

# Health Disparities and Social Determinants of Health Activities in Medicaid

---

September 2017



**Center for Evidence-based Policy**

Oregon Health & Science University  
3030 SW Moody, Suite 250  
Portland, OR 97201  
Phone: 503.494.2182  
<http://centerforevidencebasedpolicy.org>

**Center for Health Systems Effectiveness**

Oregon Health & Science University  
3030 SW Moody, Suite 200  
Portland, OR 97201  
Phone: 503.494.1989  
<http://www.ohsu.edu/chse>

## Table of Contents

Overview.....	1
Key Findings.....	1
Background.....	4
Methods.....	4
Findings.....	5
Top Priorities in Medicaid.....	5
Efforts to Address Racial/Ethnic Health Disparities.....	5
Barriers to Addressing Racial/Ethnic Health Disparities.....	6
Efforts to Address Social Determinants of Health.....	7
Barriers to Addressing Social Determinants of Health.....	8
Alignment with Oregon’s Medicaid Reform Activities.....	8
Peer Learning Opportunities.....	10
Discussion.....	11
References.....	13
Appendix A. Interview Form.....	14
Appendix B. Information Sheet.....	21
Appendix C. Participant Responses to Oregon’s Medicaid Reform Activities on Disparities.....	23

## Overview

We conducted case studies in 8 states by interviewing state Medicaid administrators and health department staff members. We queried interviewees on their state's top priorities in Medicaid, their efforts to reduce racial/ethnic health disparities, and the role of adverse social determinants of health or SDH (throughout this report, SDH refers to adverse social determinants of health). We asked whether Medicaid administrators were doing or planning to do similar activities as Oregon's coordinated care organizations (CCOs). Participants also discussed learning opportunities arising from the efforts of Oregon CCOs and other reform efforts to address health disparities and SDH.

## Key Findings

### Top Priorities in Medicaid

- The most common priority interviewees reported was how to best utilize value-based purchasing to improve the value and quality of care provided to beneficiaries. Other common priorities were managing the transition to or coordination of Medicaid managed care organizations (MCOs) and the integration of behavioral health services.

### Efforts to Address Racial/Ethnic Health Disparities

- In general, key informants reported that their state Medicaid reform efforts were focused on reducing racial/ethnic health disparities *to some extent*, including these activities:
  - Utilizing data to define and target multiple health disparities (e.g., using dashboards, analyses, quality metrics)
  - Expanding healthcare services (e.g., home visiting, access to medication-assisted treatment or other behavioral health services) and increased use of nontraditional providers or navigators (e.g., nurse case managers, community health workers)
  - Modifying MCO contracting to incorporate cultural competency plans to ensure culturally and linguistically appropriate services

### Barriers to Addressing Racial/Ethnic Health Disparities

- In general, participants said that barriers to addressing racial/ethnic health disparities in their Medicaid reform efforts existed *to some extent*, including these barriers:
  - Lack of state and federal funding to address disparities
  - Low income underlies health disparities and is challenging for a public insurer to address
  - Institutional racism
  - Differing philosophies between systems of care
  - Lack of access to timely, integrated, and accurate data
  - Competing priorities among providers
  - Governmental partisanship and federal regulations

- Interviewees most commonly cited the following factors in mitigating the above barriers:
  - Increased state and federal government funding
  - Changes to relevant statutes, rules, and regulations

#### **Efforts to Address Social Determinants of Health**

- In general, participants reported that their state's Medicaid reform efforts focused on SDH to a moderate extent. Prominent activities related to SDH included the following:
  - Connecting beneficiaries to housing, employment, and transportation
  - Enhancing linguistically appropriate health communication
  - Targeting factors leading to premature death from opioid overdoses
  - Focusing on early childhood learning
  - Assigning beneficiaries to health homes and developing robust coverage of behavioral health services
  - Developing a foundational measurement structure for SDH and designing and implementing a risk-stratified payment model that considers SDH
  - Reducing the burden of SDH at any life stage through cross-agency projects
  - Creating entities similar to accountable care organizations

#### **Barriers to Addressing Social Determinants of Health**

- Participants reported that defining and measuring SDH was the most common barrier to addressing SDH, along with these barriers:
  - Lack of funding
  - Ability to collect accurate SDH data
  - Capacity of a public insurer to address SDH
  - Complexity of programs to address SDH
  - Effectiveness of leadership within SDH-related projects
  - Coordination of care among delivery services that have typically not worked together
  - Low health literacy among beneficiaries

#### **Alignment with Oregon's Medicaid Reform Activities**

- Key informants stated that they were doing a majority of the main activities of Oregon's reform efforts that were designed to reduce health disparities and the burden of SDH.

#### **Peer Learning Opportunities**

- Activities that interviewees were most interested in learning more about were best practices and lessons learned regarding regional equity groups and community involvement in addressing disparities and SDH, in addition to enhancing collaboration between Medicaid and other state health department programs.

Although participants described barriers to addressing racial/ethnic health disparities and SDH, they were optimistic about addressing both issues in the future, and saw “great potential” for doing so through Medicaid reform efforts.

## Background

In recent years, Oregon Medicaid administrators have instituted changes to transform the Medicaid payment and delivery system,<sup>1</sup> including greater flexibility for CCOs to spend funds on nontraditional services meant to address SDH.<sup>2</sup> This attention to SDH was based, in part, on an understanding of the relatively minor contribution of health care to an individual's overall health.<sup>3</sup> Since Oregon's reform efforts began, other state Medicaid programs have shown interest in interventions to address SDH to improve health and reduce disparities, particularly racial/ethnic disparities.<sup>4</sup>

For this study, we conducted case studies in 8 states by interviewing state Medicaid administrators and health department staff members. We had 4 main objectives for this study. We wanted interviewees to describe 1) their top 3 priorities for Medicaid; 2) existing and future efforts to reduce racial/ethnic health disparities and address SDH and barriers to these activities; 3) whether their current activities align with Oregon's Medicaid reform efforts; 4) whether they were interested in learning more about Oregon's Medicaid reform efforts and other activities, and if so, we requested details on their specific interests. This report summarizes our findings from the 8 state case studies.

## Methods

We conducted semi-structured interviews with state Medicaid administrators and health department staff members in Alabama, Arizona, Colorado, Minnesota, New York, Ohio, Texas, and Washington. For this study, we described *disparities* as differences in health status and health care access, utilization, and quality, such as between racial/ethnic groups. We defined *social determinants of health* as social and structural conditions within and between communities, such as education, transportation, and housing, all of which could contribute to health status.

State Medicaid administrators received a copy of the interview form and study information sheet (Appendices A and B) in order to familiarize themselves with the material and identify additional participants within their Medicaid program and state health department. We conducted single interview sessions with multiple interviewees for each state, which generated our case studies. Because there were multiple interviewees, we asked for consensus responses when needed (e.g., top 3 priorities in Medicaid, Likert scale responses). The study and all related materials were approved by Oregon Health & Science University's Institutional Review Board. All participants consented to being recorded during the interview session. Electronic audio files were transcribed by the company [Rev](#). We used ATLAS.ti 8.0 to code and analyze qualitative data and SAS 9.4 to estimate means, medians, and modes of Likert scale responses.

