

Addressing COVID-19 Health Disparities: Opportunities for Medicaid Programs

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Policy Points

- > Many Medicaid programs are taking a two-pronged approach to addressing COVID-19-related health disparities: short-term program changes through federal regulatory flexibility options, and long-term efforts to address systemic biases and increase health equity.
- > To reduce health disparities, Medicaid programs are making short-term changes such as ensuring access to Medicaid coverage, ensuring access to needed services, and improving data collection to better identify disparities and target interventions.

ABSTRACT

The COVID-19 pandemic has taken a disproportionate toll on racial and ethnic minority populations in the United States. Communities of color face higher rates of COVID-19-related adverse social and economic outcomes, as well as higher risks of contracting the virus and related subsequent hospitalizations and deaths. Many Medicaid programs are addressing not only COVID-19-related racial and ethnic health disparities but also health disparities by income, geography, and other factors. The programs' two-pronged approach comprises short-term program changes through federal regulatory flexibility options, and a continued focus on long-term efforts to address deeply rooted systemic biases and increase health equity broadly. Short-term changes include ensuring access to Medicaid coverage, ensuring access to needed services, and improving data collection to better identify disparities and target interventions. These short-term changes are set within the context of longer-term equity work such as a continued or increased focus on prioritizing equity initiatives with Medicaid agencies, continued partnerships to support Medicaid's efforts to address health equity, and continued stakeholder engagement and communication with Medicaid members and providers.

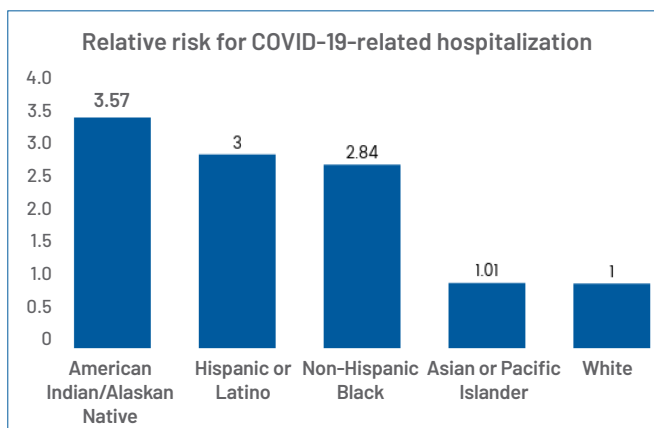
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BACKGROUND

COVID-19 Incidence, Severity, and Mortality by Race and Ethnicity

COVID-19-related racial and ethnic health disparities are stark: Black, Hispanic or Latino, and individuals identifying as being of more than one race are more likely to test positive for COVID-19 than non-Hispanic white individuals.¹ Minority populations face the greatest risk for hospitalization related to COVID-19, with non-Hispanic American Indian or Alaska Native (AI/AN) populations more than 3.5 times as likely as non-Hispanic white populations to be hospitalized with COVID-19-related conditions (Figure 1).¹

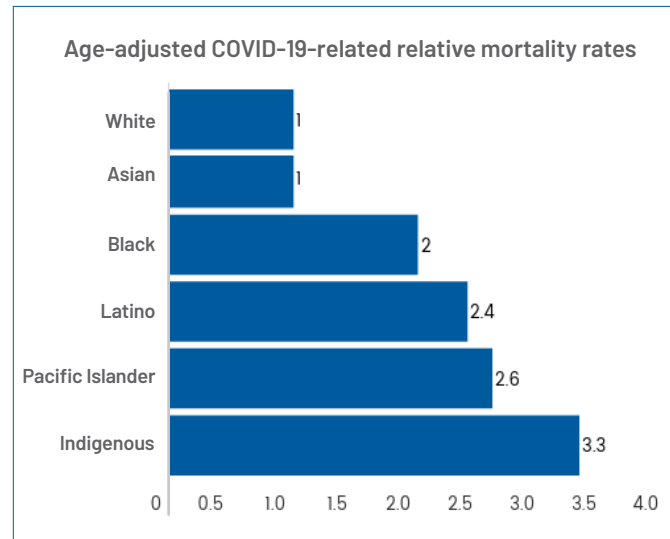
Figure 1. Racial and Ethnic Minority Populations Face the Greatest Risk of Hospitalization for COVID-19



Centers for Disease Control and Prevention. COVID-19 racial and ethnic health disparities. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html>. Updated December 10, 2020. Accessed April 5, 2021.

