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THE HEALTHCARE COST AND UTILIZATION PROJECT (HCUP)
Contract No. HHS-290-2006-00009-C**



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**REDUCING RACIAL AND ETHNIC DISPARITIES THROUGH
HEALTH CARE REFORM: STATE EXPERIENCE**

August 26, 2011

Prepared by:

**Denise Osborn, JD, MPH
Larry Hinkle
Carrie Hanlon, MA
Jill Rosenthal, MPH**

Submitted to:

Jenny Schnaier, Project Officer
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

Submitted by:

Thomson Reuters
5425 Hollister Ave, Suite 140
Santa Barbara, CA 93111

Reducing Racial and Ethnic Disparities through Health Care Reform: State Experience

Introduction

Racial and ethnic minorities make up about one-third of the U.S. population and more than half of the people who are uninsured.¹ Between 2003 and 2006, the total direct and indirect costs of health inequities affecting racial and ethnic minority populations more broadly – including lost wages and productivity –exceeded \$1.2 trillion.²

The Institute of Medicine (IOM) has examined the case for eliminating racial and ethnic health and health care disparities. They identified lack of insurance as a significant driver of health care disparities because, more than any other barrier, it negatively affects the quality of care received by minority populations.^{3,4,5} The Agency for Healthcare Research and Quality (AHRQ) documented that racial and ethnic minorities receive poorer quality of care and face more barriers when it comes to chronic disease management and preventive care.⁶ National and state disparities data pertaining to racial and ethnic populations, as well as other adversely affected groups, adds to the evidence that calls for targeted action. (The term “disparities data” in this paper refers to data related to racial and ethnic minority populations.)

States are busy implementing provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) and are facing significant challenges including constrained financial resources and aggressive deadlines. Disparities data can provide critical information for policymakers, adding insight into which populations are suffering the most from poor health outcomes, and how states can target resources strategically. According to the Joint Center for Political and Economic Studies, the ACA provides the most significant opportunity in at least a generation to reduce disparities in health and health care and improve health equity.⁷

Over 26 states have established an entity such as a workgroup, committee or task force to study the state-level impact of the ACA.⁸ Generally speaking, most of these entities are tasked with establishing statewide strategic plans that will ensure smooth implementation of the ACA. Similarly, many states had strategic plans prior to the ACA to eliminate health disparities, and many have published documents with state-specific disparities data to support those plans.

In January of 2011, NASHP authored a report titled “State Documentation of Racial and Ethnic Disparities to Inform Strategic Action” for the Healthcare Cost and Utilization Project (HCUP) of AHRQ.⁹ The report highlights leading state practices for collecting, comparing, reporting and acting upon disparities data. While many states have embraced robust data collection methodologies and have generated reports, most states are only in the beginning stages of leveraging disparities data to support health care reform implementation.

This issue brief first briefly describes provisions in the ACA relevant to disparities reduction. It then focuses on one of the states featured in the HCUP report that has begun to integrate a focus on health disparities reduction with state ACA implementation—Maryland (MD).

ACA Provisions that Support Reduction of Disparities

In April of 2011, the US Department of Health and Human Services published a report titled “HHS Action Plan to Reduce Racial and Ethnic Health Disparities – A Nation Free of Disparities in Health and Health Care.” It provides concrete strategies for states on how to eliminate disparities, leverage key provisions in the ACA, and build upon goals espoused in Healthy People 2020.¹⁰ A 2010 report, Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations, outlines significant opportunities in the ACA to reduce disparities, which include:¹¹

- Data collection and reporting
- Insurance coverage
- Cultural competence
- Access to health care
- Quality improvement
- Research

States can use disparities data in each of these areas.

Data collection and reporting: Certain provisions in the ACA call for improved race and ethnicity data collection and reporting on racial and ethnic health care disparities by states. Improved race/ethnicity data would strengthen states’ efforts to measure and report health care quality and costs and monitor performance outcomes of state health care systems. These data align with statewide health information exchange (HIE) infrastructure development and make for richer all-payer claims databases. New data generated from these activities will create an evidence base for how to reduce racial and ethnic health disparities.

