The 2024 health equity regulatory landscape across states

December 2024

CHARTIS

HealthScape Advisors

A CHARTIS COMPANY

State efforts to advance health equity

Chartis recently updated its health equity state statute tracker, a tool to assess the depth and breadth of policies related to health equity across states. The latest refresh covers more than 4 years of data (from January 2020 to September 2024) from state departments of health and state legislatures, with a more comprehensive focus on Medicaid. States have leveraged four mechanisms to close the health equity gap:

1. Legislation
2. State requests for proposals (RFPs) and managed care organization (MCO) Medicaid contracts
3. 1115 demonstration waiver programs
4. Other state guidance and requirements that focus on quality, strategy, and health equity planning

STATE ACTIVITIES BY MECHANISM (JANUARY 2020 TO SEPTEMBER 2024)

Legislation

172

Across 42 states

Other guidance

61

Across 49 states

MCO contracts

105

Across 42 states and DC

1115 waivers

21

Across 20 states and DC

In this review period, we identified more than 350 new instances of health equity-related policies across all 50 states. The most frequent mechanisms were legislation and MCO Medicaid contract proposals. The table outlines the major themes and the most active states.

Over the past four years, states have introduced and incorporated numerous state-level regulations and policies to address health-related social needs (HRSNs) and social drivers of health (also known as social determinants of health or SDOH). In addition, many states have implemented mandates requiring health plans to identify and address SDOH within existing managed care contracts.

While the pace of new legislation and SDOH-focused RFPs in managed care contracts likely will fluctuate in the next several years, a significant body of existing regulations provides a foundation for addressing SDOH within state healthcare ecosystems.

Mechanism	Overview	States with the most activity
Legislation	■ 172 bills and resolutions with health equity/SDOH provisions have been enacted since 2020. ■ 12 states introduced 31 bills that attached funding via tax revenue, appropriation, or other state resource allocations. ■ 37 bills have been enacted since January 2023, four of which have funding appropriation.	■ New York State was most active, introducing 38 pieces of legislation since 2020 and passing four into law. ■ Other highly active states starting in 2020 include Washington (30), Illinois (27), California (20), Maryland (18), and Colorado (15).
State contracts	■ 42 states and DC now include health equity/HRSN service requirements in MCO contracts (e.g., promoting health equity initiatives and capturing member HRSN factors, reporting, and analytics). ■ The most common SDOH elements included in quality and performance improvement requirements are data collection, evaluation for HRSN needs, and partnerships with community-based organizations (CBOs).	■ States with the most MCO contracts awarded are Colorado (9), Mississippi (6), Louisiana (6), and Kentucky (6).
1115 demonstration waivers	■ 20 states and DC have 1115 pilot projects that include health equity/SDOH goals. ■ A common theme for these programs is enhancing care coordination, focusing on the role of CBOs.	■ In the past 6 months, the District of Columbia, Vermont, and Tennessee have launched 1115 pilot projects.
State guidance	■ 49 states have active guidance requiring health equity/HRSN assessment and screening. ■ State guidance is typically listed in state Medicaid Quality Strategy program publications. ■ Most state guidance identifies health equity plan requirements. This includes core health equity/SDOH sets for measurement and reporting, National Committee for Quality Assurance (NCQA) accreditation requirements, and health equity service delivery and engagement requirements.	■ Since March 2024, Georgia, Michigan, Vermont, West Virginia, and Wisconsin have all released Medicaid Quality Strategy programs for implementation through 2026.

Key themes in existing state Medicaid contracts and current RFPs include health equity programs and data analytics around priority populations.

While the extent to which Medicaid funding for such programs may change in the years ahead is still unclear, many current Medicaid managed care contracts include provisions for one or more of the following:

1. HEALTH EQUITY

42 states and DC have at least one health equity requirement in their contracts, such as a health equity plan/strategy, health equity officer, SDOH reporting, staff training, and accreditation.[2]

2. PRIORITY POPULATIONS

States have increased their focus on specific populations that are particularly impacted by health inequity. Focus areas include maternal health, rural health, foster care, care for individuals with disabilities, and care for other under-resourced populations.

3. DATA COLLECTION AND ANALYTICS

Advancing health equity requires improving data collection. Health equity data can be organized by member characteristics, such as race, ethnicity, language spoken, geographic location, disability, gender identity, and other factors to uncover disparities.

More than 50% of state contracts and RFPs require MCOs to advance collection and analytics of health equity data on high-priority regions and populations in alignment with state goals.

STATE AWARDED MCO CONTRACTS WITH HEALTH EQUITY REQUIREMENTS (JANUARY 2020 TO SEPTEMBER 2024)

9 Colorado	6 Mississippi
6 Louisiana	6 Kentucky
5 New Mexico	5 Texas
5 Arizona	4 Nevada
4 Minnesota	4 Kansas
3 Rhode Island	48 All other states

Key themes in existing state Medicaid contracts and current RFPs include health equity programs and data analytics around priority populations.