COVID-19 mortality rates also underscore the vast health disparities seen during the pandemic.^{1,2} Hispanic or Latino, non-Hispanic Black, and AI/AN populations have experienced much higher rates of COVID-19-related death in relation to their representation in the general population, causing a disproportionate reduction in life expectancy for minority communities compared with white populations.^{1,2} Recent analyses from American Public Media (APM) Research Lab suggest that Indigenous and Pacific Islander populations have the highest COVID-19-related mortality rates compared to other groups, after adjusting for age (Figure 2).³

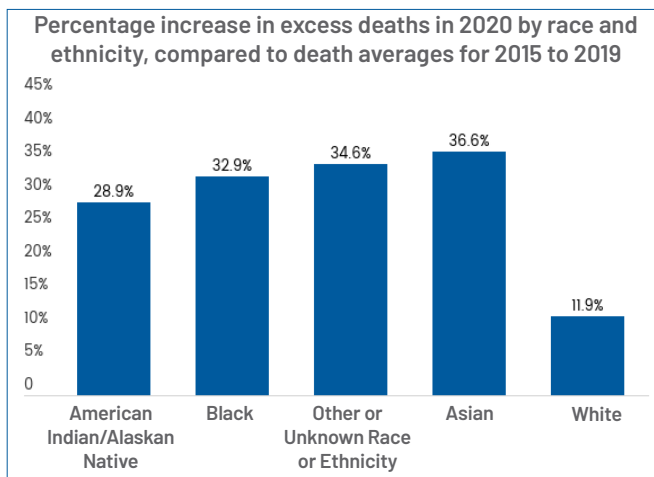
Figure 2. Indigenous and Pacific Islander Populations Have the Highest COVID-19-related Mortality Rates



APM Research Lab Staff. The color of coronavirus: COVID-19 deaths by race and ethnicity in the US. APM Research Labs website. <https://www.apmresearchlab.org/covid/deaths-by-race>. Published March 5, 2021. Accessed May 21, 2021.

The estimates for COVID-19-related racial and ethnic health disparities also vary substantially by geographic location.⁴ For example, a Centers for Disease Control and Prevention (CDC) analysis of COVID-19 cases from January 22, 2020, to July 2, 2020, found that, nationally, AI/AN populations had a 3.5 times greater risk of contracting COVID-19 compared to white populations, but the relative risk varied at the county and state level (e.g., in New Mexico, AI/AN populations had a 14.9 times greater risk of contracting the virus than white populations).⁴ In addition, it is likely that the reported COVID-19 health disparities are an underestimate of the true burden of the disease on minority populations, when factoring in the increase of excess deaths compared to previous years.⁵ Compared to the 2013 to 2018 period, Stokes and colleagues estimate that an additional 17% of excess deaths in 2020 were attributable to COVID-19, but not recorded as such; this percentage is even higher in counties with lower socioeconomic status, more comorbidities, and more non-Hispanic Black residents.⁶ Based on the CDC's National Vital Statistics System data, excess deaths occurring in the United States since March 2020, in comparison to the previous five-year average, have disproportionately affected minority populations (Figure 3).⁵

Figure 3. Asians Had the Highest Percentage Increase in Excess Deaths in 2020



Data derived from Rossen LM, Branum AM, Ahmad FB, Sutton P, Anderson RN. Excess deaths associated with COVID-19, by age and race and ethnicity - United States, January 26-October 3, 2020. *MMWR Morb Mortal Wkly Rep.* 2020;69(42):1522-1527. doi: 10.15585/mmwr.mm6942e2.