Insurance coverage: The ACA will provide more racial and ethnic minorities with insurance coverage. The law will accomplish this in part by changing income eligibility for Medicaid to 133 percent of the federal poverty level (FPL) in 2014.¹² Implementation of employer-based health insurance reforms, Consumer Operated and Oriented Plans (CO-OPS), subsidized insurance premiums, and high-risk pools, may also result in better health outcomes and insure more minority populations. By collecting, analyzing and aggregating disparities data, states can inform these efforts.

Access to health care: The ACA specifically requires states to take actions to improve access to health care. Some of the actions specified in the ACA are: testing applications for health insurance for special populations and culturally appropriate outreach for enrollment in Medicaid and the Children’s Health Insurance Program (CHIP). The ACA calls for systems to determine eligibility for Medicaid, CHIP and other insurance products to include the development of test applications for special populations. Outreach

activities to enroll children in Medicaid and CHIP as well as navigator programs (that supply fair, accurate, impartial information to consumers to help them learn about insurance products) within the health insurance exchanges are required to be culturally competent.

Quality improvement: Under the ACA, surveillance systems will track trends in quality of care measures at the national and state levels. By collecting and analyzing disparities data, states can assess and focus resources for improving population health, and can assess costs and barriers related to advancing health equity. For example, targeted prevention initiatives on obesity and tobacco addiction can have a significant impact on minority populations who suffer disproportionately from these conditions.

Cultural Competence: Certain provisions within the ACA aim to increase the health care provider and public health workforce, including those who are culturally and linguistically competent. Cultural competence training at both the individual and organizational level can improve the quality of care delivered to racial and ethnic populations.¹³

Research: Lastly, ACA provisions focused on social determinants of health, health impact assessments, and health disparities research can bolster the evidence base and inform future disparities reduction initiatives.

The table below, adapted from *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, provides a more detailed list of provisions in the ACA pertaining to, or with implications for, disparities reduction.

Topic Area	Section(s) of the ACA
Data Collection and Reporting by Race/Ethnicity/Language	4302
Workforce Diversity	4305, 5001, 5301, 5302, 5303, 5306, 5309, 5313, 5402, 5403, 5313, 5507
Cultural Competence Education and Organizational Support	5203, 5301, 5307, 5507, 10334
Health Disparities Research	2952, 4305, 5307, 5401, 6301
Health Disparities Initiatives and Prevention	2951, 2953, 3506, 3507, 4102, 10221
Addressing Disparities in Insurance Coverage	1001, 1303, 1311, 1557, 2901, 3306
Health Insurance Reforms	1101, 1311, 1322, 1421, 1501, 1513, 2001, 2005, 10104
Actions to Improve Access to Health Care	3021, 3502, 3504, 4101, 5207, 5208, 5503, 5508, 10503
Quality Improvement	2706, 3011, 3011, 3012, 3013, 3501
Cost Containment	1561, 2501, 2551, 6114, 6401
Public Health Initiatives	4001, 4002, 4306, 4401, 10413
Social Determinants of Health	4003, 4201, 5405, 9007

Source: Andrulis D, Siddiqui N, Purtle J and Duchon L. *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*. Joint Center for Political and Economic Studies, July 2010. Available online: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf

The ACA Provides Opportunities for State Action

There are a number of first steps that states can take to leverage disparities data to advance health equity through health care reform implementation. As an example, Rhode Island has developed “The Healthy Rhode Island Task Force Report: Getting National Health Reform Right for Rhode Island,” which calls out the importance of collecting disparities data for this purpose.¹⁴ Additionally, staff from the Division of Community, Family Health and Equity, including members of the Health Disparities and Access to Care Team, are participating in state health care reform workgroups.

Similarly, Maryland is integrating health equity and health care reform implementation, and the state’s activity provides promising practices of how states can collect, analyze and integrate disparities data into ACA implementation.¹⁵

Maryland

Maryland’s commitment to integrating disparities reduction activities with healthcare reform implementation permeates throughout their health care reform implementation efforts. In March of 2010, The Maryland Health Care Reform Coordinating Council (HCRCC), made up of key stakeholders was formed to advise the Governor’s administration on health care reform implementation for Maryland.¹⁶ During a recent interview the co-chair of the HCRCC and Secretary of Maryland’s Department of Health and Mental Hygiene shared his views that:

“Healthcare reform presents a tremendous opportunity to address disparities and strengthen health equity. To succeed in this challenge, we must take full advantage of key components of the Affordable Care Act and engage a wide range of stakeholders.”

