

Oregon's Effort to Reduce Health Disparities Shows Signs of Early Success

Vast and pervasive health care disparities exist for most racial and ethnic minorities across the United States. Reducing health disparities was a key part of Oregon's Medicaid reforms.

Medicaid reform offers opportunities to address health care disparities.

Across the country, large differences in health and health care quality exist among racial and ethnic groups. The average life expectancy for Oregonians who identified as black, American Indian, or Alaska Native was two years lower than for those who identified as white in 2011, and more than 35 percent of minority women in Oregon had no regular care provider, compared with 18 percent of white women, in the same year.¹ Policymakers have begun using Medicaid reform as a tool to combat such disparities. Medicaid covers nearly 20 percent of the United States population, including a relatively large proportion of racial or ethnic minorities.²

This study evaluated the impact of Oregon's Medicaid reforms on health disparities. The study team tracked disparities in health care use and quality between black and white enrollees, and between American Indian/Alaska Native and white enrollees, before and after Oregon's reform efforts began. They tracked measures of health care quality and service use where a disparity existed prior to Oregon's reforms, and used health care claims data from Oregon's Medicaid program to determine whether the disparities narrowed or widened following the introduction of health equity policies in the state.

McConnell KJ, Charlesworth CJ, Meath THA, et al. Oregon's Emphasis On Equity Shows Signs Of Early Success For Black And American Indian Medicaid Enrollees. *Health Affairs*. 2018;37(3):386-393.

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KEY FINDINGS

- Disparities in primary care use between black and white enrollees, and between American Indian/Alaska Native and white enrollees, narrowed significantly after the health equity policies were introduced.
- Disparities in access to preventive services between black and white enrollees also narrowed significantly.
- Disparities in emergency department use between black and white enrollees, and between American Indian/Alaska Native and white enrollees, did not change significantly after the health equity policies were introduced.



Importance of Medicaid

Medicaid covers almost 20 percent of the US population, including a relatively large proportion of racial and ethnic minorities.

Medicaid reform may address health disparities

Across the country, large differences in health and health care quality exist among racial and ethnic groups. For example, the average life expectancy for Oregonians who identified as black, American Indian, or Alaska Native was two years lower than for those who identified as white in 2011, and more than 35 percent of minority women in Oregon had no regular care provider, compared with 18 percent of white women, in the same year.¹ Such disparities have become an important concern for policymakers.

Medicaid reform offers opportunities to address health disparities. Medicaid covers almost 20 percent of the United States population, and a substantially higher share in some states, including Oregon.² A relatively high proportion of racial and ethnic minorities receive health care coverage through Medicaid, and racial and ethnic healthcare disparities are particularly acute among Medicaid recipients. States have a great deal of flexibility to design aspects of Medicaid programs, and they are experimenting with reforms to improve care and control spending. These efforts may also provide opportunities to address health disparities.

Oregon's Medicaid reforms targeted health disparities

In 2012, Oregon established coordinated care organizations (CCOs) to serve as the single point of accountability for the health care and outcomes of Medicaid members. CCOs were locally governed, with representation from Medicaid members, health care providers, and other local stakeholders. They received a global budget that covered physical, behavioral, and oral health care services, and they were responsible for coordinating and integrating these services.

Oregon implemented specific policies to help CCOs address health disparities:

- The state required each CCO to develop and implement a transformation plan that included efforts to reduce racial and ethnic disparities among enrollees.
- CCOs were encouraged and given support to stratify health care access and quality measures by race and ethnicity.
- Oregon established Regional Health Equity Coalitions—community-led, regionally-organized groups that provided CCOs with guidance on reducing disparities in their communities.
- Oregon trained and certified over 400 community health workers. Community health workers typically share race, ethnicity, or language with those they serve, and help to form a bridge between local health care services and the communities in which they operate.

Combined, these strategies were intended to help CCOs reduce health disparities in communities they served.

CCOs were associated with reductions in some disparities

To understand the impact of CCOs on health care disparities, the study team tracked disparities in health care quality and access measures between black and white enrollees, and between American Indian or Alaska Native (AI/AN) and white enrollees. The team focused on black and AI/AN enrollees because they experienced the most prominent disparities in health care quality and access (relative to other non-white minority groups) in the years before the establishment of CCOs.

The study team selected eight measures of health care service use and quality where significant disparities existed before CCOs were established. They calculated each measure using data from Oregon's Medicaid program. They then compared the size

of the disparity between black and white enrollees, and between AI/AN and white enrollees, in the years 2010 and 2011 (the pre-CCO period) to the years 2013 and 2014 (the post-CCO period). The study team used statistical techniques to control for the effect of factors other than the introduction of CCOs, such as geography and health conditions, on measures.

