



REACH Principles for Health Care Reform: Ensuring Health Equity

Ensuring that all residents have access to a medical home by expanding and promoting community health centers and other publicly-supported health care institutions. Having a “medical home” – a health care setting that enhances access to providers and timely, well-organized care – is associated with better management of chronic conditions, regular preventive screenings, and improved primary care. Racial and ethnic minorities are less likely to report having a medical home, but when they do, their health care access gaps are significantly reduced. The federal government should fund the development of medical homes through demonstration programs and grants to community-based organizations.

Sample legislative language: S. 2376 Medical Homes Act of 2007 (Durbin-Burr, November 2007)

Promoting cultural and linguistic competence in health care settings by ensuring compliance with Title VI of the Civil Rights Act of 1964 and promoting greater adoption of the federal National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Recipients of federal financial assistance (“recipients”) cannot discriminate on the basis of race, color and national origin. Recipients must ensure language access for individuals with limited English proficiency and comply with the HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons (August 8, 2003). In addition, recipients should implement the National Standards for Culturally and Linguistically Appropriate Services in Health Care.

The Secretary shall provide federal reimbursement for culturally and linguistically appropriate services through the Medicare, Medicaid, and the State Children’s Health Insurance Programs, and establish a block grant to fund language services for uninsured patients.

Sample legislative language: *Linguistically Appropriate Health Care Act* (available from the National Health Law Program), and H.R. 3014, Health Equity and Accountability Act.

Promote diversity among public health professionals and increase incentives for public health professionals to practice in underserved communities. Additional funding and resources should be directed to loan forgiveness and tuition reimbursement programs so that underrepresented public health and health care professions students can obtain adequate funding for their education while also encouraging them to serve in underserved communities and/or health professional shortage areas. Promoting diversity among public health and health care professionals is imperative to ensuring better health outcomes for minority clients and to help eliminate health disparities. Current public health and health care professional incentive programs are woefully underfunded and do not work to target minority students, many of whom are members of underserved and health professional shortage area communities. The federal government should fully fund public health professional and



health care professional loan forgiveness and tuition reimbursement programs. The federal government should also create new programs that incentivize minorities from underserved communities and/or health professional shortage areas to receive tuition-for-service agreements when those individuals return to serve their communities.

Sample legislative language: S. 1576, Minority Health Improvement and Health Disparity Elimination Act, Title I, Section 102-104; and H.R. 3014, Health Equity and Accountability Act, Title II, Sections 201-210.

Improving and streamlining enrollment procedures for public health insurance programs. The federal government should require and provide funding for states to award grants to support community-based education and outreach programs to reduce the number of individuals eligible, but not enrolled in Medicaid and SCHIP. A portion of funding to states should be designated for outreach, enrollment assistance, case management and follow-up services to facilitate enrollment, utilization and retention in the Medicaid and SCHIP at service points within local communities by community based organizations, safety net healthcare providers, school districts and social service organizations. Given the cost savings associated with coverage, prevention and early diagnosis and treatment, performance measures and financial incentives should be established to encourage states to maximize enrollment and participation in Medicaid and SCHIP.

Sample Legislative language: S.158, Access to Affordable Health Care Act, Section 2112. Expanded Outreach Activities, Section 252, State Option to Provide for Simplified Determinations of a Child's Financial Eligibility for Medical Assistance Under Medicaid or Child Health Assistance Under SCHIP.

The federal government should work with states to reduce barriers to enrollment through regulation, technical assistance and grant funding. Federal Medicaid waivers and funding should be made available to allow states to continue and sustain gains made in improving and streamlining enrollment procedure into public health insurance programs including coordination, streamlining and simplification of program eligibility and retention requirements. It is important to establish a clear and easy-to-understand processes and procedures for enrolling children and families into public health insurance programs. Department of Health and Human Services should establish a streamlined and simplified enrollment system including the use of information technology to coordinate various state databases to identify and enroll children and families to be administered by all states, the use of self-attestation, automatic enrollment and eligibility, if eligible for other federally-funded, means tested program, presumptive eligibility, the elimination of the documentation requirements set forth in the DRA and the elimination of asset tests.

Sample Legislative language: S.158.IS Access to Affordable Health Care Act (Introduced in Senate). Subtitle D – Simplified Enrollment, Section 222. Application of Simplified Title XXI Procedures under the Medicaid Program

Priority should be given to the enrollment of children and populations with higher morbidity and mortality rates to reduce disparities in health and close the “health



equity/achievement gap". The federal government should monitor, evaluate and link enrollment rates of minorities and other underserved groups in public health programs (including Medicaid and SCHIP) to funding for states.

Sample legislative language: S. 1576, Minority Health Improvement and Health Disparity Elimination Act, Title II, Sec. 399R, 399T, 399W.

