expanding Medicaid adult dental coverage.
- » Extend a state option for Medicaid coverage to justice-involved individuals up to 30 days prior to their release from incarceration, which would help reduce recidivism and improve their health and well-being.
- » Extend Medicaid postpartum coverage for at least 12 months after delivery.
- » Require a minimum of one year of continuous eligibility for children in Medicaid and CHIP.
- » Ensure that the Indian Health Care Improvement Act (IHCA), which authorizes many Indian Health Service (IHS) activities, remains permanently authorized and retains American Indian/Alaska Native-specific provisions.
- » Ensure that communications needs do not create barriers for people who have limited English proficiency; people who are deaf, hard of hearing, or blind; and people who cannot rely on speech to be heard and understood.

### **Call to Action**

It is long overdue for policymakers to address the barriers that lead to inequities in health and health care outcomes. The new Congress and administration must commit to advancing health equity, which also demands a commitment to achieving racial equity. The recommendations we have discussed offer a path toward achieving these goals. These recommendations also leverage the movement toward value and the need to develop and integrate policies that help to advance equity. Policymakers must prioritize the communities who are most often marginalized or harmed by systems, public policies and institutional practices, and they must consider the voices of marginalized communities when designing and implementing delivery and payment reforms.

## Endnotes

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<sup>8</sup> *Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act* (United States

Senate, July 2013), <https://www.help.senate.gov/imo/media/doc/Olmstead%20Report%20July%20202131.pdf>.

<sup>9</sup> *Advancing Effective Communication, Cultural Competence, and Patient- and Family Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide*, (The Joint Commission, October 2011), [https://www.jointcommission.org/-/media/enterprise/tjc/imported-resource-assets/documents/lgbtfieldguide\\_web\\_linked\\_verpdf.pdf?db=web&hash=1EC363A65C710BCD1D4E14ED120CB237](https://www.jointcommission.org/-/media/enterprise/tjc/imported-resource-assets/documents/lgbtfieldguide_web_linked_verpdf.pdf?db=web&hash=1EC363A65C710BCD1D4E14ED120CB237).

<sup>10</sup> Paula Braveman, Julia Acker, Elaine Arkin, Jamie Bussel, Kathryn Wehr, and Dwayne Proctor, *Early Childhood Is Critical to Health Equity* (Robert Wood Johnson Foundation, May 2018), <https://www.rwjf.org/en/library/research/2018/05/early-childhood-is-critical-to-health-equity.html>.

<sup>11</sup> Megan Martin, Leann Down, and Rosalyn Erney, *Out of the Shadows: Supporting LGBTQ Youth in Child Welfare through Cross-System Collaboration* (Center for the Study of Social Policy, May 2016), <https://cssp.org/wp-content/uploads/2018/08/Out-of-the-Shadows-Supporting-LGBTQ-youth-in-child-welfare-through-cross-system-collaboration-web.pdf>.

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Families USA  
Health Equity Solutions  
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