~Joshua M. Sharfstein, M.D.

In July of 2010, the HCRCC published an Interim Report to the Governor, which identified several crosscutting issues including strategies to reduce racial and ethnic disparities. Six healthcare reform workgroups were charged with creating action plans and in doing so considered disparities data taken from Maryland’s Chart Book of Minority Health and Minority Health Disparities, published by the state’s Office of Minority Health and Health Disparities (MHHD).¹⁷ In December of 2010 action plans and recommendations were set by all six workgroups. Examples of three groups include:

The Entry into Coverage Workgroup, charged with identifying options for expanding insurance coverage, considered disparities data while creating a plan to increase eligibility and enrollment into Medicaid and other types of coverage in Maryland.¹⁸

The Public Health, Safety Net, and Special Populations Workgroup adopted the premise that the safety net is essential to caring for special populations and promoting health equity.¹⁹ This workgroup also acknowledged that health coverage, while expected to

improve under health care reform, is necessary but not sufficient to ultimately improve health outcomes. This is because, despite insurance coverage, certain individuals may not have access to health care due to "...racial or ethnic disparities, geographic, cultural, or linguistic barriers and/or provider shortages...",²⁰ causing them to have poor health outcomes.

The Exchange and Insurance Workgroup examined the importance of "... exchange plans collecting and analyzing quality data to identify any disparities related to race, ethnicity, and language."²¹ This group considered barriers that special populations face, including issues affecting access to care, language and literacy, cost issues and continuity of care. Cultural competence and health literacy were a part of an overall theme in the group's action plan.

In January of 2011, workgroup activity officially ended. Action plans authored by these groups were merged into a final report and submitted to the Governor. The report included sixteen recommendations. Recommendation fourteen is to "achieve reduction and elimination of health disparities through exploration of financial, performance-based incentives and incorporation of other strategies."²² Within this recommendation the HCRCC also underscored the importance of integrating disparities reduction into *all* health care reform implementation activities, and the crucial role of data.

"The state's first step should be to enhance data collection to facilitate assessment of both needs and performance metrics. Having adequate data is fundamental to understanding current and future gaps and disparities, targeting efforts to address them, and evaluating the success of different strategies. Second, Maryland should ensure that all reform implementation efforts incorporate and are aligned with the goal of reducing health care disparities, including using financial incentives where appropriate."²³

Also outlined in the Council's final report are specific recommendations for reducing and eliminating health disparities. These include:

- Improve data collection and analysis through the State Health Improvement Plan (SHIP) and local implementation plans, as well as by building on ongoing work to encourage common reporting of race and ethnicity among health plans;
- Promote cultural competency training for health occupations; and
- Use the SHIP and local implementation plans to identify disparities, implement strategies to address them, and monitor performance.

A new health disparities workgroup established within Maryland's Health Quality and Cost Council will be a key force for exploring and implementing these recommendations, as well as the Council's overall disparities reduction recommendation (number 14). The Health Quality and Cost Council coordinates, develops, and implements quality improvement and cost containment initiatives in the state. The health disparities

workgroup will consider the issues outlined in the HCRCC’s recommendations; it has already received presentations from stakeholder agencies and organizations pertaining to the above recommendations.

The following table lists several additional Council recommendations for addressing health disparities; the table also highlights some examples of subsequent action in Maryland to continue the work begun by workgroups and carry out the Council’s recommendations.

Examples of Council Recommendations for Reducing Health Disparities and Subsequent Activity

Recommendation from the January 2011 Final Report to the Governor	Subsequent Activity (January-July 2011)
Use existing data and knowledge of incentives to develop programs that reward reductions in racial and ethnic health disparities.	Reduce disparities within the health care system through financial and performance-based incentives (e.g., encouraging physicians to practice in underserved communities, rewarding reductions in preventable hospitalizations among racial and ethnic communities). Combine policy changes with community programs. ²⁴
Increase workforce and strengthen the safety net through workforce development planning.	The Governor’s Workforce Investment Board the Governor’s chief policy-making body for workforce development leads comprehensive workforce planning in Maryland. The Board is now addressing the Council’s workforce-related recommendations and will be reporting up to the HCRCC.
Provide technical assistance to help safety net providers leverage health care reform opportunities to improve access and care for diverse populations.	The Maryland Community Health Resources Commission is overseeing this effort. Its mission is to increase access to care for low-income, under- and uninsured Marylanders by providing support (e.g., grants) to community health resources, which include centers or programs that provide health care services on a sliding fee scale. May 2011 legislation (Senate Bill 514) authorizes the Commission to among other things explore challenges related to implementing health care reform for community health resources and make recommendations by 2012.
Use education and outreach efforts that ensure cultural sensitivity and engage community-based organizations.	The newly established Governor’s Office of Health Care Reform has been charged with overseeing education and outreach.