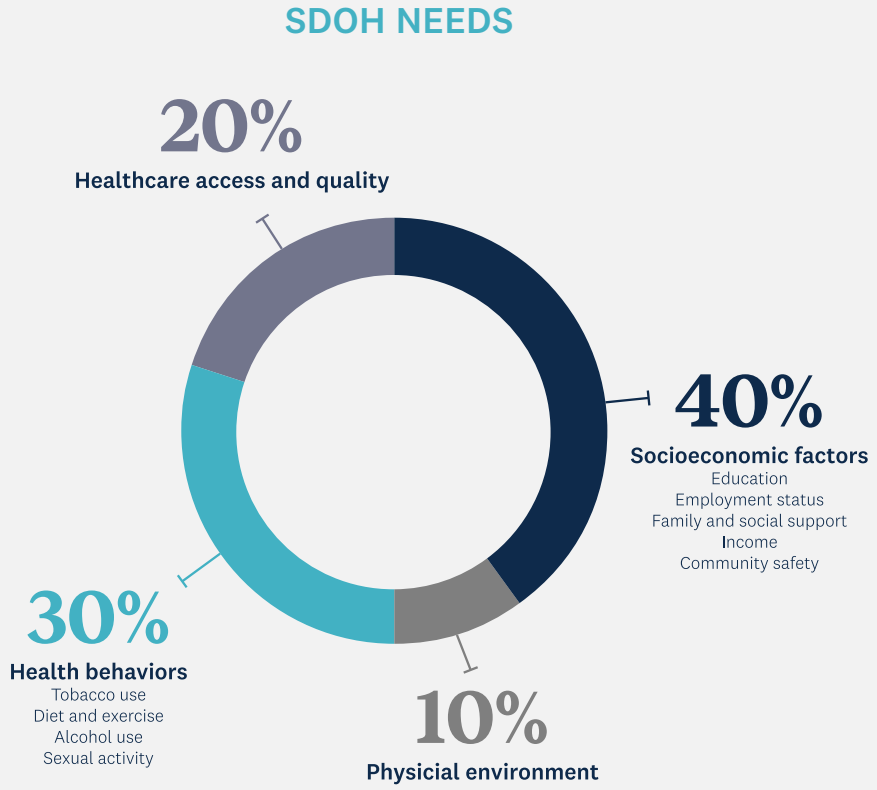
4. SDOH AND HRSN:

The 42 states with health equity requirements also require MCOs to identify and address all HRSNs and care barriers to improve health equity.

While states may prioritize specific member needs within a contract, states still expect health plans to address all HRSNs an individual member may identify. For example, as a broad strategy for addressing SDOH, a large Medicaid plan partnered with the local government and CBOs. Together, they developed programs to address key HRSNs by matching vulnerable members to secure permanent housing, healthy food deliveries, and reliable transportation to and from medical appointments. Each program improved members' health and quality of life.

5. PARTNERSHIP WITH COMMUNITY-BASED ORGANIZATIONS

Several states require MCOs to actively coordinate and build capacity with local community organizations, providers, and government entities to advance health equity and address members' HRSNs.



20 states and DC embraced 1115 waivers to achieve health equity goals

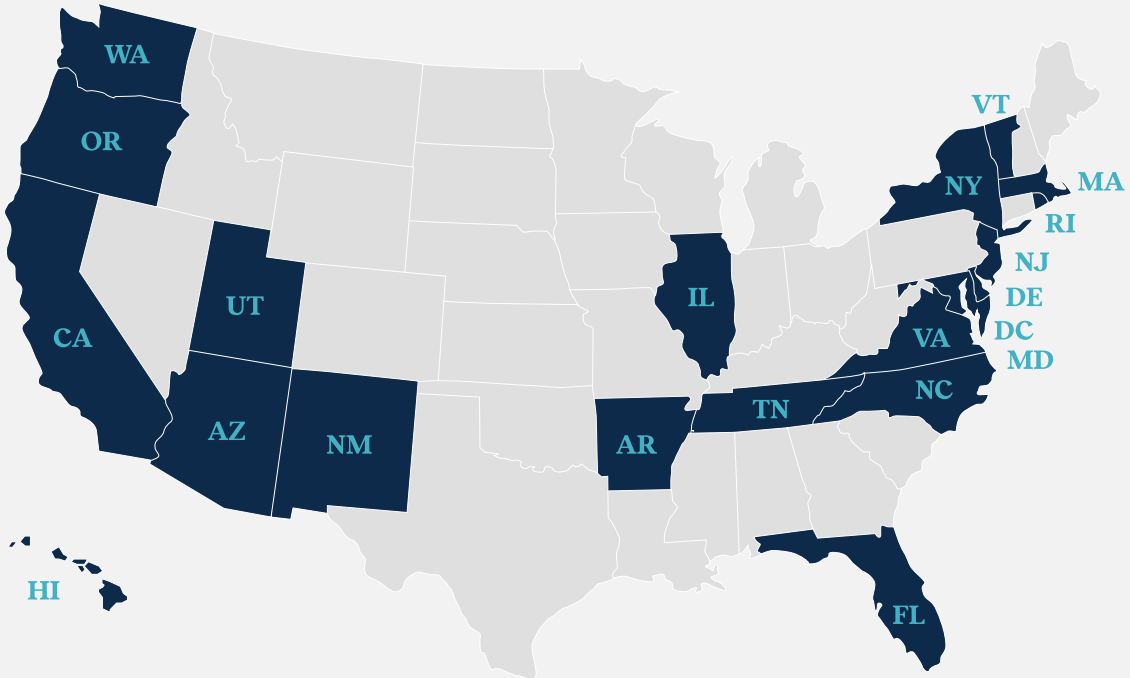
Medicaid 1115 demonstration waivers have allowed states to "waive" certain provisions of the Medicaid federal law for flexibility to design and improve their programs. States typically design 1115 demonstration programs to achieve these goals:

