Post–Briefing FACT SHEET

SPEAKERS

May 14, 2022

David Radley
Senior Scientist
The Commonwealth Fund

Jesse Baumgartner
Senior Research Associate
The Commonwealth Fund

Laurie Zephyrin
Senior Vice President
The Commonwealth Fund

May 24, 2022

Kody Kinsley
Secretary
North Carolina Department of Health and Human Services

Mark Thomas
Deputy Secretary
Louisiana Department of Health and Human Services

May 27, 2022

Jami Snyder
Director
Arizona Health Care Cost Containment System

Nathan Chomilo
Medical Director
Minnesota Medicaid and MinnesotaCare

Moderator:
Kate McEvoy
Program Officer
Milbank Memorial Fund

Milbank Memorial Fund

STATE LEADERSHIP NETWORK

Using the Health Equity Scorecard for Action

Introduction of Briefings

This three-part miniseries focused on the Commonwealth Fund's Achieving Racial and Ethnic Equity in US Health Care Scorecard of State Performance. This groundbreaking 2021 resource lays bare significant racial and ethnic disparities in health and well-being by providing evidence for the following realities:

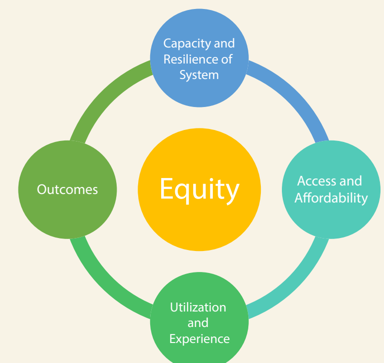
- Communities of color face multiple barriers to effective access and utilization of health care services: being uninsured or underinsured, lacking a usual source of care, shouldering high out-of-pocket cost burdens, facing interpersonal racism and discrimination and a lack of cultural competency among providers.
- Black and American Indian/Alaska Native people have starkly worse experience with, and outcomes related to, health care, particularly related to pregnancy and

Leveraging Performance Scorecards to Improve Health and Equity in Your State Series

State officials could improve their capacity to respond to complex population health issues if they routinely use national data scorecards to:

- examine their state's current performance
- benchmark against the performance of other states
- connect with best practice states around successful interventions
- establish administrative, policy and/or regulatory priorities
- increase public trust and engagement through transparency
- examine performance and course correct interventions, over time

State officials need a range of indicators covering the dimensions featured to the right to create a comprehensive picture of state health performance over the life span, from young children to older adults, and to examine equity of access, utilization, care experience, and outcomes.



management of chronic disease. They also have shorter life expectancies and are more likely to die of preventable and treatable conditions.

- Experience and outcomes range significantly across regions of the country, reflecting many factors but notably policy choices made by state officials
- The COVID-19 pandemic significantly exacerbated these longstanding disparities.

The scorecard both equips and calls policymakers to action by:

- providing specific, actionable data in performance domains including access, quality and use of health care services and outcomes
- identifying opportunities for improvement for all states, across five racial and ethnic groups; and
- enabling us to link the data to policy levers that can be adopted by leaders at the state level.

Equity Scorecard Overview

In the first session, Commonwealth Fund staff outlined how to read the overall scorecard findings and associated state reports, profiling leading-edge issues and surfacing policy choices (e.g., Medicaid expansion and review and revision of Medicaid administrative practices).

Dr. Zephryin explained that the scorecard's 24 indicators are grouped into three dimensions: outcomes, access, and quality and use of health care services. All data (mainly from 2019 and 2020) are stratified by race and ethnicity across Black, White, American Indian/Alaska Native, Asian American, Native Hawaiian and Pacific Islander, and Hispanic/Latinx populations. According to Zephryin, the equity scorecard shows that even states that have performed well on the Commonwealth Fund's general scorecard of state health performance have a long way to go toward achieving health equity.

> "In nearly every state, we see that health system performance is remarkably worse for people of color when compared to White people,"
>
> *— Laurie Zephyrin,*
> *Senior Vice President*
> *The Commonwealth Fund*

Sharing the scorecard's data, Radley showed that even among the top performing states on equity, Black people are faring substantially worse than the top performing groups. The disparities are particularly profound in Michigan and Wisconsin, he noted. Likewise, in every state, performance for Latinx populations is generally far below the highest performing group. Several states stand out for having relatively smaller disparities, such as Massachusetts and Hawaii, but states like Maryland, Delaware, and Minnesota have much wider gaps.