## Findings

### Top Priorities in Medicaid

We asked interviewees about their top 3 priorities in their Medicaid programs. Participants from 5 of 8 states prioritized improving the value and quality of care for beneficiaries through value-based purchasing, which was the most frequently cited priority. The second most frequently reported priority related to Medicaid MCOs: participants from 4 states prioritized the transition to or coordination between MCOs. Interviewees from 3 states identified integration of behavioral health as a top priority. Participants from 2 states highlighted patient engagement and activation (i.e., getting a person actively involved in their health and health care), in addition to long-term services and supports, particularly funding for home- and community-based services. The latter priority could be linked to value-based purchasing, through bundled payments or other payment models, although participants did not explicitly state a connection. Interviewees from 2 states each reported priorities of understanding the effectiveness and cost-effectiveness of physical therapy, occupational therapy, and speech therapy; improving their delivery system reform incentive payment (DSRIP) program; managing the opioid epidemic; addressing health disparities among youth in foster care; maintaining the financial stability of the Medicaid program; and treating chronic disease and substance use disorders among people who identify as American Indian.

A common theme that emerged from interviews was the financial implications of health care spending, particularly in relationship to the value and quality of care. Interviewees from only one state identified the opioid epidemic as a specific top priority, although managing chronic pain and substance use disorders likely fall under the priority of coordinating MCOs and other top priorities.

### Efforts to Address Racial/Ethnic Health Disparities

Participants were asked about the extent to which their agencies focused on reducing racial/ethnic disparities. The response options consisted of *not at all*, *to a small extent*, *to some extent*, *to a moderate extent*, and *to a large extent*. On average, interviewees responded between *to some extent* and *to a moderate extent*, with the most frequent response being *to some extent* (mean = 3.5; median = 3; mode = 3). Participants listed the following state-specific programs and efforts directed at reducing disparities:

- Conducting surveillance by developing dashboards and other tools to monitor disparities
- Using home-visiting programs, nurse case managers, and community health workers
- Developing quality metrics and financial incentives targeting multiple disparities
- Expanding coverage of certain services (e.g., smoking cessation, medication-assisted treatment)
- Increasing access to care for beneficiaries with a serious mental illness or in foster care
- Incorporating cultural competency plans to ensure that culturally and linguistically appropriate services are included in MCO contracts

Key informants from a majority of states highlighted federal regulations that require Medicaid agencies to engage and incorporate tribal communities in needs assessments or decision making related to state plan amendments, Medicaid waivers, and other activities when they involve American Indian populations.<sup>5</sup> Additionally, interviewees highlighted entities (e.g., accountable care organizations), waivers (e.g., DSRIP), programs (e.g., perinatal programs), projects (e.g., cross-agency collaborations aimed at reducing the burden of SDH), and centers (e.g., Center for Elimination of Disproportionality and Disparities) that aim to improve health and health equity.

### Barriers to Addressing Racial/Ethnic Health Disparities

Using the same scale, interviewees reported the extent to which they believed that barriers were preventing their Medicaid agencies from addressing racial/ethnic health disparities. The results were similar to the previous question: on

average, participants' responses were between *to some extent* and *to a moderate extent*, with the most frequent response being *to some extent* (mean = 3.4; median = 3; mode = 3). The most common barrier, reported by 4 of 8 case study participants, was lack of funding for programs to reduce disparities. Interviewees from 2 states described economic obstacles, specifically that they believed their Medicaid program was limited in terms of capacity to address poverty as a primary SDH and a leading factor in racial/ethnic health disparities. Interviewees cited other barriers:

- Institutional racism
- Differing philosophies between systems of care
- Other priorities among providers
- Barriers to obtaining valid data on race/ethnicity
- Inability to integrate the data from electronic health records across systems of care
- Governmental partisanship leading to inaction
- Federal regulations, particularly those limiting the permissible uses of Medicaid funds

Before shifting to SDH, we asked participants who reported barriers as being a burden (i.e., *to some extent* or greater) how likely it was that their current approach to racial/ethnic health disparities would change in the next 5 years. They were given the following options: *Not at all likely*, *not very likely*, *moderately likely*, *likely*, and *very likely*. Among interviewees from 7 states, the average response was between *to some extent* and *to a moderate extent*, with the most frequent response being *to some extent* (mean = 3.6; median = 3; mode = 3).

---

*And quite frankly, everything in Medicaid is so uncertain right now, both nationally and at the state level, in terms of what our funding will be for anything, that ... You know, it's hard to know where [addressing health disparities] will emerge in light of all of that tumult.*

---



When asked what factors could increase focus and effort on reducing racial/ethnic health disparities, interviewees consistently identified additional state and federal funding and changes to relevant statutes, rules, and regulations. Participants also described specific efforts that they might consider in the next 5 years to address these disparities, including quality-metric development, data-driven approaches to identify and address issues, and disease-specific approaches (e.g., cardiovascular disease interventions among individuals who identify as black). Although key informants said that efforts were tied to decisions made by state and federal governments, they expressed optimism about the ability of Medicaid agencies to potentially reduce racial/ethnic health disparities.

### **Efforts to Address Social Determinants of Health**

We asked participants a series of 3 questions concerning SDH: how much focus was being placed on SDH in Medicaid reform efforts; the most prominent activities focusing on SDH; and the potential for their Medicaid agency to address SDH in the future. For the first question, given the options of *not at all*, *to a small extent*, *to some extent*, *to a moderate extent*, and *to a large extent*, on average, participants rated focus on SDH between *to some extent* and *to a moderate extent* (mean = 3.75; median = 4; mode = 5). The most common response was *to a large extent*.

Participants from 7 of 8 states identified the 3 most prominent activities focused on trying to reduce the burden of SDH. (Interviewees from one state were not asked this question because the amount of focus on SDH was either *not at all* or *to a small extent*.) Participants from 6 states said that supportive housing efforts were part of their Medicaid programs or had occurred in collaboration with state or local housing authorities. Interviewees from 2 states identified support for transportation to and from health care services as a prominent activity. Several other activities were cited by participants from one state each:

- Enhancing culturally and linguistically appropriate health communication
- Targeting social factors leading to premature death from opioid overdoses
- Providing supportive employment programs
- Focusing on early childhood learning
- Modifying the home environment (e.g., purchasing air conditioners)
- Assigning beneficiaries to health homes
- Developing robust coverage of behavioral health services
- Developing a foundational measurement structure for SDH and designing and implementing a risk-stratified payment model that considers SDH
- Cross-agency projects aimed at reducing the burden of SDH at any life stage
- Creating entities similar to accountable care organizations

Regarding the potential, if any, to target SDH in the future, the majority of interviewees saw “great potential” and were optimistic. About addressing SDH, one interviewee responded, “Our Medicaid director would say we have a moral obligation to do that.” Participants from 2 states

expressed uncertainty about being able to affect SDH through their Medicaid programs, describing their potential as “limited.” Interviewees identified Medicaid waivers as potential opportunities to target SDH, such as expanding supportive transportation and housing opportunities.

