FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

Recommendations for State Policymakers to Advance Health Equity

The following recommendations are based on research and interviews with 50 community leaders in 20 states and the District of Columbia. For more information, see the related paper: Families USA, "Community Voices: Recommendations to State Policymakers for Advancing Health Equity," March 2022.

1. Equip community organizations to work for equity

States should engage directly with community-based organizations working toward equity. Specifically, state policymakers should be proactive in identifying opportunities to include community-based organizations in policymaking and in funded health initiatives. They should consult community-based organizations that serve and are led by people of color about state health policy initiatives and solicit their comments. In addition, because community organizations may have small staffs, state policymakers should reach out when there are requests for proposals that have the potential to improve equity.

2. Mobilize to fight racism and bias

State health agencies and policymakers should be proactive in efforts to combat racial myths that undermine health care. Overt racism as well as the underrepresentation of communities of color in clinical trials have contributed to race-based myths about who is at risk for various diseases and who can benefit from health interventions. Public health departments can counter myths through disease prevention and disease education campaigns. For example, these should range from HIV campaigns that explain that undetectable = untransmittable (meaning a person living with HIV who has an undetectable viral load cannot sexually transmit the virus to others) to campaigns that help patients and providers recognize, manage and treat multiple sclerosis in people of color.[1] Beginning in

2022, state Medicaid agencies can now cover the "routine costs" of participation in clinical trials, a provision that can help increase diversity in these trials. States should help residents with Medicaid learn about available trials relevant to their conditions and pay for transportation to associated appointments.[2]

State policymakers should increase the number of professionals in health care who are people of color and ethnic minorities, including professionals in behavioral and oral health. This will require affordable medical education and deliberate recruitment of a workforce that includes people of color. State workforce planning agencies — which can use a variety of federal grants, state assets and funds generated from health care systems — should make this a major goal.[3]

States should provide reimbursement for community-based doulas, midwives, and culturally centered birthing practices. States should consider options to reimburse doulas through Medicaid at a level of payment that makes doula care a viable career. Reimbursing doulas adequately as a preventive service allows them to bill Medicaid directly rather than under a physician's billing system and can allow doulas to provide more home visits and a wider array of services.[4] When crafting certification and reimbursement rules, Medicaid agencies should involve lay birthworkers and individuals representing diverse backgrounds, cultures, and experiences. States can also use maternal and child health block grants to pay for doula care and care routed in traditional and ancestral knowledge. Midwives, associated with reductions in maternal mortality, can be an especially important resource in "maternity care deserts."[5] Federally, 60 bills have been introduced in the 117th Congress to expand the use of doulas and midwives, including the Black Maternal Health Momnibus Act, which will take a major push to get through Congress and signed into law.

States should fully integrate community health workers (CHWs) into care teams. State policymakers should recognize the broad skill sets CHWs can bring to care teams and should facilitate their employment. CHWs should be at the center of any state certification process, where they can provide valuable input into what works. Medicaid state plan amendments, Section 1115 waivers and managed care contracts can provide an important source of funding for this workforce, and states should ensure that CHWs payment methodologies result in adequate pay for the full scope of their services.[6]

States may wish to register their support for legislation being considered in Congress, such as the bipartisan Building a Sustainable Workforce for Healthy Communities Act. This would create a long-term funding source to grow the CHW workforce via a competitive grant program for eligible entities (including state and local governments, Indian tribes or tribal organizations, urban Indian organizations, and community-based organizations) to develop or expand CHW programs.

3. Address disparities through research and measurement

States should examine and correct metrics that determine who gets care and improve oversight of health systems. Specifically, states should assure that racial algorithms do not undermine accountability for health systems for underdiagnosing or undertreating conditions for people of color. For example, researchers have found that an algorithm that determines who should get high-risk care management based on their previous health care costs discriminates against Black people who have serious diseases yet low previous health care costs due to access barriers.[7] In their quality oversight activities, state Medicaid managed care organizations should assure that managed care plans are not using racially biased medical algorithms to determine who gets care. State legislators can also pass legislation prohibiting the use of biased algorithms and allowing medical professionals to override algorithms when, in their judgement, a patient needs additional care.[8] Regulators, through hospital and health facility oversight surveys and accreditation reviews, should ensure that health care providers take pain seriously, provide nonpharmacological pain treatment and do not dismiss the expressed concerns of any racial or ethnic groups.

State policymakers should require health systems to measure health care disparities and reduce them. States should ensure that health systems collect data by race, ethnicity and language for all relevant populations in their communities. This may include breakdowns of the Asian American and Pacific Islander population and data on populations from the Middle East and North Africa to better understand health status and barriers faced by various immigrants and refugees, linguistic minorities, and people who have faced long-standing discrimination. States should establish a pathway toward quality improvement that reduces disparities, especially in Medicaid, marketplace plans and publicly funded health care systems.

