BRIEF • November 2021

Center for Health Care Strategies

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Cross-Agency Partnerships for Health Equity: Understanding Opportunities Across Medicaid and Public Health Agencies

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TAKEAWAYS

- State Medicaid and public health programs can advance health equity for the communities they serve, especially for people of color, working both within their agency and through cross-agency partnerships.
- State Medicaid and public health programs can use three broad strategies to promote health equity: (1) advance internal-facing health equity work; (2) leverage data to drive health equity efforts; and (3) engage community members authentically.
- Based on interviews with states and a national scan of state activities, this brief outlines key recommendations to further Medicaid and public health opportunities and cross-agency partnerships that advance health equity.

Across the nation, communities of color have experienced enduring health disparities due to systemic racism, which have been exacerbated by disproportionate physical, social, and economic impacts from the COVID-19 pandemic.[1] State Medicaid and public health programs — working within their own agencies and collaboratively — have great potential to advance health equity for the communities they serve, especially for people of color. Given Medicaid's role in delivering care to individuals with low incomes, including many from communities of color, the program is uniquely situated to address health disparities.[2] Public health agencies are responsible for improving population health for their communities, with a particular focus on addressing social determinants of health and advancing equity.

Made possible through support from the Robert Wood Johnson Foundation.
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With support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies (CHCS) and the Association of State and Territorial Health Officials (ASTHO) led a national scan to identify health equity priorities that state agencies can advance in the next two years — especially those shared across agencies. The exploration also sought opportunities to center community voices as part of these efforts. Activities included a literature review and more than 20 interviews with representatives from state Medicaid agencies, public health departments, Offices of Health Equity, member advocacy groups, community-based organizations, and health equity experts.

Drawing from this national analysis, this brief summarizes opportunities to advance health equity in three areas:

1. Advancing internal-facing health equity work;
2. Leveraging data to drive health equity efforts; and
3. Engaging community members authentically.

Key Insights to Advance Health Equity Within and Across Agencies

CHCS and ASTHO, with guidance from an expert advisory committee comprised of the National Association of Medicaid Directors, the National Partnership for Women & Families, and the Centers for Disease Control and Prevention, led a national exploration to identify opportunities that promote health equity within and across state Medicaid and public health agencies.

This analysis of Medicaid-public health opportunities explored how these agencies could advance health equity to address their current priorities, needs, and capacity, with a focus on both in-agency and cross-agency activities.

Questions raised within key informant interviews included:

- **How does your agency or organization define health equity?**
- **What are the current health equity priorities and goals within your agency or organization?**
- **How is your agency or organization thinking about racial equity as a key component of those broader health equity definitions and priorities?**
- **Are you currently partnering with Medicaid or public health to advance health equity?**
- **What types of supports, technical assistance, and facilitation would increase state capacity to partner and align across Medicaid and public health agencies to accelerate health equity efforts?**
- **How is your agency/organization communicating its priorities and goals with communities and enrollees?**
- **What barriers are impeding agency or organizational efforts to engage communities to advance health equity?**

Findings from background research and key informant interviews are discussed below under three broad areas of opportunity, with examples and practical ideas outlined under each opportunity.

1. Advance Internal-Facing Health Equity Work

Across the board, Medicaid and public health agencies remarked on the need to "get your house in order" internally as a first step of putting health equity into action. This requires a level-setting of how health equity is defined. Each state representative interviewed had adopted a working definition of health equity for their agency, by using either definitions from the Robert Wood Johnson Foundation, the Centers for Disease Control and Prevention, or establishing their own definition.[3,4] The definitions centered on recognizing that not all members of the community are starting at an equal place. States interviewed are seeking to ensure that programs and services are effectively engaging and serving community members who are impacted by systems of oppression, while also prioritizing racial equity within their own four walls.

Example Health Equity Definitions

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." – *Robert Wood Johnson Foundation*

"Health equity is achieved when every person has the opportunity to 'attain his or her full health potential' and no one is 'disadvantaged from achieving this potential because of social position or other socially determined circumstances.'" – *Centers for Disease Control and Prevention*

After the national racial uprisings during 2020 and the COVID-19 pandemic's ongoing disproportionate impacts on communities of color (including vaccine access), both Medicaid and public health agencies are investing in resources and capacity-building to equip staff with the information and tools to support equity and justice activities. Building an internal culture of equity and understanding is a critical first step before embedding a focus on health equity into agency programmatic work. Interviewees also shared that their agencies prioritized efforts to diversify agency staff across all levels, especially leadership, to fully represent the populations served. Following are examples that highlight the progress being made at state agencies.