### **Barriers to Addressing Social Determinants of Health**

Although participants consistently reported a high level of focus on SDH, they identified several barriers to addressing SDH-related issues. The most common barrier, reported by participants from 4 states, was defining and measuring SDH, particularly in Medicaid. Other barriers were the following:

---

*My biggest interest is in how [Oregon] defined and pulled data for social determinants of health.*

---

- Funding, in general, and for specific activities such as supportive housing, transportation, and education
- Collection of accurate SDH data
- Ability of a public insurer to reduce the burden of SDH
- Complexity of programs to address SDH
- Effectiveness of leadership within SDH-related projects
- Coordination of care among delivery services that have typically not worked together
- Low health literacy

### **Alignment with Oregon’s Medicaid Reform Activities**

We asked key informants a series of 8 questions related to Medicaid reform activities that are occurring in Oregon, primarily through CCOs, to reduce health disparities and the burden of SDH. The following are the 8 activities:

1. Collecting and evaluating race and ethnicity data to measure disparities (role of state health departments)
2. Conducting community health needs assessments
3. Developing community health improvement plans
4. Creating community advisory groups
5. Establishing regional equity groups
6. Utilizing community health workers
7. Ensuring diversity in the health care workforce that is representative of the community being served
8. Implementing specific health initiatives to reduce disparities (e.g., colorectal cancer screening)

If interviewees reported that they were not currently doing an activity, we asked about the likelihood that their programs would implement a similar activity in the next 5 years. To identify the likelihood of doing a similar activity, participants were given the options of *not at all likely*,

*not very likely, moderately likely, likely, and very likely.* For each of the 8 activities, interviewees from a majority of the states reported that they were currently doing a similar activity (Appendix C).

Interviewees from 5 of 8 states reported that their state health department collects and evaluates Medicaid race/ethnicity data to measure disparities in health status and health care access, utilization, and quality. Interviewees from one state stated that they were currently not doing this, but were *moderately likely* to do so in the next 5 years. Participants from 2 states were unsure or did not know.

Participants were then asked a series of 3 community health-related questions about conducting needs assessments, creating health improvement plans, and developing advisory groups. Participants from 7 of 8 states reported that their state conducts community health needs assessments. Interviewees from one state stated that they were not currently doing this activity and were *not very likely* to do so in the next 5 years.

---

*I would say that [health disparities] is pretty much what I breathe and live every single day. And so I think working on behalf of individuals who live in poverty, again that is—they are disadvantaged from that perspective, from an economic standpoint.*

---

Participants from 6 states reported that they had created community health improvement plans, one said they did not and were *not very likely* to do so in the next 5 years, and the other was unsure or did not know. Interviewees from all states reported that they had developed community advisory groups to provide advice and perspectives on reducing health disparities.

Key informants from 6 of 8 states reported that they had established regional equity coalitions, such as community-level groups to identify regional strategies to decrease health disparities or address SDH. Interviewees from one state reported that they were unsure or did not know whether their state had established regional equity groups and another said their state had not, but was *likely* to establish these groups in the next 5 years.

We asked participants 2 questions about their state health care workforce. Interviewees from 7 of 8 states said that they use community health workers to act as culturally and linguistically appropriate “trusted sources of information” who connect people with local health care services. Interviewees from one state reported that their state’s Medicaid program does not utilize community health workers, but was *moderately likely* to do so in the next 5 years. Participants from 5 of 8 states reported that their state health departments have programs to ensure diversity in the health care workforce that is culturally and linguistically representative of the communities that they serve. Interviewees from one state reported that their state health department does not do this and that they were *not very likely* to do so in the next 5 years. Key informants from 2 states stated that they were unsure or did not know whether their state health department did this activity.

Regarding specific health initiatives to reduce health disparities (e.g., colorectal cancer screening), interviewees from 6 of 8 states reported that they have these types of programs in their state; 2 did not. Among participants from the 2 states that were not currently doing this, one reported that they were *not very likely* to do this activity in the next 5 years and the other responded that they were *moderately likely* to do so.

### Peer Learning Opportunities

Of the 8 Oregon CCO-related activities listed above, we asked interviewees to name the top 3 activities that they would be most interested in learning more about. Participants from 6 of 8 states expressed interest in learning more about regional equity groups aimed at decreasing health disparities and the burden of SDH. Interviewees wanted more general knowledge about how Oregon's regional equity groups could be translated to other states' programs, whether these groups are effective at reducing disparities and SDH, and best practices on implementation.

Interviewees from 5 states were interested in state health departments collecting and evaluating Medicaid race/ethnicity data to measure disparities. Participants from one state wanted to know how states are defining and extracting data related to SDH; others were interested in how Oregon Medicaid is utilizing the state's health department, in particular their epidemiologists, to obtain accurate and timely data.

Participants from 4 states reported a desire for more information on ensuring diversity in the workforce. Interviewees wanted more general knowledge on diversity-promoting programs and how they function, best practices to ensure a workforce that represents the community that is served, and how Oregon Medicaid is working with other agencies to achieve these diversity goals. Interviewees from 3 states highlighted a need for more information on community health workers. These participants were mainly interested in licensing, including whether to do so or not, and how to reimburse for their services. Participants from 2 states wanted more information on community health improvement plans in terms of how they are structured, used, and acted upon, especially in Medicaid. Interviewees from one state expressed interest in learning more about community advisory groups and how they could be used within their state's current regional structure for addressing disparities and SDH.

Conducting community health needs assessments or implementing specific health initiatives that targeted health disparities were not identified as a top priority. This is likely indicative of the experience and knowledge that participants have in these areas or it could be that these activities were a relatively lower priority.

Participants gave mixed responses when asked whether there were other aspects of Oregon's reform efforts, particularly pertaining to disparities that they wanted to know more about. The most common theme among participants (n = 6) was a desire for evidence of effectiveness and best practices in terms of which reform efforts are and are not working well. For the activities

considered to be successful, participants wanted more information about how they were implemented. Interviewees from 2 states also wanted more information on how Oregon's CCOs were measuring and defining outcomes. Other responses included 7 requests for more information on Oregon's approach to the following:

- Measuring and addressing institutional racism
- Providing coverage for migrant or seasonal workers within Medicaid programs
- Linking community clinics and IT systems
- Addressing health disparities in tribal communities
- Enhancing collaboration between Medicaid and state health department programs
- Determining the influence of geographic distribution of Oregon's CCOs on their effectiveness
- Using predictive algorithms to identify individuals at increased risk for poor health outcomes to better target programs addressing SDH

A singular theme emerged from interviewees' final comments. In general, they highlighted that Oregon is demographically less diverse than other states. Therefore, they expressed a desire to better understand whether and how findings from Oregon could be generalized to other dissimilar states, particularly in addressing health disparities and SDH. One other response was, "I think I'm just grateful that finally we're able

to have these conversations and kind of put down a real work plan. It's the same thing as defining quality. I don't think you can define quality in health care without discussing the

---

*We exist in a very different world in terms of our population, financing, and Medicaid [than Oregon].*

---

disparities and the inequalities that we actually see." This response illustrates that advances have been made in addressing health disparities and SDH through Medicaid, but that more progress is needed.