4. Provide equitable access to coverage

States that have not yet expanded Medicaid for adults and for postpartum people should do so. States that have yet to increase health care access through Medicaid expansion should take advantage of the increased financial incentives in the American Rescue Plan. In addition, states should take the option to provide 12 months of continuous coverage for children as well as 12 months of postpartum coverage following pregnancy.

States should avoid Medicaid losses as the public health emergency ends. Specifically, states should take action to make permanent improvements that simplify and streamline enrollment processes. When the COVID-19 public health emergency ends, states can improve automatic Medicaid renewals using available data through the ex parte process. This has benefits for enrollees and state agencies as eligible people maintain coverage, coverage gaps and associated costs are limited, and states experience less administrative burden.

States can identify other data sources that will provide updated contact and eligibility information to use in the ex parte process. Leveraging the Supplemental Nutrition Assistance Program (SNAP) is a particularly powerful source for ex parte redeterminations as a significant number of Medicaid enrollees also participate in SNAP. States should also partner with Medicaid managed care organizations to obtain updated contact information.

States should program their eligibility systems so that anyone found ineligible for Medicaid can be transferred to other coverage sources.

Some states allowed remote phone and online Medicaid applications for the first time during the public health emergency. In addition to continuing these practices, states should explore other easy enrollment practices, such as using tax returns to connect people with Medicaid and marketplace coverage.

States should provide health coverage to people regardless of immigration status. States should use options available to them in the federal Medicaid program and the Children's Health Insurance Program (CHIP) to provide coverage to lawfully residing children and all pregnant people regardless of the date they entered the country. Using state funding, they can and should provide health

coverage to people in all age groups regardless of immigration status. A number of states are phasing in such coverage, starting with children and older adults.[9] Federal legislation currently pending in Congress, such as the LIFT the BAR Act and the HEAL for Immigrant Families Act, would make coverage more widely available.

5. Provide equitable access to care

State policymakers should collaborate with tribal organizations in the administration of health programs. It is up to Congress to appropriate significantly increased funding to the Indian Health Service (IHS), which will serve to address complex issues, including replacing outdated IHS health care facilities or promoting self-governance through direct funding to tribes. However, states can work with tribal and intertribal organizations to partner on the administration of federally and state-funded programs and to maximize the impact of state and federal funds. Many times there are underutilized opportunities for innovation in how programs are administered through state and tribal collaborations.

States must provide language access services in dialects spoken in the community. States should fund both professional interpreter services and community-based organizations to adequately provide language access to all health care services and coverage programs. Consistent staffing dedicated to the community, beyond contract interpreters, is critical to address community needs. States must also ensure that health care facilities are meeting their language access obligations. States and facilities should be aware of smaller linguistic groups for which there are particular national obligations, such as with people from the Federated States of Micronesia. Cross-state arrangements with expert community-based organizations could help serve such groups.

States should work to combat public charge fears. Many immigrants remain fearful that using health care services could jeopardize their own or their families' immigration status. Federal rules and court cases clarify that this is not the case (except with regard to certain federally funded long-term care benefits). States can provide outreach in many languages to assure people that they are welcome and encouraged to use community health services. It is in the public's interest for everyone to have access to health care.

When needed, states should supplement services that are federally matched in Medicaid programs with state-funded services. States should allocate state funds, for example, to provide services to people with disabilities who are on long waiting lists for Medicaid home- and community-based care.

6. Implement and expand culturally centered behavioral health care

States should incorporate culturally centered, community-based models of behavioral health care. This might include incorporating peers as full and respected members of behavioral health teams; providing integrated and co-located mental, physical and oral health care; and providing reimbursement of tribal healing practices and other culturally centered evidence-based group practices. States should examine the benefits, access and network adequacy in their children's mental health programs, enhance services available in schools[10] and provide dyadic care models (for parent and child) in Medicaid programs. Equally important is that states require both private and public insurers to have adequate behavioral health networks and to actively recruit providers reflective of the communities they serve. As the 988 telephone hotline for behavioral health crises comes online this summer, states must ensure that hotline staff members are able to provide warm handoffs for both crisis and follow-up care and can provide help in all languages spoken in the community.