EXAMPLES

- Some interviewees shared that **mandated health equity trainings** for state government employees are valuable for building expertise to identify and address the root causes of inequities. States shared insights about their experiences in preparing for and implementing these trainings. For instance, external equity consultants found that it is helpful to underscore to state employees how everyone loses when there is racial injustice, not just communities of color. Internal equity workshops developed for agency staff aim to address: "*What are current practices that need to change and/or be adapted that applies equity constructs?*" One challenge cited is identifying equity consultants to support ongoing staff capacity-building efforts. Another challenge is funding these efforts: *How can states fund ongoing trainings and development of skills needed to build and flex these newly gained equity "muscles?"*

> **If we censor racial justice in our work, we won't ever really be free of these systems of white supremacy and anti-blackness and other forms of intersecting oppressions that limit our ability to be healthy and free.**
>
> *- Expert consultant who works with state agencies to advance health equity goals*

- The **New Jersey Department of Health** shared their efforts to reexamine the process for allocating resources, such as the types of organizations they contract with and the process for procurements for external partners, especially those that serve communities of color. They are seeking to be more intentional about the community-based organizations that they invest in through grant opportunities. New Jersey is also considering how to support smaller grassroots organizations, which are often led by women of color, who may not have the infrastructure to apply for state requests for proposals.

- In 2020, **California's Strategic Growth Council (SGC)** approved a Racial Equity Resolution committing seven state agencies to take action to advance racial equity, which was supported by SGC's Racial Equity Action Plan.[5,6] This resolution is the first-of-its kind by a multi-agency state body. SGC's Racial Equity Action Plan grew out of its participation in the Government Alliance on Race and Equity-supported Capitol Collaborative on Race and Equity (CCORE), which is a racial equity capacity-building effort for California state employees, organized by the Public Health Institute's Health in All Policies program.[7] The Health and Human Services agency is a participant in the SGC Resolution, and the Department of Public Health, an early adopter of this racial equity approach, has also played a leadership role in supporting the launch of CCORE and mentoring other state entities across government as they join this movement.

- Both Medicaid and public health agencies with **Offices of Health Equity** in several states expressed that it is **important to have dedicated staff** who can ensure internal capacity-building activities are happening across the entire department. One challenge is ensuring that these offices have enough resources to accomplish this task. There are also important considerations for how to sustainably support this work within agencies, as well as the individuals leading this work, who are often people of color.

Advancing Health Equity: Leveraging Medicaid and Public Health Capabilities

There are a number of opportunities for state Medicaid and public health agencies to capitalize on each other's complementary roles and skill sets to improve health equity. The following table offers examples of where the unique capabilities of Medicaid and public health can be used to advance health equity within a state.

MEDICAID	PUBLIC HEALTH
• Insurance coverage for individuals with low income, many from communities of color • Authority over benefits and coverage • Expertise in health care payment and delivery, and how to use levers (e.g., value-based payment) to advance health equity • Ability to leverage quality improvement for health equity • Collaboration with health plans and providers • Access to and analysis of health-related data for covered individuals to identify and inform health equity goals and progress	• Disease-specific expertise, with access to data on disparities within disease patterns, causes, and locations • On-the-ground knowledge of provider and beneficiary access and utilization barriers that impact health equity • Population health focus, with expertise in addressing social determinants of health to advance equity in programs and policies • Expertise in intervention design, outreach, implementation, and evaluation to reduce health disparities and advance health equity • Experience with knowledge dissemination to communities and providers

2. Leverage Data to Drive Health Equity Efforts

Data that can be stratified by race, ethnicity, and language (REL) are fundamental to identify, assess, and address health disparities to advance equity. Medicaid and public health agencies, however, are often stymied in health equity efforts by incomplete or unreliable REL data and the inability to monitor and track REL data over time specific to localities and populations. Medicaid and public health agencies need valid, reliable, and complete data on the presence, magnitude, and significance of health disparities within their populations to use the appropriate levers at the state level to reduce disparities and achieve health equity.