## Discussion

A primary goal of this study was to collect information from state Medicaid administrators and health department staff members about whether and how state Medicaid programs, other than Oregon's, are addressing racial/ethnic health disparities and SDH. Collecting this information will provide us with a better sense of how ongoing evaluations of Oregon's CCOs and other reform efforts could potentially be generalized to other states' programs. Generalizing findings from Oregon's efforts was a main theme that participants reported as being important.

Interviewees most frequently reported that the current top priority was moving to value-based purchasing within their Medicaid programs, including the possibility of using value-based payments to reduce health disparities and the burden of SDH. Additionally, a majority of participants reported that, to varying degrees, they were engaged in similar activities as Oregon's Medicaid reform efforts. Interviewees expressed significant interest in information and

best practices for several Oregon CCO activities, including how Oregon Medicaid works with the state health department to collect and evaluate race/ethnicity data.

Although interviewees identified barriers related to federal and state funding and statutory and regulatory limits, they were generally optimistic about Medicaid's ability to address racial/ethnic health disparities and SDH, and saw "great potential" to accomplish this through their Medicaid reform efforts. Interviewees reported slightly more focus on reducing the burden of SDH, although this could be a reasonable long-term strategy because SDH are believed to be a precursor of health disparities.<sup>6,7</sup>

State Medicaid agencies have several options to design programs and activities to potentially address health disparities and SDH. Case study states that have created these types of programs did so through Medicaid state plan amendments and waivers (e.g., 1115, 1915[b], and 1915[c]). Decisions to pursue activities to target and address health disparities and SDH must be considered in the context of several factors such as the state's political climate, fiscal situation, competing budget priorities, and their likelihood of success.

## References

1. McConnell KJ, Chang AM, Cohen DJ, et al. Oregon's Medicaid transformation: an innovative approach to holding a health system accountable for spending growth. *Healthc (Amst)*. 2014;2(3):163-167.
2. DeMars C. Oregon bridges the gap between health care and community-based health. 2015; <http://healthaffairs.org/blog/2015/02/12/oregon-bridges-the-gap-between-health-care-and-community-based-health/>. Accessed August 14, 2017.
3. Schroeder SA. We can do better—Improving the health of the American people. *N Engl J Med* 2007;357(12):1221-1228.
4. Artiga S, Heiman HJ. Beyond health care: the role of social determinants in promoting health and health equity. 2015; [http://www.issuelab.org/resource/beyond\\_health\\_care\\_the\\_role\\_of\\_social\\_determinants\\_in\\_promoting\\_health\\_and\\_health\\_equity](http://www.issuelab.org/resource/beyond_health_care_the_role_of_social_determinants_in_promoting_health_and_health_equity). Accessed August 14, 2017.
5. Medicaid.gov. Indian health and Medicaid. n.d.; <https://www.medicaid.gov/medicaid/indian-health-and-medicaid/index.html>. Accessed August 1, 2017.
6. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep*. 2014;129(Suppl 2):19-31.
7. Dubiel HJ, Shupe A, Tolliver R. The connection between health disparities and the social determinants of health in early childhood. 2010; <http://www.chd.dphe.state.co.us/Resources/pubs/ECHealthDisparities2.pdf>. Accessed August 7, 2017.

## Appendix A. Interview Form

ID#: <input type="text"/>	State: <input type="text"/>
---------------------------	-----------------------------

### Interview Guide for State Medicaid Administrators on Health Disparities

*The Center for Health Systems Effectiveness is embarking on an assessment of the interplay between Medicaid policy and health disparities. We'd like to hear from you regarding any of your state's priorities, policies, or goals that might apply to health disparities. Your responses would help us understand what might be the most salient lessons from ongoing evaluations of Oregon's efforts to address racial and ethnic disparities as part of its Medicaid reform.*

*In this interview, when I refer to 'disparities', I mean differences in healthcare access, utilization and quality and health status, such as between racial and ethnic groups.*

*When I refer to 'social determinants of health', I mean differences in social and structural conditions within and between communities, such as education, transportation and housing that may contribute to health.*

#### Part I: Role of Disparities in [Name Interviewee State]'s Medicaid Programs

1. What would you define as the top three priorities of your Medicaid program today, in general?

*For this next question, I will be giving you a choice of graded responses. The choices are: 1-Not at all, 2-to a small extent, 3-to some extent, 4-to a moderate extent and 5-to a large extent.*

2. In your state's Medicaid reform, to what extent is focus being placed on reducing racial and ethnic disparities?

1	2	3	4	5
Not at all	To a small extent	To some extent	To a moderate extent	To a large extent

- a. Why? OR Why not?
- b. What specific programs or efforts are directed at reducing disparities?



3. To what extent, do you see there are barriers to addressing disparities in your Medicaid reform effort, such as other priorities, resources, or lack of interventions? Please indicate your response among the following choices.

1	2	3	4	5
Not at all	To a small extent	To some extent	To a moderate extent	To a large extent

- a. Which barriers?

4. [If the answer to question #3 is "1 or 2, not at all or to a small extent - barriers," skip this question.]

If addressing disparities is not a current area of focus for your state, how likely is it that this will change in the next five years? Please indicate your response among the following choices.

1	2	3	4	5
Not at all likely	Not very likely	Moderately likely	Likely	Very Likely

- a. What might cause this to change?  
 b. If so, what type of efforts do you think the state might consider?  
 c. What potential do you see in your Medicaid program for reducing disparities in the future?

5. [Note – if Social Determinants of Health have come up, question may need to be reworded appropriately] How much focus is being placed on addressing Social Determinants of Health in your state’s Medicaid reform?

1	2	3	4	5
Not at all	To a small extent	To some extent	To a moderate extent	To a large extent

- a. Why? Or Why not?  
 b. Do you see barriers to addressing Social Determinants of Health? Which barriers?

6. [If the answer to question #5 is, "1 or 2, not at all or to a small extent", skip this question.]  
What three activities feature most prominently in your efforts to address Social Determinants of Health?
  
7. What potential, if any, do you see in your Medicaid program for addressing Social Determinants of Health in the future?