One example of Maryland’s efforts to carry out the Council’s recommendation to incorporate and align all reform implementation efforts with the goal of reducing health care disparities is through the health insurance exchange. The enabling legislation for the exchange includes the following:²⁵

- A requirement that expertise for the Exchange Board of Trustees include “public health and public health research, including knowledge about the health needs and health disparities among the state’s diverse communities.”²⁶
- Similar language to describe Exchange Advisory Committee membership;
- A requirement for the Exchange to annually report data to identify disparities among enrollees;
- Inclusion of disparities reduction efforts as a possible activity the Exchange can use under a selective contracting model; and
- The requirement that the Exchange include a study provision in its recommendations about how to structure the Navigator program to describe how to ensure Navigators provide (and have the capacity to provide) cultural, linguistically and otherwise appropriate information to meet the needs of diverse populations served by the Exchange.

Early Lessons

Maryland’s experience to date shows that states can:

- Make a commitment to health equity by explicitly mandating that ACA implementation plans serve the overarching goal of advancing population health, with particular focus on eliminating racial and ethnic disparities in health status and health care.
- Use health and health care disparities data as an evidence base to support implementation of the ACA.
- Charge ACA workgroups with considering the health and health care needs of racial and ethnic minority populations, and provide those workgroups with disparities data and health literacy principles as they undertake tasks.
- Involve state officials who are focused on disparities reduction, particularly representatives from state Offices of Minority Health, in health care reform workgroups.
- Use state data on the cost of health and health care disparities to provide momentum to efforts to address disparities in health reform implementation.
- Ensure that the needs of diverse populations are considered and addressed throughout implementation, such as within the development of health insurance exchanges.

Conclusion

The ACA provides significant opportunities to reduce disparities in health and health care and improve health equity. As states prepare to roll out health reform implementation, they may choose to incorporate a focus on disparities reduction into their plans and use disparities data to inform their actions. Efforts in Maryland suggest that health disparities data can inform and help guide implementation of the ACA. By connecting disparities data and disparities reduction goals to health reform implementation activities, particularly by infusing such data into the deliberations of health reform workgroups, states will be better positioned to improve both health status and the quality of health care.²⁷

¹ Smedley, B. "Moving Beyond Success: Achieving Equity in State Health Care Reform." Health Affairs. 2008: 27(2); 447-455. DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica C. Smith, U.S. Census Bureau, Current Population Reports, P60-238, Income, Poverty, and Health Insurance Coverage in the United States: 2009, U.S. Government Printing Office, Washington, DC, 2010.

² Andrulis D, Siddiqui N, Purtle J and Duchon L. *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*. Joint Center for Political and Economic Studies, July 2010: pg. 6. Available online: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

³ A health disparity is "A particular type of health difference that is closely linked with social or economic disadvantage..." Source: U.S. Department of Health & Human Services (DHHS), The National Partnership for Action to End Health Disparities: *Changing Outcomes – Achieving Health Equity*. Available online: <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34>.

⁴ Health equity is "...attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices and the elimination of health and healthcare disparities." Source: U.S. DHHS, The National Partnership for Action. Available online: <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34>.

⁵ Institute of Medicine (IOM). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press; 2002.

⁶ Agency for Healthcare Research and Quality (AHRQ). *National Healthcare Disparities Report, 2008*. Rockville, MD; 2009. Available online: www.ahrq.gov/qual/measurix.htm.

⁷ Andrulis et al., *Patient Protection and Affordable Care Act of 2010*, pg. 14. Available online: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf

⁸ Robert Wood Johnson, *State of the States: Laying the Foundation for Health Reform*. Robert Wood Johnson Foundation, February 2011: sections 3.6-3.9. Available online: <http://www.statecoverage.org/stateofthestates2011>.

