Post-Convening FACT SHEET

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PANELISTS

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STATE LEADERSHIP NETWORK

Virtual Convening of State and Local Public Health Leadership: The Commonwealth Fund 2024 State Health Disparities Report

May 20, 2024
12:00-1:00pm ET

Introduction

Racial and ethnic disparities in health and health care are longstanding and rooted in underinvestment in racial minority communities and discriminatory policies. This briefing covered the latest State Health Disparities Report from the Commonwealth Fund and state approaches to ending those disparities. The report offers a comprehensive analysis of health care access, quality, service use, and health outcomes across racial and ethnic groups — and highlights recent successes and areas for improvement. During this briefing, key findings were presented and state health leaders applied those findings to the health equity landscape and strategies in their states.

Key Findings

The 2024 State Health Disparities Report, which uses data from 2021 to 2022, stratifies data by five racial and

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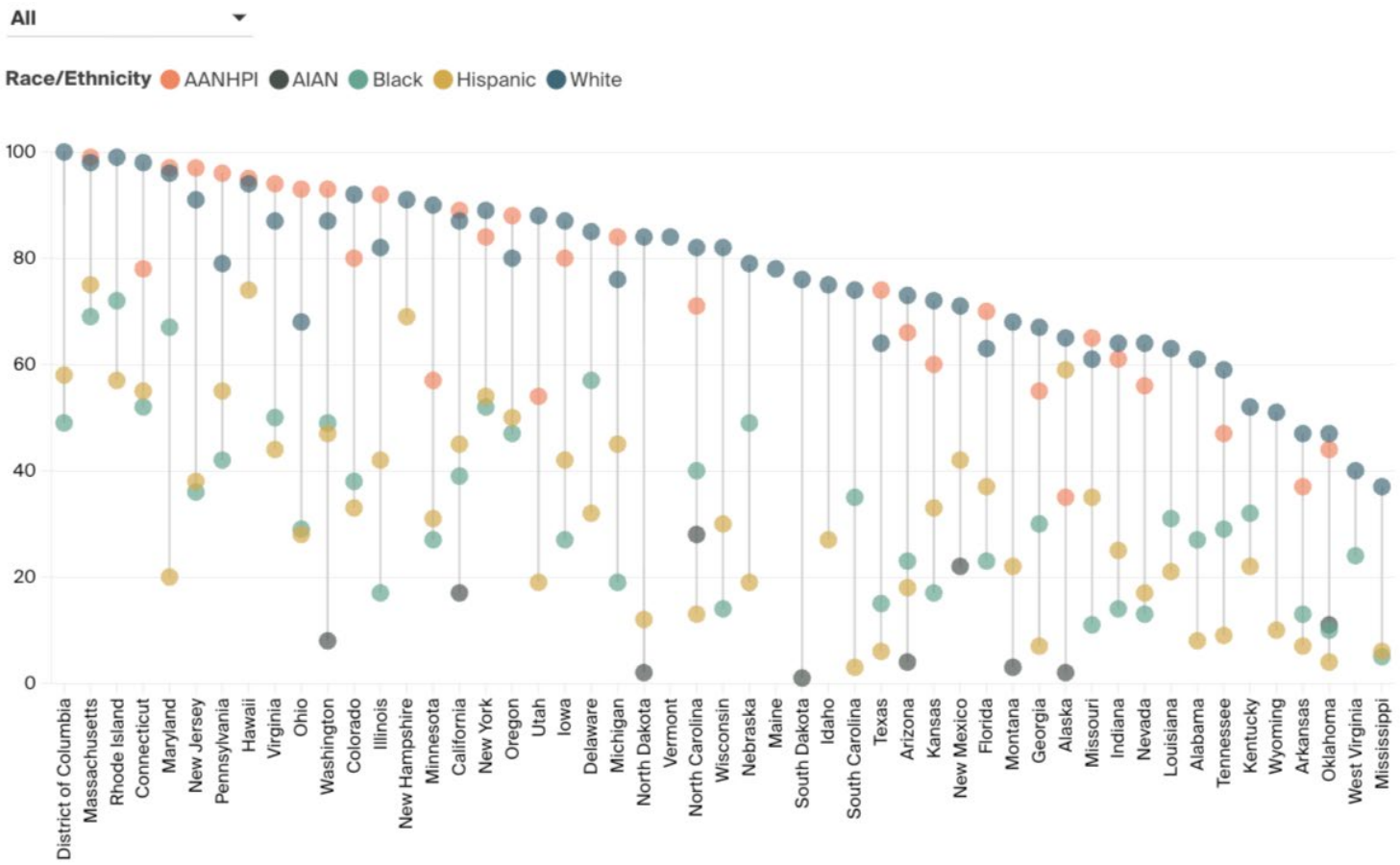
EXHIBIT 1