1. Increase eligibility based on disease groups to cover individuals who may not otherwise be eligible for Medicaid or the Children's Health Insurance Program (CHIP).
2. Offer additional services not typically covered by Medicaid. This includes clinical and nonclinical services that address SDOH and community-based benefits.
3. Employ innovative service delivery systems in addressing SDOH and health equity to reduce healthcare disparities.

As of September 2024, 21 approved section 1115 Medicaid waivers with SDOH provisions exist. Several additional states continue to push for 1115 waiver approvals before the end of 2024.

Provisions include infrastructure funding and delivery system reform, housing support, nutrition and employment support, and medical respite services. New York and New Jersey are two of the most recent states with approved 1115 waivers. Their key SDOH provisions provide funding and other support to establish innovative approaches to address HRSNs and SDOH.

STATES WITH 1115 PILOT PROJECTS WITH HEALTH EQUITY AND SDOH CONSIDERATIONS



CASE STUDY

New York health equity reform waiver expands Medicaid program and deploys $7.5 billion

On January 9, 2024, the Centers for Medicare & Medicaid Services (CMS) announced its approval of the New York Health Equity Reform ("NYHER") waiver amendment under Section 1115 Medicare Redesign Team (MRT) waiver.

The approved NYHER waiver is a significant expansion to the New York State Medicaid program that will deploy approximately $7.5 billion in funding over 3.25 years. It will transform how New York State promotes health equity and works to reduce health inequities for its more than 7.6 million residents with Medicaid coverage. The following are key parts of the waiver:

- NYHER addresses health-related social needs ("HRSN") via the creation of the Health Equity Regional Organization (HERO). HEROs coordinate formalized partnerships between MCOs, hospitals, community-based providers, and other stakeholders.
- NYHER aims to transform care delivery models into global value-based payment structures, aligned with recent federal opportunities from the Center for Medicare and Medicaid Innovation (CMMI). This is expected to have implications for safety net and distressed hospitals.
- NYHER provides funding to address healthcare workforce challenges emanating from the pandemic.

NEW YORK 1115 WAIVER FUNDING BY INITIATIVE

$125M
HE regional organization

$694M
Workforce

$2.2B
Hospital initiatives

$3.7B
HRSN services and infrastructure

Four next steps for healthcare organizations to advance health equity

Recent state efforts underscore the need for providers and health plans to approach health equity holistically across their operating models and in alignment with their overall strategic plans. These efforts focus on reducing disparities in care and improving quality of care for all populations by utilizing data and analytics to make informed decisions on improvements, investments, and collaboration opportunities.

Healthcare organizations can take the following steps to continue this progress:

1. **Designate a leader** to oversee the strategy related to health disparities and monitor the legislative and regulatory landscape. The legislative and regulatory environment has evolved rapidly over the past several years, with new mandates, reporting requirements, and various funding mechanisms at both the state and federal levels. This leader will ensure compliance with these requirements and position the organization to be prepared for policy changes and risks associated with noncompliance.
2. **Invest in data integration and analytics** to strengthen the organization's competitive advantage. Addressing health disparities has become an area of focus for regulatory agencies and value-based care, and these programs rely on the ability to disaggregate and analyze data. Organizations that have strong data and analytics capabilities are better able to improve health outcomes and the costs associated with delivering care. Such capabilities should include data that helps identify and mitigate the impact of SDOH.