7. End inequities generated by health systems that have ramifications beyond health

State policymakers should require health systems to be good citizens that combat racial inequities. Health systems should make care readily accessible in low-income neighborhoods, and states should require or incentivize them to meet specific community needs. For example, state planning agencies can determine needs for health centers, facilities licensed to provide emergency services and mobile health units in various communities, and determine what (if any) requirements or financial incentives are appropriate. States can hold health systems accountable for: investing in affordable housing and not displacing it[11]; providing their workers with adequate pay and paid leave; diversifying staffs by

examining diversity, equity and inclusion policies; creating workforce pipeline training programs; and addressing social and environmental determinants of health. State health planning agencies should also require notice and review of planned health care consolidations,[12] and both state attorneys general and state hospital regulators can act to prevent health care consolidations that would reduce care or impose religious restrictions on the care available to entire communities.

States should improve free and reduced-price care policies and oversight. The federal government requires nonprofit hospitals to provide some free and reduced-price care, but leaves them to set their own guidelines. States should set specific requirements for nonprofit hospitals to ensure they are meeting community health needs assessment and community benefit requirements. In particular, states should monitor financial assistance programs to ensure that nonprofit hospitals are applying the federal tax benefits they receive to direct patient care. States should consider extending free and reduced-price care requirements to all hospitals. People's health should not be shortchanged because they have poor credit histories.

Endnotes

[1] "MS in the Black Community," National Multiple Sclerosis Society, accessed March 22, 2021, https://www.nationalmssociety.org/What-is-MS/Who-Gets-MS/MS-in-the-Black-Community.

[2] Samuel U. Takvorian, Carmen E. Guerra, and William L. Schpero, "A Hidden Opportunity — Medicaid's Role in Supporting Equitable Access to Clinical Trials," New England Journal of Medicine 384, (2021): 1975-1978, https://doi.org/10.1056/NEJMp2101627.

[3] Antezzo et.al, "State Strategies."

[4] Asteir Bey et al., Advancing Birth Justice: Community-Based Doula Models as a Standard of Care for Ending Racial Disparities (Ancient Song Doula Services, Village Birth International and Every Mother Counts, March 25, 2019), https://everymothercounts.org/wp-content/uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf; "Doula Medicaid Project," National Health Law Program, accessed March 22, 2021, https://healthlaw.org/doulamedicaidproject/.

[5] Black Mamas Matter: Advancing the Human Right to Safe and Respectful Maternal Health Care (New York: Center for Reproductive Rights, 2018), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf. The following organizations also provide resources: National Birth Equity Collaborative, the Midwives Alliance of North America which tracks state legislation, Center for Health Care Strategies, https://www.chcs.org/resource/midwifery-led-care-in-medicaid-virtual-learning-series/.

[6] Emmett Ruff and Eliot Fishman, Building Capacity for Community Health Worker Integration: Three Key Steps State Policymakers Should Take During the COVID-19 Criss and Beyond (Washington, D.C.: Families USA, July 2020), https://familiesusa.org/wp-content/uploads/2020/07/HE-267_Integrating-CHWs_Report_7-21-20.pdf.

[7] Starre Vartan, "Racial Bias Found in a Major Health Care Risk Algorithm," Scientific American, October 24, 2019, https://www.scientificamerican.com/article/racial-bias-found-in-a-major-health-care-risk-algorithm/.

[8] Donna M. Christensen, Jim Manley, and Jason Resendez, "Medical Algorithms Are Failing Communities of Color," Health Affairs Forefront, September 9, 2021, https://doi.org/10.1377/forefront.20210903.976632.

[9] National Immigration Law Center, "Table: Medical Assistance Programs for Immigrants in Various States," revised July 2021, https://www.nilc.org/issues/health-care/medical-assistance-various-states/.

[10] Olivia Randi and Zack Gould, "States Take Action to Address Children's Mental Health in Schools," National Association of State Health Policy, February 14, 2022, https://www.nashp.org/states-take-action-to-address-childrens-mental-health-in-schools/

[11] Marc Shi, "Health Care Institutions Must Acknowledge Their Role in Neighborhood Change," Shelterforce, January 8, 2021, https://shelterforce.org/2021/01/08/health-care-institutions-must-acknowledge-their-role-in-neighborhood-change/; David Tuller, "To Improve Outcomes, Health Systems Invest in Affordable Housing, Health Affairs, 38, no. 7 (July 2019), https://doi.org/10.1377/hlthaff.2019.00676.

[12] Alexandra D. Montague, Katherine L. Gudiksen, and Jaime S. King, State Action to Oversee Consolidation of Health Care Providers (New York: Milbank Memorial Fund, August 2021), https://www.milbank.org/publications/state-action-to-oversee-consolidation-of-health-care-providers/#:~:text=States%20must%20monitor%20consolidation%20in,at%20least%20one%20state%20entity.