**Part II: Oregon’s Medicaid Reform Activities on Disparities**

*In this second half of the survey, I’ll be asking questions that are intended to gauge interest and involvement by your state in certain types of disparities activities. I will describe eight (A through H) specific activities in Oregon’s reform efforts to eliminate disparities.*

*I will ask you about whether your state is implementing similar activities. If your state is not currently conducting a specific activity, then I will ask you about the likelihood of your state implementing a similar type of disparity activity with your Medicaid program in the next 5 years.*

*Please keep in mind that there are no expectations that any state should necessarily be engaging in any of these disparities activities at this time or in the future.*

- A. Does your state health department collect and evaluate Medicaid race and ethnicity data to measure disparities in healthcare access, utilization, and quality and health status?

1	2	3
Yes	No	Not Sure/Don’t Know

- 2) [If answer is ‘Yes’, skip this question] What is the likelihood that your state would implement a similar type of activity in the next 5 years? The choices of response are:

1	2	3	4	5
Not at all likely	Not very likely	Moderately likely	Likely	Very Likely

- B. Does your state conduct any type of Community Health Needs Assessments, such as systematic reviews of health issues facing a population that lead to agreed upon priorities to improve health and address health disparities?

1	2	3
Yes	No	Not Sure/Don’t Know

- 2) [If answer is ‘Yes’, skip this question] What is the likelihood that your state would implement a similar type of activity in the next 5 years? The choices of response are:

1	2	3	4	5
---	---	---	---	---

Not at all likely	Not very likely	Moderately likely	Likely	Very Likely
-------------------	-----------------	-------------------	--------	-------------

C. Does your state develop any type of Community Health Improvement Plans, such as long term plans to improve health and address health disparities in a local population?

1	2	3
Yes	No	Not Sure/Don't Know

2) [If answer is 'Yes', skip this question] What is the likelihood that your state would implement a similar type of activity in the next 5 years? The choices of response are:

1	2	3	4	5
Not at all likely	Not very likely	Moderately likely	Likely	Very Likely

D. Has your state created any Community Advisory Groups to specifically address health disparities, such as conducting a health needs assessment?

1	2	3
Yes	No	Not Sure/Don't Know

2) [If answer is 'Yes', skip this question] What is the likelihood that your state would implement a similar type of activity in the next 5 years? The choices of response are:

1	2	3	4	5
Not at all likely	Not very likely	Moderately likely	Likely	Very Likely

E. Has your state established any types of Regional Equity Groups, such as community-driven groups to identify regional strategies that could decrease health disparities or address the social determinants of health?

1	2	3
Yes	No	Not Sure/Don't Know

2) [If answer is 'Yes', skip this question] What is the likelihood that your state would implement a similar type of activity in the next 5 years? The choices of response are:

1	2	3	4	5
Not at all likely	Not very likely	Moderately likely	Likely	Very Likely

F. Do you utilize Community Health Workers to act as culturally and linguistically appropriate 'trusted sources of information' who provide a link between people and local healthcare services?

1	2	3
Yes	No	Not Sure/Don't Know

2) [If answer is 'Yes', skip this question] What is the likelihood that your state would implement a similar type of activity in the next 5 years? The choices of response are:

1	2	3	4	5
Not at all likely	Not very likely	Moderately likely	Likely	Very Likely

G. Does your state health department have activities to ensure diversity in the healthcare work force that is culturally and linguistically representative of the communities that you serve?

1	2	3
Yes	No	Not Sure/Don't Know

2) [If answer is 'Yes', skip this question] What is the likelihood that your state would implement a similar type of activity in the next 5 years? The choices of response are:

1	2	3	4	5
Not at all likely	Not very likely	Moderately likely	Likely	Very Likely

H. Has your state developed specific health initiatives targeted for reducing health disparities such as, increasing colorectal cancer screening rates among specific populations?

1	2	3
Yes	No	Not Sure/Don't Know

2) [If answer is 'Yes', skip this question] What is the likelihood that your state would implement a similar type of activity in the next 5 years? The choices of response are:

1	2	3	4	5
Not at all likely	Not very likely	Moderately likely	Likely	Very Likely

2. Among the Oregon reform activities that I just described, could you indicate the top three activities that you would be most interested in learning more about?
  - a. What, specifically, would you like to learn about these activities?
3. Are there other aspects of Oregon's reform efforts that would be helpful for your state to know more about, particularly as they pertain to disparities?
4. Do you have any final comments or questions that you'd like to share?

## Appendix B. Information Sheet



### Information Sheet

IRB# 16848

---

**TITLE:** Assessing Translational Lessons from Oregon's Medicaid Reform Model to Reduce Disparities

**PRINCIPAL INVESTIGATOR:** K. John McConnell, PhD, 503-494-1989

**PURPOSE:**

You have been invited to be interviewed for this research study because you work for or with a state Medicaid agency. The purpose of this research study is to assess the extent to which Oregon's Medicaid reform model can reduce racial and ethnic disparities. Your responses to the interview will help us identify translational lessons from this research for other state Medicaid agencies.

**PROCEDURES:**

You are being asked to participate once in a telephone interview during this project. The interview will be audio-recorded and will last approximately 45 minutes. Audio files will be summarized and professionally transcribed. Audio files will be destroyed at the end of the study. One or more members of the research team may participate in the semi-structured phone interview. We will ask questions about your state Medicaid agency's and/or health department's interests, activities and barriers towards reducing race and ethnic disparities in health care access, resource use and quality.

If you have any questions, concerns, or complaints regarding this study now or in the future, or you think you may have been injured or harmed by the study, contact Rani George, MPH at 503-494-1073.

**RISKS:**

Although we have made every effort to protect your identity, there is a minimal risk of loss of confidentiality.

**BENEFITS:**

You may or may not benefit from being in this study. However, by serving as a subject, you may help to increase knowledge about generalizable lessons from Oregon's Medicaid reform to reduce race and ethnic disparities.

**CONFIDENTIALITY:**

Only researchers that are part of this study will have access to the results that you provide. These notes will also be password-protected and only researchers that are part of this study will have access. Information from interviews will be assigned a code and personal identifying information will be removed. Your name and any personal identifying information will not appear in any published or presented materials resulting from this work.

**COSTS:**

It will not cost you anything to participate in this study.

