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COMMENTARY

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Medicaid can and should play an active role in advancing health equity

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Currently, 92% of Americans have health insurance, the highest coverage rate in our nation's history.[1] Much of the growth in coverage comes from states expanding Medicaid eligibility over the past decade and maintaining enrollment in Medicaid programs in response to the COVID-19 crisis. Medicaid is the nation's largest single source of coverage.[2] Nearly 90 million Americans, more than one-in-four, are enrolled in Medicaid or Children's Health Insurance Program (CHIP) across the 50 states and DC, and an even greater percentage of residents are enrolled in Medicaid in US territories like Puerto Rico.[3] Medicaid covers nearly half of all low-income Americans, 40% of our children,[2] and is the largest payer of behavioral health services,[4] institutional and community-based long-term care services,[5,6] and reproductive health care coverage.[7,8] Medicaid covers 42% of births nationally and 60% of nursing home residents in the United States, highlighting its importance in coverage across the lifespan.[2,9] Moreover, nearly 60% of adults enrolled in Medicaid and 70% of children enrolled in Medicaid/CHIP identify as American Indian and Alaska Native, Asian American and Pacific Islander, Black, Hispanic/Latino, or multiracial.[10]

As the United States grapples with its racist history and present,[11] policy makers, researchers, and communities are searching for pathways to meaningfully redress and eradicate centuries of structural disparities. Medicaid, as a state-federal partnership focused on low-income families, offers a unique set of policy tools to improve health and social needs equitably.[12,13] Indeed, the first sentence of the June 2022 Medicaid and CHIP Payment and Access Commission (MACPAC) Report to Congress on Medicaid's role in health equity states[14]: "Medicaid can and should play an active role in advancing health equity, in particular addressing racial disparities in health care and health outcomes."

While Medicaid expansion has improved health and social needs outcomes for its members,[15,16] findings regarding improvements in health equity are mixed.[17–20] After Medicaid expansion, Black and Latino populations experienced larger reductions in uninsurance rates compared to White populations but remained more likely to be uninsured than White populations.[12] Further, other studies document no reduction in disparities in receiving flu shots, accessing primary care,[21] or cancer screening between Black and White Medicaid members.[22–24] However, other evidence suggests that Black Medicaid members experienced a greater reduction in worrying about paying for health care costs and housing compared to White members after expansion.[17,25] Perhaps this mixed evidence is not surprising given that improving equity has not historically been a stated policy goal of public health coverage, although this is changing in Medicaid.

1 | NEWER EVIDENCE ON MEDICAID AND HEALTH EQUITY

While much of the work on health equity in Medicaid has focused on racial and ethnic disparities, less work has investigated disparities across disability or immigration statuses. This is particularly important as CMS highlights the need for health equity in every policy.[14] Our commentary focuses on health equity in Medicaid policy as it relates to disability and citizenship status, as well as race/ethnicity, highlighting the merits of two contributions to this HSR special issue on health care equity. The papers by Creedon, Zuvekas, Hill et al.,[26] and Rivera-González Roby, Stimpson et al.,[27] provide evidence on understudied populations and extend our understanding of how different funding mechanisms of Medicaid programs can influence equity.

2 | IMPROVEMENTS IN ACCESS TO CARE AFTER MEDICAID EXPANSION ARE AMPLIFIED AMONG ADULTS WITH DISABILITIES

One in four working-age adults have at least one disability,[28] yet the health disparities that people with disabilities face are often overlooked in public health discourse and research.[29] Medicaid expansion offers a new eligibility pathway, allowing low-income adults with disabilities, who do not meet the strict medical disability criteria of traditional Medicaid, to enroll in expansion instead. Early studies have shown greater improvements in outcomes after expansion for those with a disability, but this literature is limited.[30] Creedon, Zuvekas, Hill et al.,[26] use data from the Medical Expenditures Panel Survey and the Agency for Health care Research and Quality's PUBSIM model to present a much-needed analysis focused on the difference in coverage, access, and utilization among those with a disability and those without a disability following expansion.

