



AMERICA'S ESSENTIAL HOSPITALS

Structural Racism and Chronic Underfunding of Medicaid

Structural racism causes harm and is a public health threat leading to health inequities, poorer health, and early death. People of color experience higher rates of diabetes, hypertension, asthma, and heart disease than their white counterparts and have a lower life expectancy.ⁱ They also are more likely to be covered by Medicaid. In 2019, 20 percent of Medicaid beneficiaries identified themselves as Black and 30 percent identified as Hispanic, while comprising only 13 percent and 19 percent of the general population, respectively.^{ii,iii}

Many essential hospitals serve a greater share of people of color than other hospitals in their communities: people of color made up 51 percent of member discharges in 2019.^{iv,v} They also serve a much greater portion of Medicaid and uninsured patients (these groups make up nearly 40 percent of inpatient and 35 percent of outpatient care at essential hospitals).^{vi} This diverse patient population means essential hospitals have a unique opportunity to offer services and programs to address racial health inequities experienced by their patients perpetuated by chronic underfunding of the Medicaid program.

Role of Medicaid in Overcoming Health Inequities

The Medicaid program was created to assist states and localities in providing health coverage to people with low incomes who often experience barriers to good health, such as limited access to health care and healthy food, low health literacy, and unstable housing, among other factors. Medicaid requires a set of services be provided so beneficiaries have meaningful access to health care while also allowing for enabling services to combat these barriers. The program allows flexibility to tailor support to local needs and policy priorities, addresses socioeconomic barriers to care, and expands access to care through new technology, such as remote patient monitoring. Given these features and the diversity of beneficiaries, the Medicaid program has unique potential as a tool to overcome racial inequities in health.

Medicaid provides programs and services for conditions exacerbated by racial inequity, such as diabetes and behavioral and maternal health issues.^{vii,viii,ix} For example, Black people in the United States are up to four times more likely to experience pregnancy-related death compared with white people, even when accounting for factors such as education and income levels.^x To improve Black maternal health and coverage stability, Congress recently allowed states to extend full coverage for postpartum people one year after birth.^{xi} Medicaid also can cover services in nontraditional settings and through telehealth, though gaps remain in equitable access to broadband and devices.

Further, while Medicaid cannot address all root causes of poverty, it can pay for services to alleviate some conditions of poverty, such as providing access to nonmedical transportation, education, employment, nutritional services, and housing.^{xii} Several states are working with their managed care organizations to implement performance improvement projects focused on healthy weight and physical activity counseling.^{xiii} In addition, Medicaid can pay for home

modifications and housing supports to assist beneficiaries in maintaining housing; many states are implementing these services through managed care contracts and Section 1115 waivers.^{xiv}

Medicaid also has the potential to address racial health inequities through other routes, including:

- leveraging Medicaid graduate medical education funding to recruit and retain a diverse and inclusive workforce to better meet the needs of Medicaid beneficiaries;
- providing equitable access to new technology, such as telehealth and remote patient monitoring, or the latest treatment for substance use disorder; and
- prohibiting race-biased clinical risk assessments in treatment decisions, such as the vaginal birth after cesarean algorithm, among many others.^{xv}

While some states have used Medicaid to address health inequities, more can be done. Chronic and systematic underfunding of the program remains a barrier to further dismantling racism by blocking providers' abilities to implement interventions.

Chronic Underfunding: A Form of Structural Racism

Medicaid provides high-quality coverage to millions, but the program often pays providers substantially less than the cost of care. In 2019, aggregated Medicaid payments were below providers' costs, resulting in a \$19 billion shortfall. This translated to hospitals receiving payment of only 90 cents for every dollar spent caring for Medicaid patients.^{xvi} The history of low Medicaid reimbursements and payments is part of the fabric of structural racism in our country—discriminating against and undervaluing the provision of care to patients served by this program.

Medicaid statute has long required states to pay rates sufficient to ensure equal access for program beneficiaries compared with the general population.^{xvii} Medicaid rates, however, are almost uniformly set at levels well below what the commercial market pays.^{xviii,xix,xx} Yet, courts have rebuffed beneficiary and provider attempts to enforce this statutory mandate, indicating this responsibility lies with the Centers for Medicare & Medicaid Services (CMS), which has federal oversight of the program.^{xxi} To date, the federal government has not viewed hospital payment rates as a metric of access to care, although it has used the regulatory process to cap payments for hospitals and other providers. Payments have been capped at Medicare payment levels; however, the Medicare program also underpays hospitals. In 2019, the aggregate Medicare margin for hospitals was negative 8.7 percent.^{xxii} Today, care provided by Medicaid providers is effectively undervalued when compared with care given to patients with employer-sponsored or other commercial coverage that pays well above Medicare rates. Medicaid underpayment exacerbates health inequities by devaluing care for patients who need the most assistance and services, while further financially stressing providers willing to meet that need.

Policy Recommendations

Addressing chronic underfunding of Medicaid will immediately and directly impact care for people of color with low incomes. Investments in Medicaid have the potential to increase access to care for beneficiaries by attracting more providers to the program and better funding equity-related initiatives, such as those for maternal health—putting financial resources into the health system where they are needed the most.