**PARTICIPATION:**

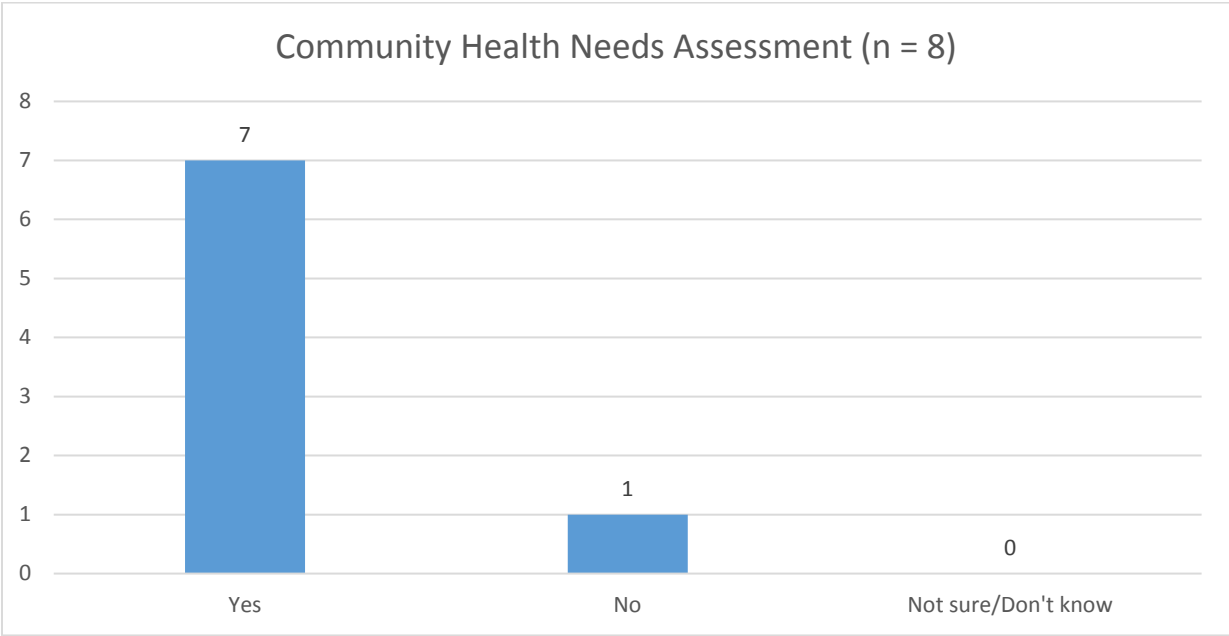
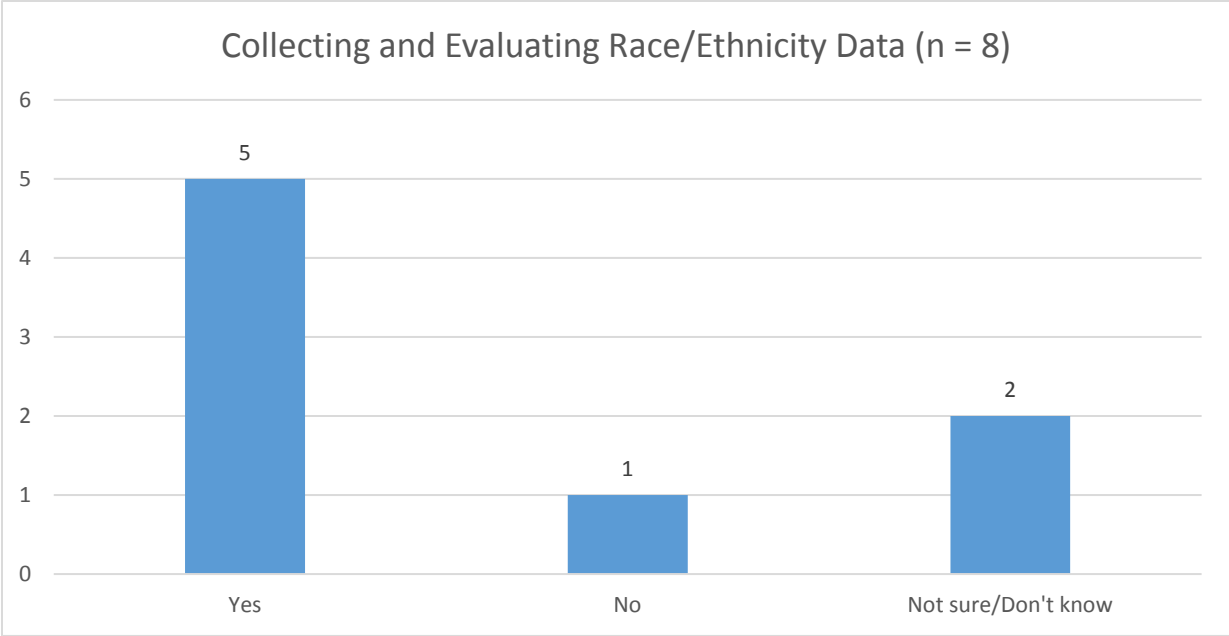
If you have any questions regarding your rights as a research subject, you may contact the OHSU Research Integrity Office at (503) 494-7887 or [irb@ohsu.edu](mailto:irb@ohsu.edu) if:

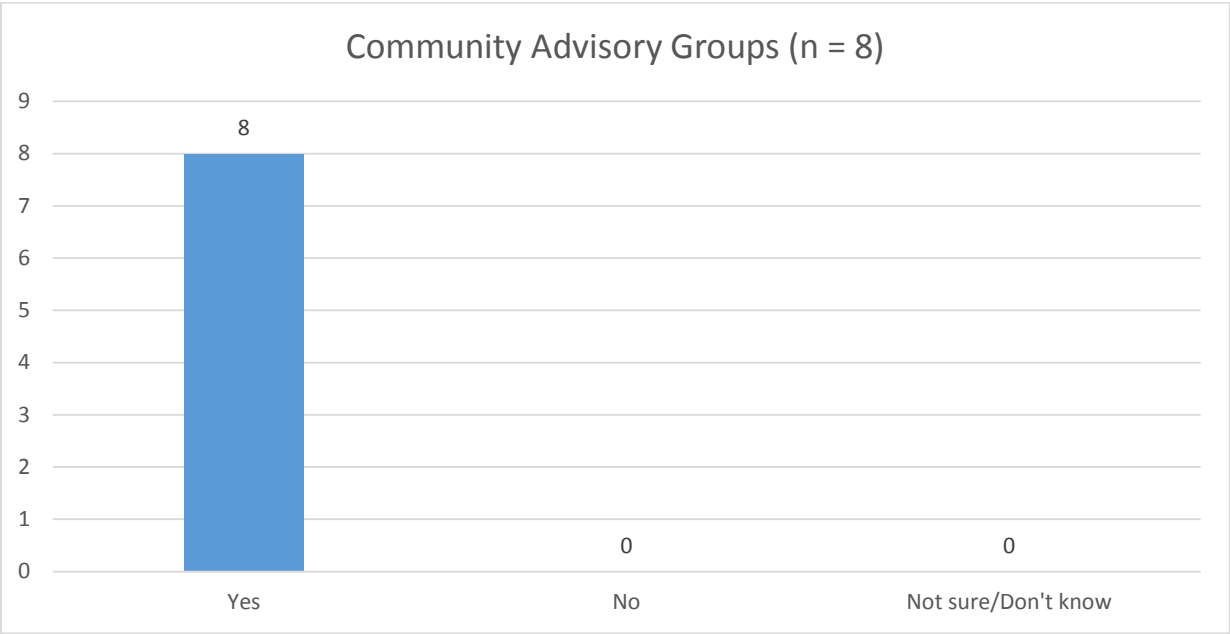
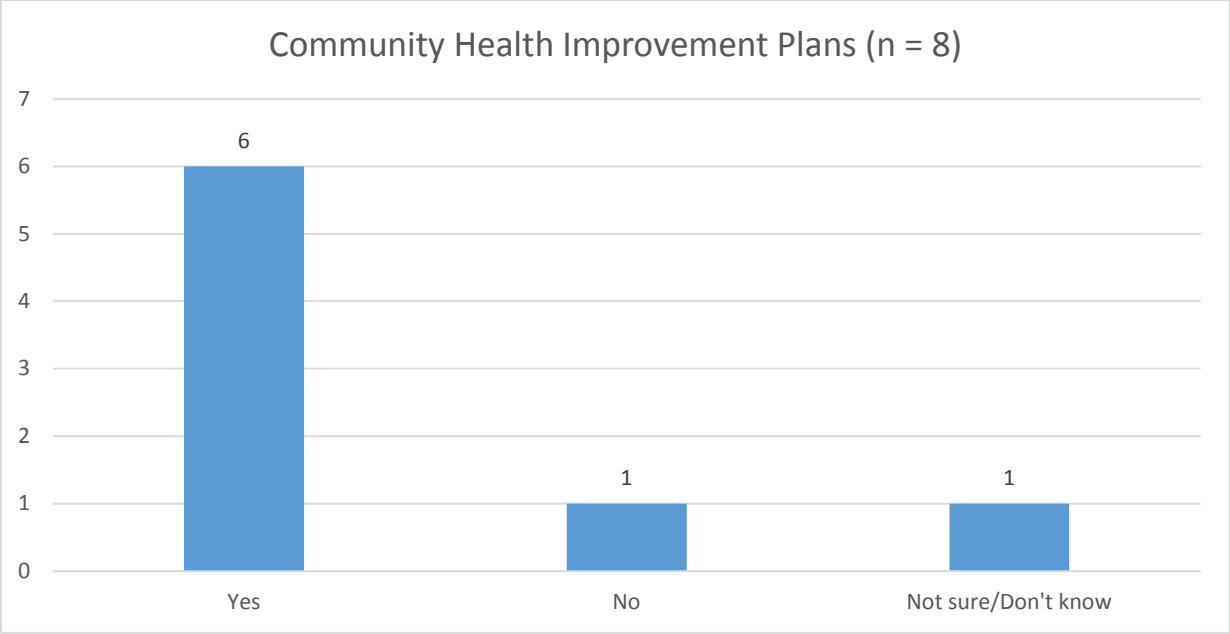
- Your questions, concerns, or complaints are not being answered by the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get more information or provide input about this research.