This paper advances our understanding of Medicaid expansion effects on adults with disabilities by studying a sample of adults with disabilities who were not eligible for Medicaid before expansion in their states. Uniquely, the authors exclude those who were above 100% of the federal poverty level (FPL); (who would therefore be eligible for marketplace subsidies), correcting potential underestimates of expansion effects previously reported.[30,31] Their findings suggest that Medicaid expansion is associated with an increase in having full-year Medicaid coverage among adults with and without disabilities (36 and 25 percentage points, respectively), with a significantly larger increase among adults with disabilities. This provides more evidence that expansion is an important source of insurance for people with a disability, particularly because they are more likely to have incomes below 138% of the FPL compared to adults without disabilities.[32]

The findings reported by Creedon, Zuvekas, Hill et al.,[26] on health care utilization are particularly interesting as they suggest adults with disabilities were more likely than those without disabilities to receive preventive services, including having a flu shot and a blood pressure check, after expansion. Also, adults with disabilities were more likely to report having a primary care visit after expansion, but no significant difference in the emergency department (ED) or specialty care utilization was noted, suggesting that adults with disabilities are receiving appropriate management of their health care needs in primary care settings after expansion. Additional analyses disaggregating ED use by avoidable and unavoidable visits could clarify the trends in health care utilization within this group and support a more accurate interpretation of these findings. For example, it may be that as primary care use increases, the appropriate use of the ED increases, and the inappropriate use of the ED decreases after expansion, resulting in no noticeable change in the aggregate.

Additional analyses worth pursuing here and in other health equity-centered studies of Medicaid policies include the consideration of more flexible and robust extended two-way fixed effects approaches. These would offer more detailed insights into comparisons of earlier expansion states, later expansion states, and states that have yet to expand.[33] Further, because minoritization is socially constructed in a structurally racist society, it modifies the association of many, if not all, covariates (e.g., income) on outcomes of interest in health services research (e.g., primary care use). As a result, added insights may be gained by stratifying quasi-experimental models by, in the case of Creedon, Zuvekas, Hill et al.,[26] disability status, particularly when determining how the roles of "enabling" or "need" factors differ across groups.[34]

3 | THE ROLE OF MEDICAID FINANCING IN ADVANCING HEALTH EQUITY AMONG LATINO POPULATIONS

Latino individuals compose the largest minoritized ethnic group in the United States,[35] and they tend to have higher rates of uninsurance and challenges in accessing health care.[36] Importantly, one-third of Medicaid members are Latino. Despite evidence that Latino individuals experience improvements in health care access after Medicaid expansion,[37] expansion-related gains among Latino populations tend to be smaller than among other minoritized populations.[23] Rivera-González, Roby, Stimpson et al.,[27] measured levels of access to care among Latino populations living in New York, Florida, and Puerto Rico to examine how differences in Medicaid funding structures can reduce health disparities within the understudied Latino population. New York expanded Medicaid in 2014, which allowed individuals earning up to 138% of the FPL to enroll. Florida has not expanded Medicaid. In Puerto Rico, where 99% of the territory's population is Latino,[38] and nearly half live under the FPL,[39] Medicaid is funded through an annually fixed block grant that is determined by Congress and has a spending cap, meaning that there is no guarantee of coverage for eligible individuals if the predetermined grant spending cap is surpassed.

Using Behavioral Risk Factor Surveillance System, American Community Survey, and Puerto Rico Community Survey data, the study finds that Latino people living in Florida had the lowest levels of coverage and were the least likely to have a personal doctor or a routine checkup during the 2011–2019 study period. Those living in Puerto Rico had the most positive health outcomes: they had the highest level of coverage, were the least likely to have delayed care due to cost, and were most likely to have a personal doctor and to have had a routine checkup. Overall, Latino populations living in New York reported less access to care than those living in Puerto Rico but more access than those living in Florida.

Although Latino citizens living in low-income households were more likely to have public coverage in New York relative to Puerto Rico after 2014, the likelihood of having any coverage for this population in New York and Puerto Rico was comparable after Medicaid expansion. Further, the results shown by Rivera-González, Roby, Stimpson et al.,[27] suggest that Florida may be using expansions in private insurance to close the gap between New York and Florida. Additionally, New York may be using expansions in private and public insurance to catch up to Puerto Rico in overall coverage rates and

surpass Puerto Rico in public coverage. For example, Latino populations residing in Florida, a non-expansion state, had the largest (in terms of magnitude) post-ACA marginal effects in coverage gains (13–14 percentage points) during the study period. This important finding indicates that ACA-related private and public coverage expansions increased access to care among Latino populations in Florida, and it highlights the potential for private coverage in filling coverage gaps among minoritized populations. These results also emphasize the importance of complementary approaches to financing public coverage for low-income populations, including Federal Medical Assistance Percentage (FMAP), Medicaid expansion, and Basic Health Plans,[40] to improve coverage and access equity.

In summary, Creedon, Zuvekas, Hill et al.,[26] and Rivera-González, Roby, Stimpson et al.,[27] contribute to the Medicaid and health equity literature by focusing on common but understudied populations and distinct funding mechanisms. Importantly, as Creedon, Zuvekas, Hill et al.,[26] note, expanded Medicaid eligibility is necessary but not sufficient to improve health equity, and additional policy interventions aligning improvements in social determinants of health with public coverage expansions are required.