Tracking data suggests that the racial and ethnic health disparities seen in COVID-19 incidence, severity, and mortality persist in efforts to vaccinate and protect against the virus.⁷⁻¹⁰ However, as of May 21, 2021, the CDC reported that race and ethnicity data were only available for 56% of vaccine recipients who had received at least one dose, making it difficult to fully identify disparities in vaccination efforts, and to plan mitigation strategies to reduce the further inequities from COVID-19.¹⁰

Health disparities exist in other marginalized populations as well, including low-income communities, older adults, individuals with special health care needs (including developmental or intellectual disabilities, serious mental illness, or dementia), pregnant women, children, and people living in rural or inner-city areas, nursing homes, or other congregate settings (e.g., homeless shelters, group homes, prisons; Pennsylvania Medicaid staff, personal communication).⁶⁻¹² Artiga and colleagues note these groups are not mutually exclusive, and there can be subgroup variations in the degree of health disparities experienced by individuals within these groups.⁹

Factors Underlying COVID-19 Health Disparities

Racial and ethnic COVID-19 health disparities are indicative of larger systemic and social inequities, which have been uncovered and exacerbated by the pandemic.¹¹ These inequities span all aspects of life, from an individual's occupation, education, and income to housing and living conditions to access and use of health care and experience of systemic discrimination. The overarching disparities in these social and economic indicators of health put communities of color at greater risk for contracting COVID-19, developing a severe COVID-19 infection, and dying from COVID-19-related factors.¹¹ Although it has been widely publicized that certain underlying health conditions (e.g., smoking, type 2 diabetes mellitus, obesity) can exacerbate COVID-19 illness,^{12,13} additional analyses suggest that COVID-19 health disparities are more likely the result of exposure-related factors than comorbid conditions.^{14,15}

STATE STRATEGIES

State Medicaid programs are using a two-pronged approach to address COVID-19-related health disparities: short-term strategies to address immediate needs of communities, and longer-term strategies to achieve health equity goals (Figure 4).

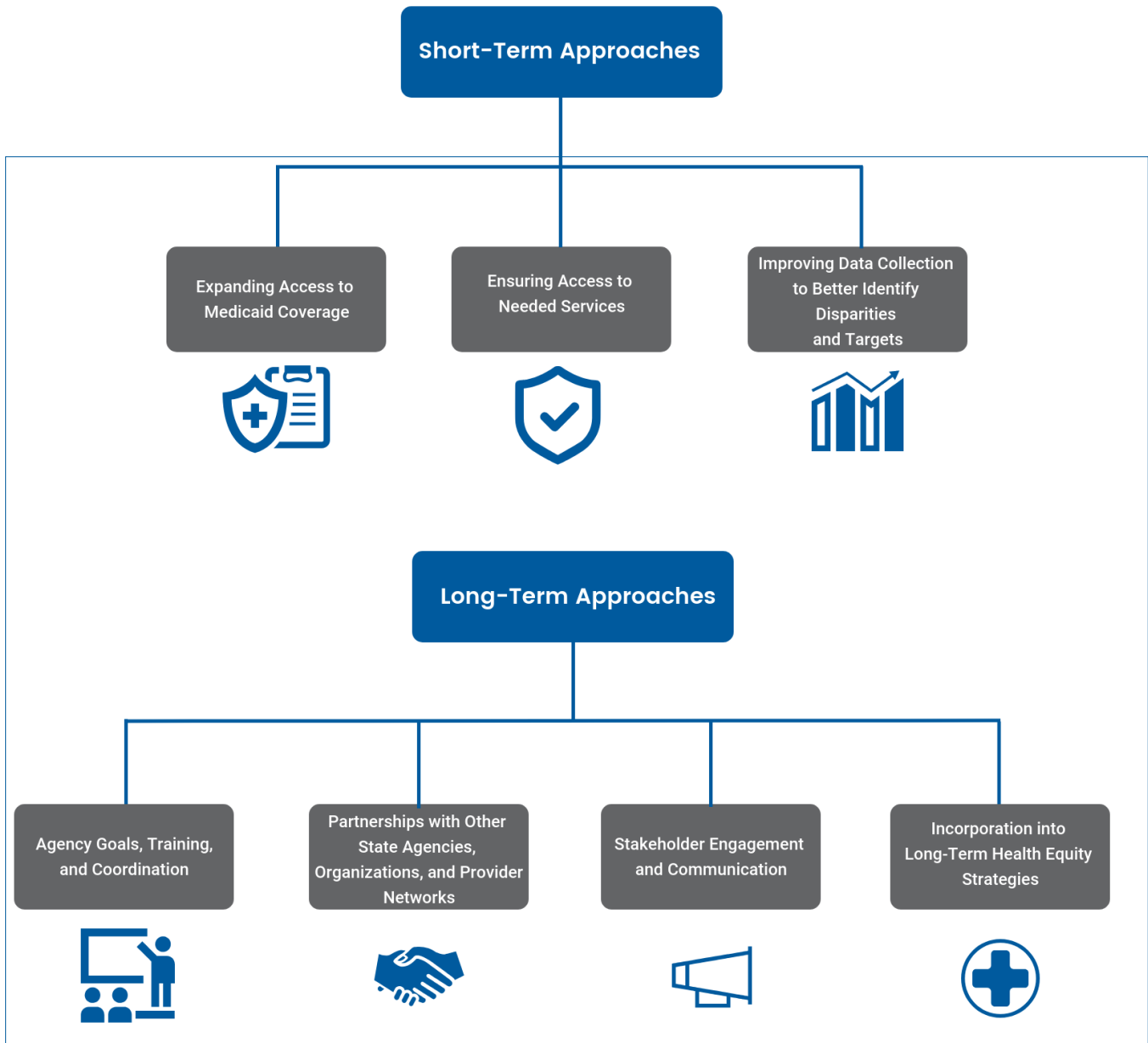
Short-Term Program Changes Through Federal Regulatory Flexibility Options