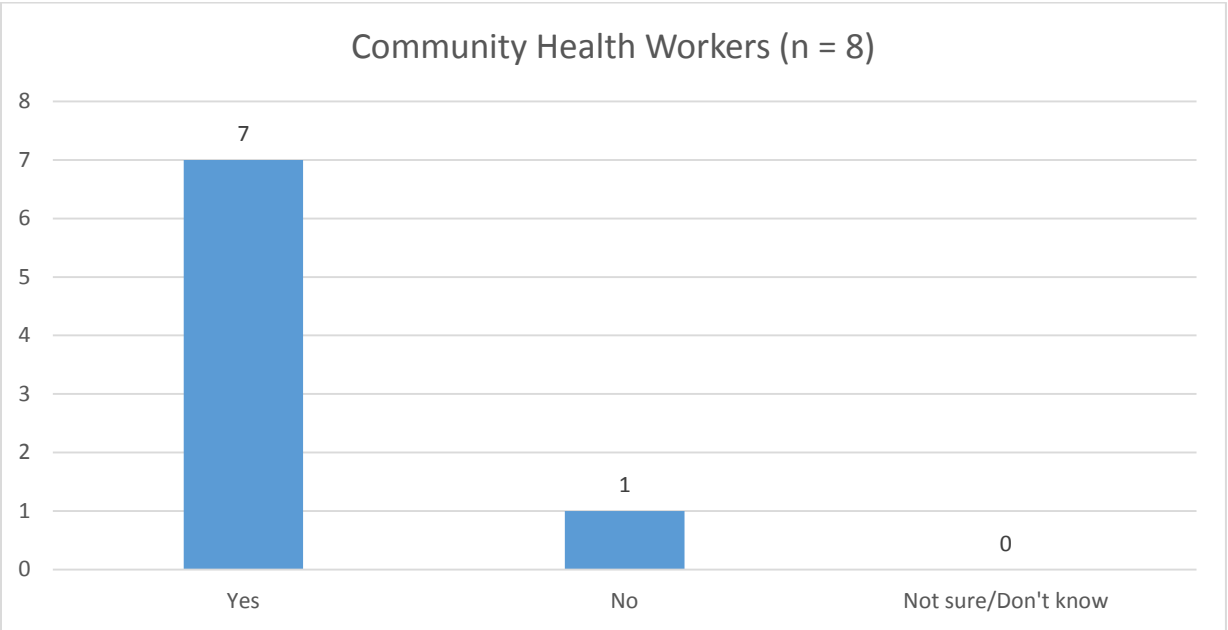
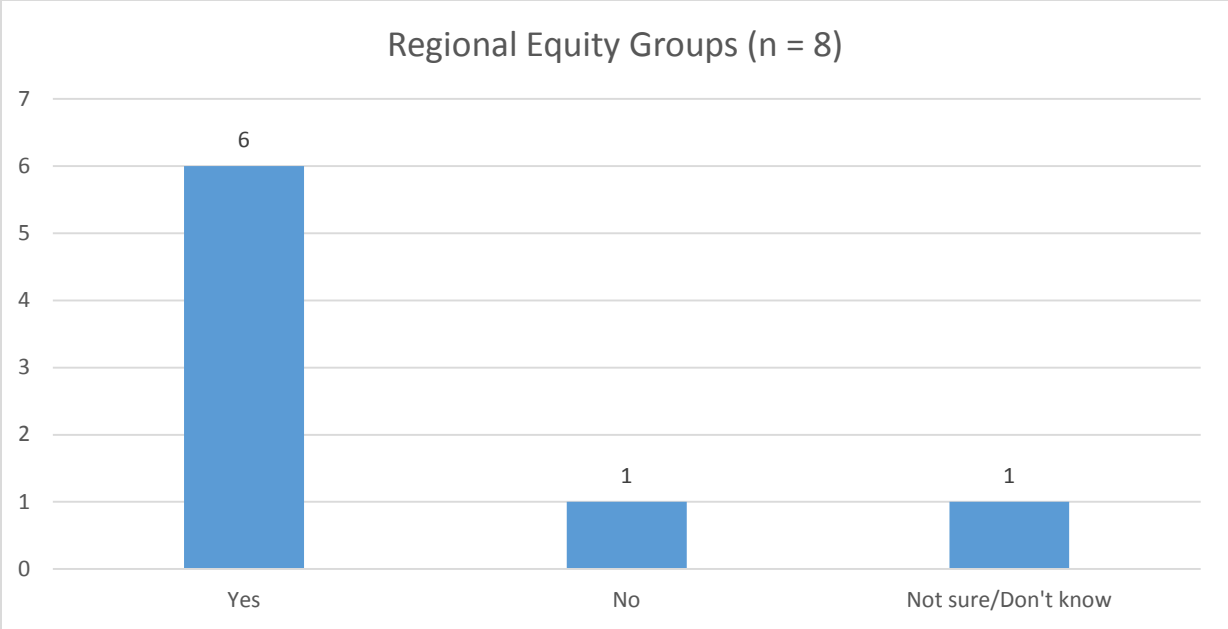
You do not have to join this or any research study. If you do join, and later change your mind, you may quit at any time. If you refuse to join or withdraw early from the study, there will be no penalty or loss of any benefits to which you are otherwise entitled. If you wish, you may request that specific comments be deleted from the record.