MEDICAL SPEND MANAGEMENT FACTORS

- Reduction in avoidable admissions and readmissions (30-day visit)
- Reduction in emergency department and urgent care visits
- Reduction in out-of-network utilization rates for inpatient and outpatient visits
- Increase in primary care follow-up visits and care plan adherence

AREAS FOR INVESTMENTS IN HEALTH EQUITY AND SDOH

- Integrated care management protocols to drive telehealth visits, 7-day follow-ups, and medication adherence
- Community partner engagement
- Direct payments for SDOH services like housing assistance, transportation, healthy food, and child education
- Outreach, events, and community health workers

Opportunity savings are driven by the number of members engaged in the health equity and SDOH programs, especially members with chronic conditions that can cause more hospital visits (e.g., behavioral health, septicemia, diabetes, and CKD/ESRD).

Four next steps for healthcare organizations to advance health equity

3. **Stratify and regularly review your key performance indicators (KPIs).** Doing so can help your organization identify the largest gaps in clinical and financial performance and develop targeted interventions. Regularly reviewing your KPIs, processes, and policies will ensure organizational and leader accountability.

4. **Collaborate with community and public health-based organizations.** Partnerships with community organizations (e.g., housing authorities and food banks) can quickly expand a healthcare organization's access to SDOH services (e.g., community health worker programs). They can also establish a blueprint to speed the scaling process of successful programs across regions, markets, or lines of business. SDOH-focused community events (e.g., health fairs and screenings for social needs) and investments in community projects targeting health disparities can enhance a healthcare organization's role in community health. This will lead to better health outcomes and patient/member engagement.

WAYS TO APPLY HEALTH EQUITY AND SDOH DATA INTEGRATION AND ANALYTICS

- Incorporate SDOH into health records (EHRs)
- Develop risk stratification and personalized care plans that address social needs and health equity
- Design community health interventions
- Establish standards and benchmarks for measuring performance on health equity and quality of healthcare delivery

The implications of advancing health equity as part of healthcare organizations' overall strategies are clear: timely access to care, better health outcomes, lower death rates, fewer health problems, and a better patient experience. Such strategies can also position organizations for increased patient/member retention and cost reduction.

Although the specific trajectory of health equity initiatives remains uncertain, understanding the current landscape is crucial for navigating the evolving environment. While changes to current funding mechanisms are a significant concern, their impact will take time to unfold as many health equity efforts are driven by state initiatives, private funding, and existing regulations that are not easily reversed. The core principles of health equity will likely remain relevant, and investments to address HRSNs will still be evaluated based on their demonstrated value and impact moving forward.

Healthcare organizations that embrace these fundamental steps will help usher in a new era of better healthcare that meets the needs of all people.

Methodology

Chartis maintains a tracker of state health equity requirements that address health equity and SDOH. The tracker covers data from state departments of health and state legislatures from January 2020 to September 2024. Underlying data is from the Centers for Medicare & Medicaid Services (CMS) Medicaid/CHIP regulations and guidance, CMS Health Equity Priorities publications, state departments of health services, and federal and state law trackers.

Sources

1. "Advancing Racial Equity in U.S. Health Care: The Commonwealth Fund 2024 State Health Disparities Report," the Commonwealth Fund, April 18, 2024, https://www.commonwealthfund.org/publications/fund-reports/2024/apr/advancing-racial-equity-us-health-care?mc_cid=b82439102c&mc_eid=UNIQID.
2. Elizabeth Hinton, et al, "How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023: Health Equity," KFF, October 25, 2022, https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-health-equity/.
3. Elizabeth Hinton, et al, "How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023: Health Equity," KFF, October 25, 2022, https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-health-equity/.
4. "National Action Plan to Improve Health Literacy," U.S. Department of Health and Human Services, https://health.gov/our-work/national-health-initiatives/health-literacy/national-action-plan-improve-health-literacy.

Authors

Shaifali Ray

Partner and Vice President,
Chartis Center for Health Equity & Belonging

shray@chartis.com

Ahmed Naguib

Associate Partner, HealthScape Advisors

anaguib@healthscape.com

Colin Blaney

Senior Partner, HealthScape Advisors

cblaney@healthscape.com

About Chartis

The challenges facing US healthcare are longstanding and all too familiar. We are Chartis, and we believe in better. We work with over 900 clients annually to develop and activate transformative strategies, operating models, and organizational enterprises that make US healthcare more affordable, accessible, safe, and human. With over 1,000 professionals, we help providers, payers, technology innovators, retail companies, and investors create and embrace solutions that tangibly and materially reshape healthcare for the better. Our family of brands—Chartis, Jarrard, Greeley, and HealthScape Advisors—is 100% focused on healthcare and each has a longstanding commitment to helping transform healthcare in big and small ways.

CHARTIS