CMS and Congress must take action to ensure the Medicaid program is an effective tool to improve equity, rather than an ongoing contributor to inequities. The following federal policy recommendations address the structural racism inherent in low Medicaid reimbursement.

FULLY IMPLEMENT THE EQUAL ACCESS PAYMENT REQUIREMENT

Section 1902(a)(30)(A) of the Social Security Act states Medicaid plans must “assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

In 2014, the Supreme Court decided it was up to CMS to enforce this equal access requirement, but the agency has failed to do so. CMS requires states to measure access to a specific set of Medicaid services through a fee-for-service delivery system and report their findings every three years, or when states propose to change provider rates. This method of measuring equal access has proved ineffective as the majority of Medicaid beneficiaries are in managed care. While CMS does, in certain circumstances, compare Medicaid payment rates to estimations of average commercial rates for the same services, it is done through the lens of ensuring upper limits are not exceeded rather than as a threshold for sufficient access. We must stop allowing states to pay Medicaid providers under cost, thus discouraging providers from serving Medicaid beneficiaries. CMS must enforce the equal access payment requirement to ensure beneficiaries have equitable access to providers.

INCREASE FMAP INCENTIVES

Increasing Medicaid payments alone is not enough to eradicate health disparities among people of color. Some beneficiaries need additional health programs and support, such as housing and healthy food access, for conditions exacerbated by structural racism in other socioeconomic systems. Such programs provide tailored services to mitigate these inequities but lack sufficient funding. Ensuring equal access to providers would not completely solve these problems.

Higher federal medical assistance percentages (FMAPs) frequently are used to encourage certain policies in Medicaid, such as the health home program, and can address the health impact of structurally racist systems. Congress should provide a higher FMAP for equity-related services, including value-based or incentive payments to providers that are tied to addressing equity, such as programs to eliminate disparities in maternal health.

ELIMINATE CUTS TO MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Congress adopted cuts to Medicaid disproportionate share hospital (DSH) payments as part of the Affordable Care Act under the assumption all states would expand Medicaid and the number of uninsured patients would dramatically decrease across the country. However, this assumption did not fully occur. The cuts have been postponed multiple times, but a \$32 billion cut over four years looms on the horizon. The disparate impact that cuts of this magnitude would have on providers serving people of color is unimaginable. Congress should eliminate all DSH cuts immediately.

Mass. Considers State-Level Action to Mitigate Low Medicaid Payments

Absent federal action, some states are taking on the work of mitigating low Medicaid payment rates. Commercial health insurers in some Massachusetts markets inappropriately disadvantage providers that serve a high rate of Medicaid and low-income patients by offering lower rates than they do to other providers for comparable services. In response, Massachusetts has taken steps to solve the problem at the state level.

In summer 2021, a bill was introduced in the Massachusetts legislature to reduce racial and ethnic health disparities by requiring commercial insurers to pay high Medicaid safety net acute hospitals, defined as those with at least a 25 percent Medicaid payer mix, at or above the insurer's statewide average commercial rate for the same service. Under the legislation, rates would be subject to annual approval by the state's commissioner of insurance. The bill remains under review.

CONCLUSION

Medicaid can be a critical tool to support health equity if chronic underfunding is addressed through higher, equity-based FMAP increases and secure DSH payments. We call on the administration and Congress to act on these recommendations to address inequities for the millions of people of color in the Medicaid program.

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ⁱⁱⁱ *Population estimates, July 1, 2019, (V2019)*. Census Bureau. <https://www.census.gov/quickfacts/fact/table/US/PST045219>. Accessed August 5, 2021.

^{iv} Harder B, Corgel R, Binger T. Analysis of Racial Gaps in Hospital Care. *U.S. News & World Report*. July 27, 2021. <https://health.usnews.com/health-news/blogs/second-opinion/articles/2021-07-27/analysis-of-racial-gaps-in-hospital-care>. Accessed August 2, 2021.

^v Clark D, Roberson B, Ramiah K. Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2019 Annual Member Characteristics Survey. America's Essential Hospitals. May 2021. <https://essentialdata.info>. Accessed August 4, 2021.

^{vi} *Ibid.*

^{vii} Lee J, Callaghan T, Ory M, Zhao H, Bolin J. The Impact of Medicaid Expansion on Diabetes Management. *Diabetes Care*. 2020; 43(5):1094–1101. <https://care.diabetesjournals.org/content/43/5/1094>. Accessed August 6, 2021.

^{viii} Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals. *Kaiser Family Foundation*. <https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/>. Accessed August 9, 2021.

^{ix} Racial Disparities in Maternal and Infant Health: An Overview. *Kaiser Family Foundation*. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-maternal-infant-health-overview/>. Accessed August 9, 2021.

^x Working Together to Reduce Black Maternal Mortality. *Centers for Disease Control and Prevention*. <https://www.cdc.gov/healthequity/features/maternal-mortality/index.html>. Accessed August 9, 2021.

^{xi} Medicaid Postpartum Coverage Extension Tracker. *Kaiser Family Foundation*. <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>. Accessed August 10, 2021.

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- ^{xiv} Verma S. Letter to state health officials on January 7, 2021. <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>. Accessed August 17, 2021.
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