Profound racial and ethnic inequities in health and health care exist across and within states.

Health system performance scores, by state and race/ethnicity



ethnic groups: Black, White, American Indian/Alaska Native (AIAN), Asian American, Native Hawaiian, and Pacific Islander (AANHPI), and Latinx/Hispanic across all 50 states. The 25 indicators are grouped into three dimensions: 1) health outcomes, 2) health care access, and 3) quality and use of health care services. State-specific data are available in state profiles.

The Commonwealth Fund's report found that health system performance varies widely by race and ethnicity,within and between states. The report also finds health and health care disparities between White and Black, Hispanic, and AIAN populations in nearly all states. Notably, there are large disparities in premature deaths in all states; Black and AIAN people are more likely to die before the age of 75 from preventable and treatable causes. Additionally, the report documented large disparities in health care access by race and ethnicity groups across states. Hispanic people have the highest uninsured rates and the most cost-related problems in getting care.

Finally, the report notes that unequal access to and use of primary care is a key driver of disparities related to health care quality. Barriers to accessing primary care, including cost and lack of providers, drive people to utilize low-value, costly care in emergency departments settings, according to the report.

State Perspectives

Massachusetts

Despite high rates of health coverage in Massachusetts, there are health

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disparities across communities, including a life expectancy gap of 11 years between the most privileged and most disenfranchised communities.

> "Any serious health equity effort in the country today must have a place-based dimension. When you know the data tell you that your zip code is literally more predictive of your life expectancy than your own genetic code, then we know we have to be extremely intentional about how our work intersects with the heat map of our state. . . The neighborhoods that light up in red under almost any indicator are tragically consistent."
>
> *—Karen Tseng, JD, Senior Advisor, Health Policy, Massachusetts Executive Office of Health and Human Services*

To address this gap, Massachusetts approaches disparities in health outcomes through a detailed health equity plan, Advancing Health Equity in Massachusetts (AHEM). Karen Tseng of Massachusetts Executive Office of Health and Human Services shared how the state compiled its existing data sets and identified communities that were not scoring well across 50 different health indicators. The 30 communities with the poorest health outcomes are the focus of the state health equity strategy, which emphasizes community involvement and leadership.

AHEM is place-based, condition-specific, outcomes-anchored, and community-engaged. The two arms of the initiative are maternal-perinatal health and social drivers of cardiometabolic disease. Across the state, there are disparities in these health outcomes by place and race. By addressing root causes of health disparities, the plan allows the state to support upstream interventions and collaborate with other agencies and departments, including housing, economic development, education, and labor.

North Carolina

One of the foundational levers to address health equity in North Carolina is its recent Medicaid expansion, which launched in December 2023. Six months into the program, Medicaid expansion has already enrolled 456,000 North Carolinians. North Carolina Department of Health and Human Services's Debra Farrington shared that the state's priority is to not only ensure that individuals gain health coverage, but also access to health services.