4 | A PATH FORWARD

Through Medicaid expansion, the United States has robust, publicly financed coverage for low-income families in 39 states and DC. Building on the evidence presented by Creedon, Zuvekas, Hill et al.,[26] and Rivera-González, Roby, Stimpson et al,[27] we argue that Medicaid can be a critical policy vehicle to redress the negative, reinforcing factors that perpetuate health care inequities. Specifically, Medicaid policy can improve health equity through several pathways, including (1) collecting member demographics and social determinants of health, (2) monitoring and evaluating health equity in Medicaid policy, and (3) incentivizing health equity.

5 | COLLECTING MEMBER DEMOGRAPHICS AND SOCIAL DETERMINANTS OF HEALTH

In many Medicaid programs, basic information on race/ethnicity is not reliably available in administrative data. Additional information critically important to addressing health disparities, such as sexual orientation, gender identity, food and housing security, and educational attainment is even more rare. According to a 2019 report, 36 of the 50 states plus DC reported that race/ethnicity data for Medicaid members in the Transformed Medicaid Statistical Information System (T-MSIS) were categorized as "medium concern," "high concern," or "unusable".[41] T-MSIS is used by researchers and policy makers to understand and improve Medicaid programs, and reliable data are critical. While some states require Medicaid managed care plans to collect these data, CMS should require that all states collect and report a standard set of race/ethnicity and, ideally, social determinants of health in administrative files submitted to T-MSIS. Progress is being made by the National Committee for Quality Assurance (NCQA).[42] NCQA, recognizing that "quality care is equitable care," is updating its health care effectiveness data and information set (HEDIS) and adding race/ethnicity stratification for five HEDIS measures for measurement year 2022.[43] These race/ethnicity stratifications of quality measures will be critical for managed care plans, as well as state and federal Medicaid programs to measure equity, identify gaps, and learn from bright spots. NCQA is also exploring adding assessments of social risk and needs (e.g., housing and food security) to further stratify data quality measures.[44] Collecting these data is the first step in the ability to monitor, evaluate, and incentivize health care equity in Medicaid.

6 | MONITORING AND EVALUATING HEALTH EQUITY IN MEDICAID

Without federal Medicaid analytic data sets that enable and accelerate equity-focused research, coalitions of the willing are taking the first steps in driving policy change by innovating in this space to monitor and evaluate health equity. One collaborative work to meet these challenges is the Medicaid outcomes distributed research network (MODRN).[45] MODRN is comprised of 13 states conducting rapid, multi-state analyses via a distributed research network and using a common data model. Based on Medicaid agency priorities, MODRN is embarking on a new research initiative to inform Medicaid policies aimed at improving equity in opioid use disorder treatment. MODRN is well-positioned to evaluate health equity in Medicaid as it consists of a collaboration between two Medicaid policy networks: AcademyHealth's State-University Partnership Learning Network, which supports partnerships between state Medicaid agencies and university research partners in 27 states, and its Medicaid Medical Directors Network, which provides a knowledge exchange among 43 Medicaid programs to advise states' Medicaid directors on clinical policy and practice. Platforms like MODRN provide cross-state evidence needed to facilitate evidence-based policy making in Medicaid programs, including emerging efforts to incentivize equity in Medicaid managed care contracts.

7 | INCENTIVIZING HEALTH EQUITY

Medicaid agencies can adopt policies to alter financial incentives for providers and provide contracts to managed care plans to improve equity. For example, Medicaid programs could invest in building capacity for minority-serving Medicaid providers, center equity measures in provider performance assessments, and update managed care contracts to address inequities. Massachusetts, for example, is seeking approval from CMS to incentivize providers to collect data on social risks, track health disparities through stratified data reporting as discussed above, and achieve measurable reductions in health disparities.[12,46] Although most states have not done so to date, the trend toward incentivizing equity in Medicaid is clearly increasing. A 2021

survey by the Kaiser Family Foundation of 47 state Medicaid programs found that 12 are linking financial incentives to health disparities metrics, an increase from only two states in 2019.[12] There is, however, little evidence on which of these levers is most effective in advancing health equity, creating critical opportunities for health services researchers to evaluate and inform emerging Medicaid policy.

In conclusion, Medicaid expansion has increased coverage and access for nearly 20 million low-income adults, making it among the most significant public policies to improve health equity in our history, although its promise is limited by the existing structures of racism. Indeed, over half of those in the coverage gap in nonexpansion states are Black and/or Latino.[12] The papers by Creedon, Zuvekas, Hill et al.,[26] and Rivera-González, Roby, Stimpson et al.,[27] add to the mounting evidence that helps us to understand the mechanisms that perpetuate health inequities as a step toward conceptualizing the tools and policies that are needed to effectively dismantle them.

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CONFLICT OF INTEREST

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