Many of the strategies discussed in this report focus on emergency flexibilities that Medicaid programs have taken during COVID-19 to increase access to coverage and services and increase data use to inform care. Although not a solution to health disparities, ensuring access to Medicaid coverage and services, and using data to support decision-making, can contribute to the reduction of pre-COVID-19 and COVID-19-related health disparities.

Expanding Access to Medicaid Coverage

Almost all state Medicaid programs have used the available emergency flexibilities granted by the Centers for Medicare and Medicaid Services to make it easier for individuals to obtain and maintain Medicaid coverage.¹⁷

Figure 4. Medicaid Opportunities to Address COVID-19 Health Disparities



Access to Medicaid coverage enables individuals to receive affordable care and services for their health conditions and certain social needs, and, as of the onset of the pandemic, receive targeted education and information regarding COVID-19 prevention and treatment.¹⁸ Medicaid agencies have changed eligibility criteria, with particular attention to populations that have experienced greater COVID-19-related health disparities (e.g., racial and ethnic minorities, including immigrant populations and subpopulations such as children and pregnant women).¹⁷ Key opportunities for Medicaid programs to expand eligibility include:

- Changes to income eligibility criteria
- 12-month continuous eligibility for children
- 12-month postpartum coverage
- Lawfully present children and pregnant women
- COVID-19 testing and treatment for uninsured populations
- Out-of-state and non-state residents
- Incarcerated populations
- Medicaid expansion

Even for eligible individuals, the application and enrollment process can be burdensome and prohibitive for those seeking Medicaid coverage.^{19,20} Under federal COVID-19 public health emergency (PHE) policy options, state Medicaid programs have several opportunities to reduce barriers to enrollment, including:

- Adopting presumptive eligibility that grants temporary Medicaid coverage to those who likely qualify
- Allowing for self-attestation of application information, which allows members to provide supporting information without it being verified by the Medicaid program prior to enrollment
- Conducting post enrollment verification of conflicting information, which allows for quick enrollment of applicants without verifying eligibility criteria before providing health care coverage
- Widening reasonable compatibility standards, which allows for more variability between self-attested and electronic source data
- Extending reasonable opportunity periods in which members can provide additional documentation to support eligibility
- Suspending the eligibility redetermination process and electing to automatically extend Medicaid coverage for a specific period of time
- Taking action to simplify and streamline the Medicaid application, such as using online applications, reducing application length, and allowing for integrated application processing for families

As the PHE slowly draws to a close, Medicaid programs have the option to adopt these COVID-19-related actions as long-term strategies to expand access to Medicaid coverage, but to do so may require submission of a state plan amendment or Section 1115 waiver.