Interviewees noted an opportunity for state Medicaid and public health agencies to partner with communities, especially as it relates to REL data. Efforts to understand patient privacy concerns as well as help communities understand why states are collecting and using REL data are important to ensure that accurate demographic data is being collected from the beginning. Partnering with communities from the outset of data collection ensures that states have data to use within agencies and share across agencies.

Improving data infrastructure and/or sharing data between Medicaid and public health are key opportunities to advance equity, particularly in terms of collaboration to advance health equity. State agencies can use cross-agency data to: (1) identify unmet needs; (2) assess the health equity impacts of policy decisions; (3) target opportunities to promote health and advance health equity; and (4) monitor and measure progress and impact of strategies.

There are many challenges, however, in cross-agency data-sharing efforts, including a lack of interoperable systems, regulatory barriers, limitations on stratifying data by factors such as race, ethnicity, and language, and data access restrictions. In addition, even in cases where states are collecting the necessary data, there is often an unclear understanding of ownership. Differing agency priorities and a lack of clear guidance on data-sharing processes can hinder progress to achieving health equity priorities. There are various formal agreements to foster data sharing between Medicaid and public health: Memorandum of Understanding, Data Sharing Agreements, Data Use Agreements, and Interagency Agreements. Following are two promising state examples related to leveraging data to drive health equity efforts:

- The **Michigan** Department of Health and Human Services includes both Medicaid and public health. This agency structure has helped align goals and promote collaboration. In 2021, for example, Michigan identified that a lack of REL data was being reported for COVID-19 vaccination reports. Although not an easy process given the amount of missing REL data, the state leveraged Medicaid and other databases to match public health vaccine records to eligibility and other administrative information to fill in race and ethnicity gaps. As a result, the state was able to publish vaccination rate data by race and ethnicity transparently for the public.

- The Center for Minority Health under the **Illinois** Department of Public Health (IDPH) is focused on standardizing programs to improve REL data collection. This is to ensure a common vocabulary across data systems and that equivalent categories are being collected to enable monitoring disparities and to allow mapping of categories from one system to another. While there are formal data-sharing agreements with sister agencies, challenges remain to access the proper data. IDPH formed a COVID-19 equity team that is focused on building a better data infrastructure to service the "whole community." The goal is to promote collaboration between state agencies to advance shared equity goals by ensuring that each agency is capturing the same standardized types of data. This includes developing standards for funding opportunity notices, health equity assessment questions, and data-reporting standards.

3. Engage Community Members Authentically

Interviewees recognized the importance for Medicaid and public health agencies to meaningfully engage community members in policy and program design and be accountable to the community for their actions. Interviewees noted that moving from a checkbox mentality for consumer engagement to a more intentional partnership is critical for driving long-term health equity efforts by state Medicaid and public health agencies. Agencies interviewed identified authentic community engagement as a critical opportunity both within agencies as well as for cross-agency alignment to drive shared health equity priorities.

> **I never want us — the collective us — to act as a savior, walking into someone's community saying: 'Here's what we're going to give you and be grateful for it.' … We need to take the time to understand each community's needs. We have to earn the trust of the communities. If not, we will do an injustice and be counterproductive.**
>
> *- Medicaid representative*

Many interviewees from Medicaid and public health agencies explained that this authentic form of engagement involves creating equitable and mutually beneficial partnerships with community members by valuing their time and expertise and allowing them to drive decisions. States highlighted varying mechanisms for engagement — ranging from ad-hoc town hall meetings, focus groups, member advisory councils, surveys, managed care organization relationships, public comment periods, and community partnerships. They still, however, cited the need for guidance to operationalize and sustain that engagement with an equity lens.

Many state interviewees noted challenges with community engagement and partnership, including:

- Providing financial assistance to community members to facilitate partnership;
- Earning and sustaining the trust of community members;
- Identifying and connecting with members and communities to enable feedback on programs and policies, with a focus on establishing meaningful decision-making roles;
- Leveraging community resources and partnerships to better serve members and communities;
- Facilitating and maximizing member and community engagement; and
- Addressing barriers to participation.