Requiring public and private health systems to collect, monitor and report data on racial/ ethnic, primary language, education and/or income-based health care disparities. The federal government should require and provide financial support to public and private health systems to collect and report data on health care access, quality and outcomes by patient demographic factors, including race and ethnicity, gender, language status, socio-economic position, geographic location, and health literacy, while ensuring appropriate privacy and security protections for the data. The federal government should devise a strategy for developing appropriate standardized measures, indicators and methods for collecting and reporting data. Data should be analyzed for trends in disparities and interactions between various disparity indicators. Data and findings should be disseminated to government agencies to inform policy decisions and assist in efforts to eliminate health disparities. When appropriate, data should be made accessible to nongovernmental entities and the public to promote greater public accountability.

Sample legislative language: S. 1576, Minority Health Improvement and Health Disparity Elimination Act, Title IV.

Encouraging the adoption of quality improvement programs that consider the health care challenges and needs of underserved communities; implementing health equity as a performance measurement and financial policy. The federal government should adopt quality improvement programs that consider the health care challenges and needs of the underserved communities and supports the reduction in health disparities. Implementation of health equity standards and performance measure is needed in the Medicaid, SCHIP and Medicare programs to achieve healthcare equity. The federal government should expand current quality improvement efforts and quality of care requirements for all health plans and healthcare providers, to reduce disparities in healthcare for ethnic and racial populations. These requirements must include benchmarks and evaluation on the outcome of a consumer's treatment and/or services. In order to achieve greater quality of care, the federal government should also increase resources allocated to licensing and certification bodies that will assure quality of care in hospitals, clinics, and physician offices.

Sample legislative language: H.R.7192 Preserving Patient Access to Primary Care Act (Introduced in House) Section 303. MEDICARE PRIMARY CARE PAYMENT EQUITY AND ACCESS PROVISION. Section. 304. ADDITIONAL INCENTIVE PAYMENT PROGRAM FOR PRIMARY CARE SERVICES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.

The federal government should expand the financial incentives, particularly through Medi-Cal and Healthy Families, to providers that adopt electronic information systems to improve care and offer grants or other assistance to support adoption in underserved



communities. This method will ensure greater accountability and management of care for organizations providing services.

Sample legislative language: S. 1576, Minority Health Improvement and Health Disparity Elimination Act, Title IV.

Developing and funding patient education, the training and use of community health workers and prevention programs. The federal government should award grants to support community-based education and outreach programs designed to reduce health disparities through improved access to health care, primary prevention activities, health promotion and disease prevention activities, and health literacy education and services. Grants should also be made available to facilitate partnerships between health care providers, the public, health agencies, and other stakeholder groups; coordinate and integrate community-based activities like education, housing, environment, labor, and transportation that help improve public health; and train community health workers. Priority should be given to health systems that are underserved and target minority and health disparity populations, such as safety net organizations, safety net hospitals, federally qualified health centers, community-based consortia, Indian organizations, and faith-based organizations.

The federal government should award grants to support community health workers. Community health workers, also known as lay health navigators or promotoras, are trained members of medically underserved communities who work to improve community health outcomes. Community health workers teach healthy behaviors and disease prevention, conduct simple assessments of health problems prevalent in their communities, help their neighbors access and enroll in public and private health and human services, and teach community wellness and awareness. In health care contexts, they serve as a liaison between communities and health systems and will be instrumental in helping individuals, families and communities transition to and navigate a new, reformed health system.

The federal government should monitor and evaluate grant programs and assess their impact, including an evaluation of enrollment rates of minorities and other underserved groups in public health programs (including Medicaid and the Children's Health Insurance Program) to assess the impact of outreach efforts.

Sample legislative language: S. 1576, Minority Health Improvement and Health Disparity Elimination Act, Title II.

Provide financial resources and other support to safety net hospitals and community health centers serving poor and ethnic minority communities; and institute measures to ensure that the funds meet their intended use.

Federally qualified health centers (FQHCs), safety net hospitals, and community health centers ("health facilities") should use shortage area designations to secure enhanced reimbursement rates for all primary care providers serving in Health Professional Shortage Areas (HPSAs) and other underserved communities with high rates of low-income patients, racial and ethnic minorities, and individuals with limited English



proficiency. Eligible health facilities must be: a) disproportionate share hospital (as defined in Section 1923(b)(3) of the Social Security Act) that has a low income utilization rate of greater than 25 percent; b) a clinic as defined in Section 1905(l)(2)(B) of the Social Security Act; or c) any clinic determined by the Secretary of HHS that performs a similar function for a similar population as that performed by federally qualified health centers; and shall submit an application to the Secretary, at such time and in such manner, and accompanied by such information as the Secretary may require to ascertain the entities' eligibility for funding.

In addition, safety net hospitals, community health centers, and FQHCs should also use other provider incentive programs (e.g., the J-1 Visa Waiver program and National Health Service Corporation) to attract and retain primary care providers to serve in health facilities in underserved areas.

Enhanced reimbursement to health facilities shall not offset payments under Section 1923 of the Social Security Act (for disproportionate share hospitals).

Sample legislative language: Based on the *Linguistically Appropriate Health Care Act* (available from the National Health Law Program); NYC Health and Hospitals Corporation, Letter to Elizabeth Duke, Ph.D., Administrator of Health Resources and Services Administration, re: Designation of Medically Underserved Populations and Health Professional Shortage Areas, Proposed Rules, 73 Federal Register, 11232, et. seq. (February 29, 2008).