Ensuring Access to Needed Services

In efforts to address COVID-19-related health disparities, Medicaid programs have largely focused on maintaining access to services by amending covered service policies, offering administrative and financial support to providers, easing beneficiary cost-sharing and premium requirements, and leveraging existing managed care contracts. Key opportunities for Medicaid programs to support access to covered services include:

- Relaxing telehealth coverage criteria and expanding services allowable through telehealth
- Expanding access to mental and behavioral health services (e.g., coverage of peer supports)
- Supporting maternal health by expanding coverage of supporting services (e.g., doula, community health workers, peer supports, out-of-hospital births)
- Providing housing-related services (e.g., covering temporary housing)
- Addressing food security (e.g., expanding home-delivered meal services)
- Connecting members to social services (e.g., North Carolina's NCCARE360 website)
- Increasing language access (e.g., providing additional reimbursement for language-access services)
- Reimbursing vaccine administration (e.g., enhanced reimbursement for COVID-19 vaccine administration)

Medicaid programs can also play an important role in ensuring beneficiaries have adequate access to services by providing payment support stabilization options to providers facing closure due to decline in revenue related to the pandemic (e.g., advance interim payments, retainer payments); offering education and technical support on how to safely provide care amidst a pandemic (e.g., infection control); relaxing provider regulatory requirements; and promoting the use of community-based providers (e.g., community health workers).^{17,20-24}

Medicaid managed care plans, in partnership with state Medicaid agencies, can play a substantial role in the prevention and mitigation of COVID-19 health disparities.²⁵ These entities have robust health data tracking systems and established partnerships to promote connection to needed health and social services.²⁵ Using managed care contracting, payment, and other levers, state Medicaid programs have several opportunities to address COVID-19 health disparities, including:

- A requirement for plans to qualify for the National Committee for Quality Assurance's [multicultural distinction](#)
- Value-added and "in lieu of" services to offer additional benefits (e.g., food assistance, enhanced case management outreach, provision of personal protective equipment)

- Quality metrics to focus on health disparities related to COVID-19 (e.g., Ohio Medicaid’s managed care contract [requirements](#))
- Provider payments to provide short-term financial support
- Beneficiary outreach to provide additional support, education, and connection to services
- Integration of COVID-19 vaccine administration into capitation rates

Improving Data Collection to Better Identify Disparities and Target Interventions

Granular, real-time data are critical to the identification of COVID-19-related health disparities as well as to inform targeted outreach and mitigation strategies for minority and marginalized communities experiencing disproportionate health effects from COVID-19. However, data collection, particularly within the Medicaid population, can be difficult as it’s common to have missing or incomplete data, particularly related to race and ethnicity.²⁶ A specific focus on data elements that can be stratified by the areas of COVID-19-related disparities (e.g., race, ethnicity, age, gender, geography, residence type), coupled with use of innovative techniques (e.g., using choice architecture to increase response rates) to increase the accuracy and granularity of data captured, can help state Medicaid agencies more effectively target efforts to reduce COVID-19-related health disparities. Collection of data should be partnered with strategies to make findings actionable, such as the use of health equity metrics and dashboards, the work of COVID-19 health equity task forces, and COVID-19 vaccine administration. For example, the California Department of Health uses a health equity metric (California Healthy Places Index) to address COVID-19 health disparities and county readiness to relax COVID-19 mitigation strategies.²⁷⁻²⁹

Continued Focus on Long-Term Efforts to Address Deeply Rooted Systemic Biases and Increase Health Equity

Maintaining and creating access to coverage, health and social services, and accurate data have been essential components for Medicaid programs addressing COVID-19-related health disparities. Strong leadership, a willingness to examine internal policies and procedures through a health equity lens, and the engagement of

STATE EXAMPLE: PENNSYLVANIA

In response to COVID-19, Pennsylvania Medicaid collaborated with six academic health partners to create Regional Health Care Collaboration teams (RHCC) to work in six regions across the state. In partnership with 11 health systems, the RHCC teams received advance payments to deploy rapid response and strike teams to the almost 1,900 skilled nursing facilities, personal care homes, and assisted living facilities across the state. These facilities provide services to approximately 120,000 individuals, many of whom have Medicaid coverage. The RHCC teams were originally supported through CARES Act funding, with 12% of funding tied to performance metrics that would have to be paid back by academic health partners if metrics were not met. The overall program goal was to reduce mortality by 70% from that of the first three months of the pandemic. The program also had goals related to testing, dividing facility residents into cohorts, and onsite consultation. In addition to this work, Pennsylvania Medicaid has created Regional Accountable Health Councils that are focused on closing regional disparities and creating linkages to resources to address social health risk factors within each region. Pennsylvania Medicaid continues to work to increase health equity through managed care pay-for-performance incentives related to postpartum care, controlling blood pressure, and addressing poor control of diabetes (Pennsylvania Medicaid staff, personal communication).

beneficiaries and providers in this mission, have bolstered efforts by Medicaid programs to increase health equity.