Interviewees from community-based organizations (CBOs) and advocacy groups noted the above-mentioned challenges as opportunities for advancing equity. These stakeholders expressed a need for bidirectional communications to help community members understand how the information they are providing is being used. After collecting information from community members, state Medicaid and public health agencies should share how they will act on the information and/or why they did not use information for program and policy implementation to address equity. This presents a unique opportunity for state Medicaid, public health, and community partners to align around shared goals and priorities and leverage each other's expertise and resources to build a supportive infrastructure for successful community engagement.

Following are examples of how states can authentically engage with community members:

- Some Medicaid and public health interviewees highlighted the **need to build trust** with the communities they serve. Strategies to build trust include meeting the community where they are; setting up communication structures between communities and state agencies; and working with CBOs and community leaders from other groups (e.g., faith-based organizations, advocacy organizations) to identify and understand communities' needs. For example, participants noted Medicaid and public health agencies at the state level may not be the best stakeholder to directly engage with local communities. Instead, participants suggest having a trusted community stakeholder (e.g., CBO representative) serve as a liaison to the agency. This provides an opportunity for agencies to learn directly about a community's health equity priorities and how to address these priorities.

Interviewees expressed a need for state agencies to learn from and communicate with communities as well as dedicate time and resources to build enduring community partnerships.

- Many Medicaid and public health interviewees stressed that federal and state regulations prohibited them from directly **compensating or providing incentives for engagement** to community members, who deserve reimbursement for their time and expertise. This was especially true for Medicaid agencies, which cited potential alternatives to provide this type of support, such as partnering with CBOs or public health agencies to explore different funding streams and mechanisms to directly pay community members or incentivize participation through assistance with transportation and childcare services.
- Prior to COVID-19, staff from **Vermont's Medicaid agency** used a number of strategies to engage with their communities. They incorporated members' voices into policy and program decisions through monthly Medicaid exchange and advisory board meetings that invite community members to share stories and address key issues. State officials who attend the meetings get the opportunity to hear directly from members to inform policy and program decisions. State officials also worked with community-based organizations to understand community needs and received guidance on culturally appropriate communication materials and health campaigns.

Practical Opportunities to Promote Health Equity Within and Across State Agencies

As part of its exploration, CHCS and ASTHO engaged state officials, representatives from community advocacy groups, and individuals with expertise in implementing health equity activities with Medicaid and public health officials in a small group convening. This meeting in July 2021 generated innovative and practical ideas to support within and across agency health efforts to advance equity for the communities they serve. Following are six ideas that offer the potential to be impactful, practical, equitable, and sustainable:

1. Seek to institutionalize equity efforts within and across agencies.

To advance internal agency department work, there needs to be a comprehensive commitment to move beyond valuing equity (where states are now) to institutionalizing equity (where many states want to be). This means Medicaid and

public health agencies should prioritize equity efforts across their agencies instead of siloed to certain offices. This allows for spread of information across all areas of the organization and decreases burnout of staff who work in Offices of Health Equity. Considerations to take action include:

- **Normalize discussions around health and race equity issues** so that these topics are embedded in every decision-making point; and
- **Operationalize equity efforts by creating structures to build long-lasting change.** This can enable conversations around equity capacity-building and educational trainings, the types of language used, and/or which organizations are benefitting from RFPs and grant opportunities that would be more meaningful and ultimately benefit the population with the greatest need.

2. Establish a larger equity team within and across agencies and provide the resources needed to fully dedicate to this work.

While Offices of Health Equity are powerful resources to advance health equity at the state level, these offices are often understaffed and under-resourced to drive all health equity work at state agencies. To complement the expertise of the Offices of Health Equity, champions outside of these offices should be identified and supported to advance health equity priorities within agencies and across agencies through larger health equity teams or workgroups. To the extent feasible, staff driving health equity work, inside the Office of Health Equity and health equity champions, should represent the community, as they can leverage their lived expertise to inform budgeting, policies, and programs. States should set aside dedicated funding to support not only the creation of these teams, but also examine compensation and promotion structures to increase diversity in leadership positions, and support the extra burden of advancing health equity at the agency on top of their day-to-day activities. Dismantling current structures and creating new ones is taxing work and compensation should reflect this.