North Carolina strives to center community voices and address both the medical and non-medical drivers of health. Through the health equity portfolio, the North Carolina Health and Human Services Department shares relevant data across services systems and coordinating community outreach efforts. This data, as well as community stories, inform the state health improvement plan, which identifies top areas of focus, including life expectancy, maternal mortality, and infant mortality.

> "When we look at our data in North Carolina we found that mental health conditions and injuries comprised almost half of pregnancy-related deaths—specifically unintended overdoses, homicides, and suicides. That data helped to drive a multi-pronged approach to address violent deaths to women and make sure they have access to mental health care. With federal dollars and bipartisan support from our general assembly, significant investments in behavioral health will enable us to address those drivers of health outcomes that we're seeing for children and for families."
>
> *—Debra Farrington, MSW, LCSW, Deputy Secretary and Chief Health Equity Officer, North Carolina Department of Health and Human Services*

In addition, North Carolina has piloted a program called Healthy Opportunities that addresses the social drivers of maternal and child health. The state also has a multipronged approach to address violent deaths and access to mental health care, as mental health conditions and injuries comprise almost half of pregnancy-related deaths in North Carolina. These efforts have garnered bipartisan support, including investments in behavioral health from the North Carolina General Assembly.

Washington

The Washington State Health Care Authority (HCA) formed the Pro-Equity Anti-Racism (PEAR) Team by executive order in 2022 to embed equity efforts into the organization. Washington State Health Care Authority's Quyen Huynh shared how the PEAR Team performed a gap analysis of existing health contracts. Four new contract terms were identified for health plans to build health equity infrastructure, requiring state Medicaid plans to:

1. Hire specific equity staff who have executive power
2. Obtain National Committee for Quality Assurance (NCQA) health equity accreditation
3. Offer free trauma-informed training for all staff, subcontractors, and providers
4. Create a community advisory council

These terms will be implemented on July 1, 2024, for all five Washington state Medicaid plans.

Additionally, Huynh described how HCA is working with other HHS agencies to standardize race, ethnicity, and language data where possible. This effort ties into a five-year strategic plan for a health equity scorecard for all health insurers contracted with HCA. The goal of the health equity scorecard is to hold health plans accountable to advancing health equity and improving health outcomes; the intention is to add financial incentives or penalties over time. These efforts detail an intentional rebuild of health equity within the payer system, including how data are collected, synthesized, and operationalized to advance health equity.

Discussion

Following the panel, attendees asked several questions regarding health equity data, efforts, and challenges. One of the challenges discussed was navigating managed care organizations (MCOs) and tying investment to addressing health disparities.

The conversation covered the benefits of fee-for-service (FFS) versus MCOs for enabling health care access and improving quality. Kiame Mahaniah of the Massachusetts Executive Office of Health and Human Services shared recent state data showing that it is unclear if there is a difference in health care access or quality between care supported by capitation or FFS payment structures in their Medicaid program. North Carolina's Farrington explained that partnership with an entity outside the agency has been an opportunity for additional oversight and accountability. However, this entity wasn't always MCOs; North Carolina Medicaid previously worked with a FFS clinical care management system for primary care. In the case of both FFS and MCO partnerships, the level of state investment informed the state's ability to hold plans accountable. For example, health plan contracts with metrics on quality indicators, which are tied to financial incentives and penalties, allow for improved accountability.

The group also discussed workforce, including the impact of different doctor-patient ratios and racial and ethnic representation among providers. Dr. Mahaniah pointed to the lack of primary care physicians in Massachusetts and the static percentage of medical students of color over the last 10 years. Huynh highlighted Washington's workforce equity strategy, particularly for rural and other underserved populations. The strategy includes creating pathways for training, recruitment, and retention of the health care workforce for these groups in partnership with stakeholders.

> "We're exploring ways to create a healthy workforce to serve all of Washington, especially for rural and underserved populations . . . To do that we're partnering with education institutions, private health care organizations, and other government agencies."
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> *—Quyen Huynh, DNP, FNP, ARNP, FAAN, Health Equity Director, Washington State Health Care Authority*