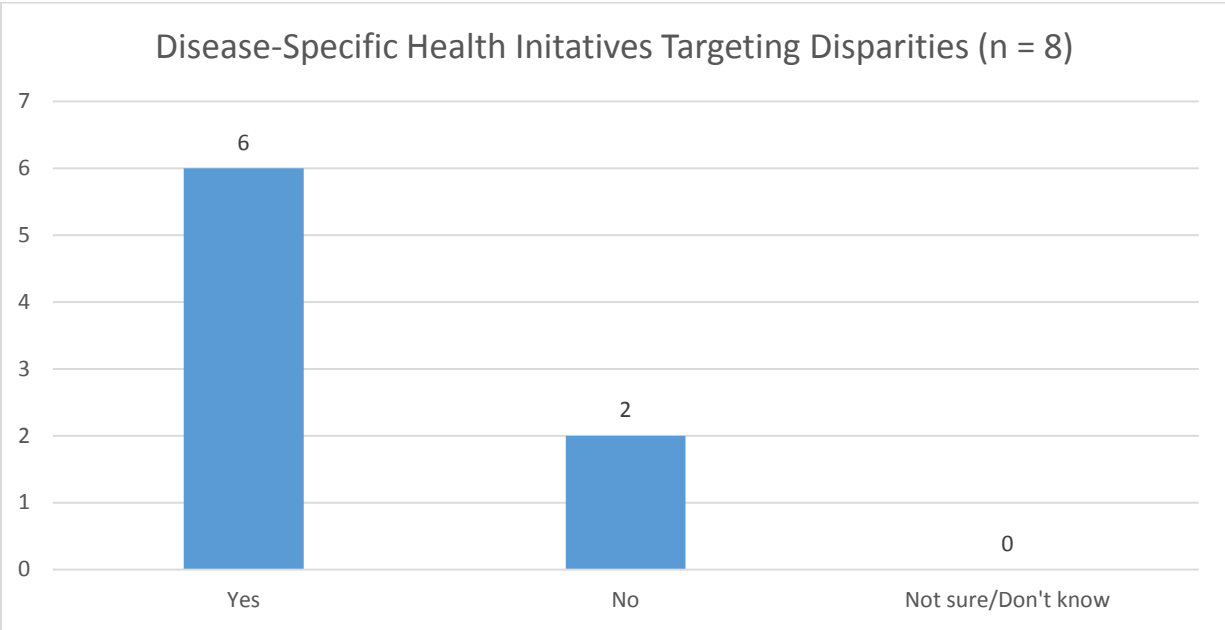
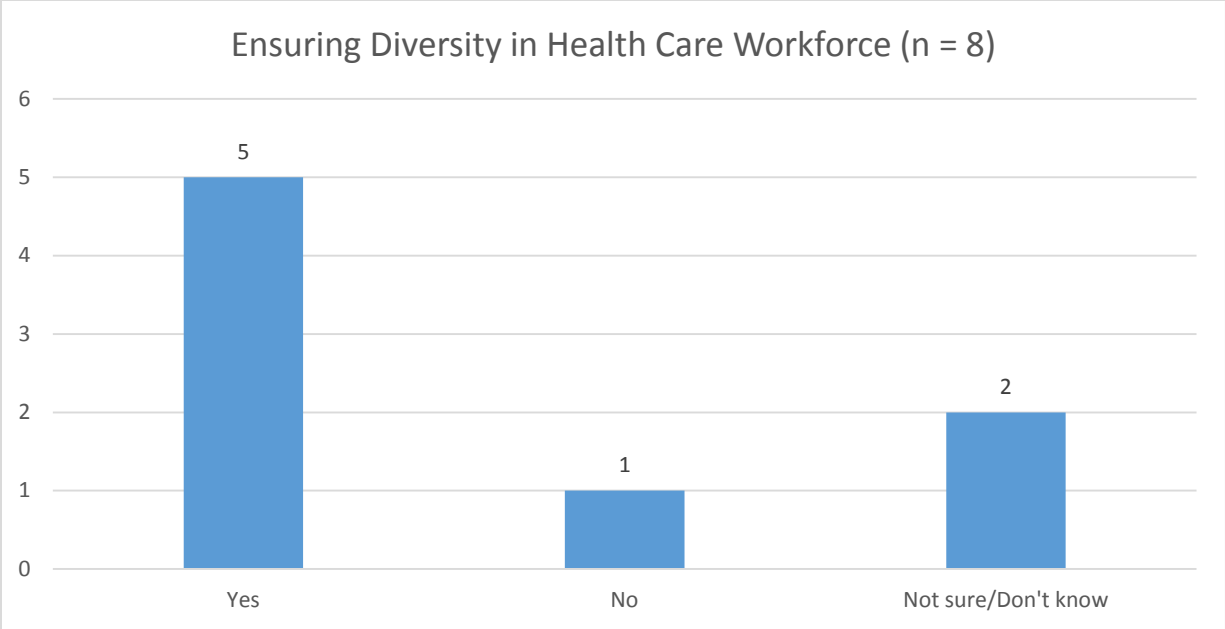


### Appendix C. Participant Responses to Oregon’s Medicaid Reform Activities on Disparities









**Suggested citation: Harrod, C. S., Obley, A., George, R., & McConnell, K. J. (2017). *Health disparities and social determinants of health activities in Medicaid*. Portland, OR: Center for Evidence-based Policy and Center for Health Systems Effectiveness, Oregon Health & Science University.**

Conflict of Interest Disclosures: No authors have conflicts of interest to disclose. All authors have completed and submitted the Oregon Health & Science University form for Disclosure of Potential Conflicts of Interest, and none were reported.

Funding/Support: This research was fully-funded by the Center for Health Systems Effectiveness at Oregon Health & Science University.

This document was prepared by the Center for Evidence-based Policy and the Center for Health Systems Effectiveness at Oregon Health & Science University. The document is intended as a reference and is provided with the understanding that the Centers are not engaged in rendering any clinical, legal, business, or other professional advice. The statements in this document do not represent official policy positions of the Centers. Researchers and authors involved in preparing this document have no affiliations or financial involvement that conflict with material presented in this document.