⁹ Hanlon C, Rosenthal J, and Hinkle L. *State Documentation of Racial and Ethnic Health Disparities to Inform Strategic Action*. Online March 11, 2011. U.S. Agency for Healthcare Research and Quality (AHRQ), pg. 39. Available: <http://www.hcup-us.ahrq.gov/reports.jsp>.

¹⁰ U.S. DHHS published a report in 2011 titled: *HHS Action Plan to Reduce Racial and Ethnic Health Disparities – A Nation Free of Disparities in Health and Health Care*. Available online: <http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285>.

¹¹ Andrulis et al., *Patient Protection and Affordable Care Act of 2010*. Available online: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf

¹² Andrulis et al., *Patient Protection and Affordable Care Act of 2010*, 8. Available online: http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

¹³ Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. Washington, DC: US Department of Health and Human Services; 2002. For more information please visit: <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=15>.

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- ¹⁴ “Healthy RI Task Force Report: Getting National Health Reform Right for Rhode Island,” Office of Lt. Governor Elizabeth H. Roberts: September 2010. Available online: <http://www.ltgov.ri.gov/taskforce/>.
- ¹⁵ Information pertaining to MD contained within this brief is based solely upon recent interviews and research conducted by NASHP staff and is not meant to represent a comprehensive rendition of efforts being taken in those states relative to implementation of the ACA and/or data collection for disparities in health and healthcare.
- ¹⁶ The Maryland Health Care Reform Coordinating Council was created by Executive Order 01.01.2010.07
- ¹⁷ Mann D, Fatogun T, and Hussein C. *Maryland Chartbook of Minority Health and Minority Health Disparities Data: With Sections on Gender-specific Health and Jurisdiction-specific Health*, Maryland Office of Minority Health and Health Disparities, Maryland Department of Health and Mental Hygiene, December 2009, pg. 34. Available online: http://www.dhmfh.maryland.gov/hd/pdf/2010/Chartbook_2nd_Ed_Final_2010_04_28.pdf.
- ¹⁸ Maryland Behavioral Risk Factor Surveillance System. *Maryland behavioral risk factor surveillance system ad hoc reporting tool*. [cited December 7, 2006]; Available from: <http://www.marylandbrfss.org/cgi-bin/broker>.
- ¹⁹ For more information please visit the Maryland Department of Health and Mental Hygiene Public Health, Safety Net and Special Populations Workgroup Page. Available online: <http://dhmfh.maryland.gov/healthreform/worgroups/public.html>.
- ²⁰ Maryland Health Reform Coordinating Council; Public Health, Safety Net, and Special Populations Workgroup Report. Issued October 31, 2010: pg. 12. Available online: <http://dhmfh.maryland.gov/healthreform/worgroups/public.html>.
- ²¹ Maryland Health Reform Coordinating Council, Exchange and Insurance Markets Workgroup Report. Issued October 31, 2010: pg. 3. Available online: <http://dhmfh.maryland.gov/healthreform/worgroups/exchange.html>
- ²² Maryland Health Reform Coordinating Council, *Final Report and Recommendations*, pg. viii. Available online: <http://dhmfh.maryland.gov/healthreform/worgroups/delivery.html>.
- ²³ Maryland Health Reform Coordinating Council, *Final Report and Recommendations*, pg. 26 Available online: <http://dhmfh.maryland.gov/healthreform/worgroups/delivery.html>.
- ²⁴ Lt. Governor’s Office Press Release, “Lt. Governor Brown Announces New Effort to Address Health Disparities: Highlights Baltimore’s Innovative Barbershop Men’s Health Outreach Program.” Office of Maryland Lt. Governor Anthony G. Brown. Available online: <http://dhmfh.maryland.gov/healthreform/news/ltgov062311.html>
- ²⁵ Maryland House of Representatives, *Health Benefit Exchange Act of 2011*. House Bill 166, Chapter 2, 2011. Available: http://dhmfh.maryland.gov/healthreform/exchange/pdf/MHBEA_Enrolled.pdf
- ²⁶ Maryland House of Representatives, *Health Benefit Exchange Act of 2011*, Sec 31-104, B4, II, 7.
- ²⁷ For more information from AHRQ on state resources for addressing disparities in health care quality, see the State Snapshots page on the AHRQ webpage at www.ahrq.gov.