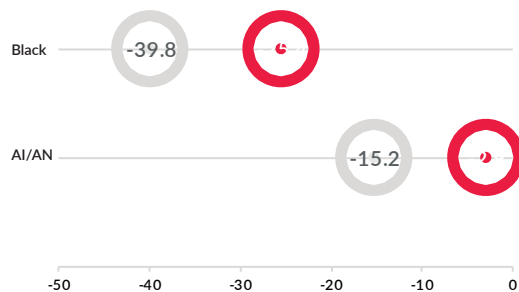
Disparities in access to primary care and other outpatient services narrowed

Disparities in use of primary care and other outpatient services between black and white enrollees, and between AI/AN and white enrollees, decreased substantially from the pre-CCO period to the post-CCO period. Most notably, the disparity in primary care visit rates between black and white enrollees narrowed by one-third, from a difference of 40 visits per 1,000 member months to 25 visits per 1,000 member months (Figure 1). However, use of primary care and other outpatient services among black and AI/AN enrollees remained lower than among their white counterparts.

The disparity in access to preventive services between black and white enrollees also narrowed substantially from the pre-CCO period to the post-CCO period. Such a disparity did not exist between AI/AN and

Figure 1. The disparity in primary care visit rates between minority and white enrollees decreased substantially from before CCOs to after CCOs.

However, the primary care visit rate was still higher for white enrollees than for minority enrollees after CCOs.



Visit rate = visits per 1,000 member months. Disparity in visit rates = rate for black and AI/AN enrollees minus rate for white enrollees.

white enrollees before the establishment of CCOs.

Disparities in emergency department use persisted

The disparity in emergency department (ED) use between black and white enrollees, and between AI/AN and white enrollees, did not change substantially from the pre-CCO period to the post-CCO period (Figure 2). While the ED visit rate declined among black, AI/AN, and white enrollees, disparities between black and AI/AN enrollees and white enrollees did not change substantially.

Implications

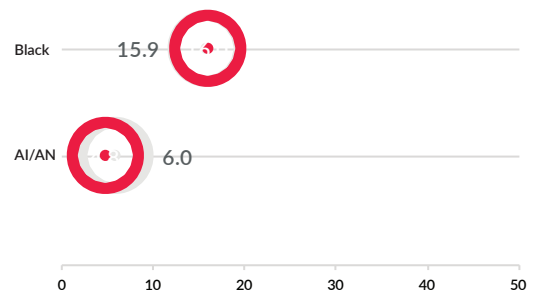
The establishment of CCOs was associated with reduced disparities in use of primary care between black and white enrollees, and between AI/AN and white enrollees.

Concurrently with CCOs, Oregon adopted specific policies to raise awareness of disparities and encourage CCOs to address these disparities. Evidence from Oregon suggests that these strategies may help other states address health disparities in their communities.

The establishment of CCOs was not associated with a reduced disparity in ED use. While the ED visit rate declined among

Figure 2. The disparity in emergency department visit rates between minority and white enrollees did not change substantially from before CCOs to after CCOs.

Emergency department visit rates fell for all groups from before CCOs to after CCOs, but the gap between groups did not narrow substantially.



black, AI/AN, and white enrollees, disparities between black and white enrollees, and between AI/AN and white enrollees, did not narrow substantially from the pre-CCO period to the post-CCO period. This suggests that reducing the number of visits made to the ED may not be tied directly to increasing primary care use, at least in the population we studied. States may need to employ diverse strategies to address disparities in different aspects of health care use and quality.

Many health care quality and outcome measures are available to help states monitor and address health disparities. Selecting the right measures for each state will depend on its Medicaid population and priorities for addressing disparities. An important task for Oregon and other states will be continuing to refine their choice of metrics to use in monitoring and incentivizing efforts to reduce disparities.

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Cite as: Levy A. Oregon's Effort to Reduce Health Disparities Show Signs of Early Success. Center for Health Systems Effectiveness, Oregon Health & Science University; 2018.

Original article: McConnell KJ, Charlesworth CJ, Meath THA, George RM, Kim H. Oregon's Emphasis On Equity Shows Signs Of Early Success For Black And American Indian Medicaid Enrollees. *Health Affairs*. 2018;37(3):386-393. doi:10.1377/hlthaff.2017.1282

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