Agency Goals, Training, and Coordination

Clearly articulated health equity goals supported by strong leadership are necessary to gain forward momentum in reducing the health disparities from COVID-19 and those persisting beyond the PHE.^{30,31} In addition, state Medicaid programs can turn an eye inward and examine

how internal state structures and processes may be exacerbating health disparities. For example, Wisconsin Medicaid has had a cultural competency committee for several years and has required staff to go through annual equity and inclusion training (Wisconsin Medicaid staff, personal communication). They have recently expanded these efforts, led by an Equity and Inclusion Committee (Wisconsin Medicaid staff, personal communication). Appointing an equity coordinator or team responsible for guiding the agency's COVID-19 response may also be helpful for state Medicaid programs working to reduce the health disparities from COVID-19.³² For example, North Carolina Medicaid uses a dedicated work group to focus on incorporating health equity into all of the program's initiatives and work streams (North Carolina Medicaid staff, personal communication).

STATE EXAMPLE: NORTH CAROLINA

North Carolina Medicaid has used a blended approach to addressing COVID-19 health disparities by integrating short-term actions into longer-term health equity goals. North Carolina Medicaid COVID-19 response efforts focus on four key areas (prevention, testing, contact tracing, and supports for isolation and quarantine), all supported by a work group focused on historically marginalized populations (North Carolina Medicaid staff, personal communication). The state's Medicaid program used braided funding to offer various payment strategies to support providers, such as rate increases, interim payments, and supplemental payment for inpatient services.³³ For longer-term efforts, the state of North Carolina fast-tracked the rollout of its NCCARE360 statewide technology platform to connect health care and human services (North Carolina Medicaid staff, personal communication). The platform provides a single access point for the state's 211 system, integrates other resource directories, and creates an electronic referral system for health and human service providers to communicate, send, and receive referrals.³⁴

Partnerships

Partnerships with other state agencies, managed care organizations, community-based organizations, and provider networks can extend and accelerate state Medicaid efforts to address health disparities. In particular, partnerships with trusted leaders of minority and marginalized communities might create opportunities for effective and targeted COVID-19-related health disparity mitigation strategies. Kentucky and Virginia Medicaid programs have leveraged interagency partnerships to target populations that might be newly eligible for Medicaid coverage, either because of a change in an individual's employment status or a change in the state's Medicaid eligibility criteria under federal COVID-19 regulatory flexibilities.³⁵ North Carolina Medicaid partnered with the state's public health agency to quickly stand up testing sites in communities with historically marginalized populations, using a data-driven approach to identify populations at greatest risk for COVID-19 (North Carolina Medicaid staff, personal communication).

Stakeholder Engagement and Communication

The communities most affected by COVID-19 can benefit from targeted, culturally and linguistically appropriate communication on COVID-19 prevention and mitigation strategies. Medicaid programs can identify and partner with local knowledge brokers to facilitate awareness, understanding, acceptance, and engagement with COVID-19-related information. For example, Washington State issued emergency contracts with community-based organizations to provide COVID-19 language and outreach services that were culturally relevant and linguistically appropriate.³⁶ Wisconsin's Division of Public Health awarded grant funding to nine community-based organizations in historically underserved communities to support proactive messaging around COVID-19 testing and vaccinations (Wisconsin Medicaid staff, personal communication).

In addition, health care and social services providers can play a critical role in promoting and achieving health equity among the Medicaid population.³⁷ But implicit biases held by providers may disproportionately affect health outcomes of beneficiaries from minority and marginalized groups.³⁷ In efforts to reduce COVID-19-related health disparities and those that persist after the end of the PHE, state Medicaid programs could

consider partnering with provider communities to provide antiracism and communication skills training to increase the ability of providers to be aware of bias and how they can affect care, and to increase the ability of health care delivery systems to be culturally sensitive.³⁸⁻⁴¹