State Reports on Health Equity

In session two, Commonwealth Fund staff joined Kody Kinsley, Secretary of North Carolina Health and Human Services, and Mark Thomas, Deputy Secretary of the Louisiana Department of Health, to review the state reports for North Carolina and Louisiana. The state reports offer a window into both areas of relative strength across racial groups (e.g., coverage, in Medicaid expansion states) and areas that require attention

> "For many, the COVID-19 pandemic has unveiled more clearly the impact of systemic racism on health and health outcomes, and intentionally naming it and addressing it is critical. When we think about insurance coverage, that's the floor of ensuring that people have access to health and health care. The other aspects that are important are addressing the social drivers of health and investing in social services… as well as the work that's happening at the federal and state levels around collecting race, ethnicity, data [because] we wouldn't be able to have this conversation without the data."
>
> *— Laurie Zephyrin,*
> *Senior Vice President*
> *The Commonwealth Fund*

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(e.g., maternal mortality, out-of-pocket costs, incidence of vaccinations, emergency department utilization – see below).

Kinsley began his remarks by acknowledging that "you can't solve a problem that you don't understand," and pointed to the scorecard as an important source of insight into areas that require attention. He said that it is essential for leaders who aim to reduce disparities to ensure there is representation from the lived experience of people who receive services, as well as the community-based organizations that represent their interests, at the policymaking table. Finally, he identified data on disparities as an essential requisite for a comprehensive COVID vaccine effort and Healthy North Carolina 2030.

Thomas affirmed that the scorecard will inform policy decisions in Louisiana, particularly the department's internal strategy processes and its focus on improving services for African-Americans and improving vaccination rates and colorectal cancer screening.

The final session featured Commonwealth Fund staff highlighting findings in the state reports for Arizona and Minnesota. Of note in these reports is that while both states have relatively low rates of uninsured individuals, that rate is not consistent across all racial groups.

According to Jami Snyder, Director of Arizona's Cost Containment System, the report reflects an opportunity to learn and a call to action. She outlined how her approach has focused on thinking beyond clinical care to encompass housing supports, employment assistance, interventions for people leaving the justice system, and help for those facing social isolation. Arizona has optimized the use of a Medicaid 1115 research and demonstration waiver to build in services that expand on traditional medical supports. Snyder described this expansion as both an opportunity to achieve savings and a means of enabling reinvestment in services to address social drivers of health.

> "Some of the areas that were highlighted when we talked to our Black community members were issues with enrollment and eligibility and access to cultural relevant care. And when you look at the rankings amongst Black Minnesotans in the scorecard, access was the area for which Minnesota was amongst the lowest ranked."
>
> *— Mark Thomas, Deputy Secretary, Louisiana Department of Health and Human Services*

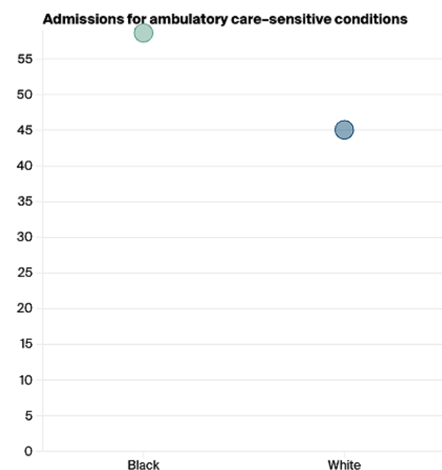
Thomas then affirmed Minnesota's commitment to addressing health disparities, which is memorialized in his standard-setting Building Racial Equity into the Walls of Minnesota

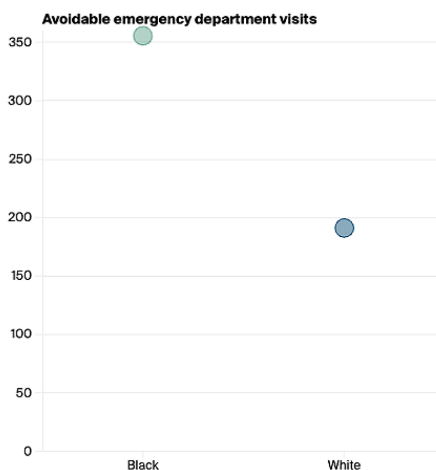
EXHIBIT 7

Black Medicare beneficiaries are more likely than white beneficiaries to be admitted to a hospital or to seek care in an emergency department for conditions typically manageable through good primary care.