3. Develop data governance structures within and across state agencies to advance health equity to facilitate current health equity priorities and long-term capacity related to health equity.

- **Standardize collection of REL data** within and across state agencies, including state Medicaid and public health agencies. Adopting standard data elements can help state agencies uniformly collect data, compare, and share

data across agencies in a meaningful way to understand health disparities, and allow for informed and targeted programs and policies. Standardizing data, including REL data, may require legislation, regulations, or additional policy changes.

- **Develop data-sharing agreements and memoranda of understanding** to create data-sharing structures between agencies, including Medicaid and public health. Formalizing agreements between agencies with clearly defined terms and conditions and requirements for processing, storage, access, and transmission of data may catalyze cross-agency buy-in for sharing data.
- **Connect data functions across agencies.** For example, establish communities of practice for common agency data functions, such as data management, analytics, and user support, to better promote efficiency, collaboration, and coordination.
- **Incorporate qualitative data collection**. In addition to quantitative data, state Medicaid and public health agencies can incorporate qualitative data to make "data-informed" decisions, especially as pertaining to policies and programs to advance health equity.

4. Ensure that communities are engaged and included in the data collection and use process.

- **Train researchers, evaluators, and consumers of data on culturally responsive methodologies** to drive the use of data in services of advancing health equity.
- **Invest in community-based social service programs and organizations** to develop capacity building for data sharing.
- **Collaborate across agencies to align on messaging** that communicates to the community why data collection is important and shares how states are using data.
- **Partner with communities** to develop data collection and use processes that reflect community priorities and ensure data transparency and continued communication regarding results as well as how data is or is not used to inform policies and programs.

5. Create accountability that is transparent and shared with communities.

To earn the trust and build mutually beneficial relationships with community members, state agencies should hold themselves accountable, both internally and externally, and demonstrate agency commitment to equity, their staff, and the communities they serve. State Medicaid and public health agencies can work within their respective agency, across their agencies, and with their communities to develop accountability measures that prioritize transparency in decision and planning processes.

6. Meet communities where they are and go through trusted partners.

When building authentic and meaningful engagement and partnership efforts, it starts with "going to where the people are." These efforts should be expanded to develop ongoing mechanisms for responding to community feedback, especially related to policies and programs that seek to reduce health disparities and advance equity for members and communities. To do so, public health and Medicaid state agencies should work together and through trusted members from communities (e.g., CBOs) to establish communication mechanisms and community hubs. This will allow agencies to better understand the unique challenges and persistent issues communities and members face. The agencies can then partner with community members to develop equitable solutions to improve members' health outcomes and experiences.

Looking Ahead

It is clear that state public health and Medicaid agencies across the nation have prioritized health equity and have a foundation for advancing these efforts, both within and across their agencies. Medicaid and public health agency staff can learn from each other to advance this work. Medicaid leaders can learn from public health's population health approach that focuses on how addressing social determinants of health can advance health equity in programs and policies. Public health can build their understanding of how Medicaid funding structures work and leverage Medicaid data to focus on specific population demographics. While this exploration emphasized cross-agency partnerships to advance equity, results also demonstrate the need to support within-agency efforts to advance equity in the three opportunity areas of advancing internal-facing equity work; leveraging data to drive equity efforts; and engaging community members authentically.

Given the changing state landscape of priorities and resource allocation, there is a short timeframe to implement real change. Dedicated equity champions within state agencies as well as those who work with them feel as though they have a window of opportunity over the next two to three years to institutionalize equity efforts in Medicaid and public health departments. The actionable opportunities discussed in this brief outline impactful, practical, and durable strategies that state Medicaid and public health agencies have the appetite to take on in the next two years. They also represent the first of many steps necessary within and across Medicaid and public health agencies to advance health equity for communities of color across the country.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

ABOUT ASTHO

ASTHO is the national nonprofit organization representing the public health agencies of the United States, the U.S. territories and Freely Associated States, and the District of Columbia, as well as the more than 100,000 public health professionals these agencies employ. ASTHO members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and to ensuring excellence in public health practice. For more information, visit **www.astho.org**.

ENDNOTES

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