Incorporation into Long-Term Equity Strategies

The health disparities from COVID-19 reflect broader systemic health disparities that existed prior to the PHE,¹ and several state Medicaid programs have preexisting efforts to increase health equity across beneficiaries (e.g., states participating in the Robert Wood Johnson Foundation-funded Advancing Health Equity: Leading Care, Payment, and Systems Transformation program; requiring managed care organizations to stratify HEDIS measures by race, ethnicity, age, gender, individuals with disabilities, individuals with serious mental illness, geography, long-term services and supports needs, and primary language spoken).^{42,43} State Medicaid strategies to reduce COVID-19-related health disparities can be integrated into these long-term efforts to address systemic inequities.³⁷ However, in rapidly changing policy environments, Medicaid programs may find value in reflecting on how COVID-19-related policy changes are lessening or worsening COVID-19-related health disparities and health disparities in general, by carefully examining the opportunities discussed in this brief through a health-equity lens. Medicaid programs may also consider what internal structural and policy components that were implemented in response to COVID-19 could fuel further innovation and advancement of long-term health equity goals.

New Opportunities for Medicaid Programs Under the American Rescue Plan Act

The passage of the American Rescue Plan Act (ARPA) created additional opportunities for state Medicaid programs to further work to reduce health disparities related to COVID-19.⁴⁴ Most notably, the ARPA created additional, temporary incentives for states to expand access to Medicaid, targeting the 12 states that have not yet done so.⁴⁴ The ARPA also created a new state plan option

for Medicaid programs to create 12-month eligibility for postpartum women, which is a significant expansion from the current 60-day coverage option,⁴⁴ and reflects the efforts of at least eight Medicaid programs to expand coverage for post-partum women through Section 1115 waiver flexibilities.

CONCLUSION

Although the strategies presented in this brief for state Medicaid programs to address COVID-19-related health disparities are not a cure-all for systemic racism and inequities, they provide a point of reference to reflect on how institutional policies and procedures may be disproportionately affecting the most vulnerable communities across the nation. As we continue to learn more about how systemic health disparities can be identified, addressed, and prevented, state Medicaid programs can use the ideas presented here to take initial, immediate, and actionable steps toward health equity within the COVID-19 PHE and beyond. Although there is an urgent need to mitigate the disproportionate effects of the pandemic on marginalized groups, there is also a broader need to understand and address problems within the underlying and inequitable systems.

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METHODS

Center for Evidence-based Policy researchers searched the center's policy sources for literature and resources using the search terms "Medicaid" and "covid." We searched Ovid MEDLINE through January 26, 2021, and limited the search to citations published since January 2020 and published in English. We also conducted extensive Google searches, and searched Twitter and YouTube for related materials. In addition to the literature search, we conducted interviews with state Medicaid staff in five states (Michigan, North Carolina, Pennsylvania, Washington, Wisconsin) and with four national policy experts.

INTERVIEW CONTACTS

The authors would like to acknowledge the contributions of interviewees who provided their experience and knowledge to the development of the Center for Evidence-based Policy's report.

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Pam Curtis, MS, is the cofounder and director at the Center for Evidence-Based Policy. Ms. Curtis is responsible for the overall effectiveness of the center as well as maintaining a portfolio of direct state work. Prior to founding the center, Ms. Curtis served as a policy advisor to Oregon's governor on health and human services issues, as well as elected officials at the state, county, and national levels. Ms. Curtis has clinical experience in the fields of substance abuse, behavioral health, and child abuse. Her professional background also includes collaborative governance.

Valerie King, MD, MPH, is the research director for the Center for Evidence-Based Policy and a professor in the School of Medicine at Oregon Health and Science University (OHSU) and in the Portland State University and OHSU School of Public Health. Dr. King oversees research methods across clinical evidence and policy implementation research projects at the center.

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The Center for Evidence-based Policy is recognized as a national leader in evidence-based decision making and policy design. The center understands the needs of policymakers and supports public organizations by providing reliable information to guide decisions, maximize existing resources, improve health outcomes, and reduce unnecessary costs. The center specializes in ensuring that diverse and relevant perspectives are considered and appropriate resources are leveraged to strategically address complex policy issues with high-quality evidence and collaboration. The center is based at Oregon Health and Science University in Portland, Oregon. The Medicaid Evidence-based Decisions Project is housed at the center. Its mission is to create an effective collaboration among Medicaid programs and their state partners for the purpose of making high-quality evidence analysis available to support benefit design and coverage decisions made by state programs.

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