Per 1,000 Medicare beneficiaries

Louisiana





Notes: Dots represent states. Missing dots for a particular group indicates that there are insufficient data for that state. Race data only available for Black and white populations—ethnicity is unknown.

Data: Centers for Medicare and Medicaid Services, 2019 Limited Data Set (LDS) 5% sample. Analysis by Westat.

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Medicaid report. He described this process as necessarily involving both a review of Medicaid's specific roles and responsibilities, and determining how Medicaid figures among other payers of health care services. He also reinforced the imperative around actively engaging with communities to surface issues and concerns, inform policymaking and ensure fidelity to intent once interventions are put in place.

Winding up with important cautionary notes, Thomas underscored that this work can't be captured in one budget cycle and that a longitudinal approach is needed.

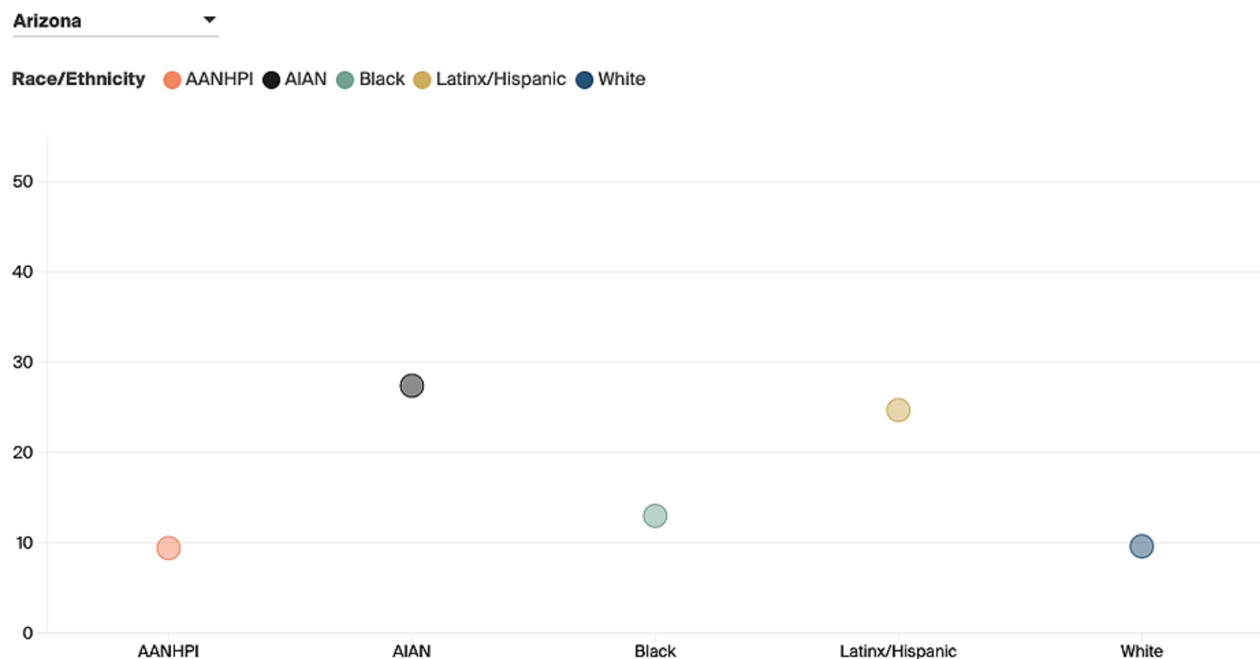
Resources:

1. Achieving Racial and Ethnic Equity in US Health Care Scorecard of State Performance
2. Building Racial Equity into the Walls of Minnesota Medicaid

EXHIBIT 5

Although the ACA's coverage expansion improved inequities, state uninsured rates are generally higher and more variable for Black, Latinx/Hispanic, and AIAN adults compared to AANHPI and white adults.

Percent of adults ages 19–64 who are uninsured, by state and race/ethnicity



Note: Dots represent states. Missing dots for a particular group indicate there are insufficient data for that state. AANHPI = Asian American, Native Hawaiian, and Pacific Islander; AIAN = American Indian/Alaska Native. ACA = Affordable Care Act.

Data: American Community Survey Public Use Micro Sample (ACS-PUMS) 2019 1-year file.

Source: David C. Radley et al., *Achieving Racial and Ethnic Equity in U.S. Health Care: A Scorecard of State Performance* (Commonwealth Fund, Nov. 2021).