



RACIAL/ETHNIC DISPARITIES IN ACCESS TO MEDICAID CARE

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Executive Summary

Medicaid is a federal-state partnership that provides healthcare coverage for the nation's most vulnerable populations. The program covers low-income adults and children, those with disabilities, pregnant women, and many high-need seniors. However, racial/ethnic minorities often face disproportionate barriers accessing physicians and adequate care even once enrolled in Medicaid. The COVID-19 pandemic has demonstrated the inequities in healthcare including Medicaid, and motivated policymakers to begin addressing these disparities. Research shows that White providers are 16 percentage points less likely to accept Medicaid patients in areas where the poor are non-White and racially segregated (and there is an even greater difference for specialists) (Greene et al., 2006). Also, racial/ethnic minorities report less satisfaction with physicians, less participation in medical decision making, and lower levels of satisfaction with care (*Cultural Competence in Health Care*, n.d.).

The National Association of Medicaid Directors (NAMD) represents the Medicaid Directors in each state who are responsible for guiding programs to achieve the state's policy priorities. They have identified equity as a primary concern for the program to address. This report focuses on interventions on the provider side of healthcare to improve access for non-White Medicaid members through Medicaid Managed Care. Although there is a lack of data and research on race/ethnicity within Medicaid, I examine the available literature to better understand racial disparities in the program as they relate to providers. I then propose 4 policy alternatives:

- I. Provide a financial incentive through MCO contracts for MCOs to have more diverse provider networks
- II. Risk-adjusted payments for providers based on the members they serve
- III. Use MCO contracts to require MCOs to track disparities within their networks and develop plans to address them
- IV. Status Quo

I evaluate the alternatives according to the criteria of cost, political feasibility, administrative feasibility, and effectiveness at reducing disparities. I recommend that NAMD implement alternative #3, requiring that MCOs track disparities and create programs to address them, because it builds off of work being done on social determinants of health and places most of the administrative burden on MCOs rather than State Medicaid Agencies. I conclude the report by discussing implementation and the need for future research.

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Honor Statement

On my honor as a student, I have neither given nor received unauthorized aid on this assignment.

A handwritten signature in blue ink, reading "Andy McElwain". The signature is fluid and cursive, with the first name "Andy" and last name "McElwain" clearly distinguishable.

Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

Acronyms

CMS	Centers for Medicare and Medicaid Services
HHS	(Department of) Health and Human Services
NAMD	National Association of Medicaid Directors
MCO	Managed Care Organization
FFS	Fee-for-Service
SMA	State Medicaid Agency
SDOH	Social Determinants of Health
REL	Race, Ethnicity, and Language

Introduction

Access to healthcare and insurance to cover it are extremely important determinants of health, economic security, and overall well-being. However, in the United States, not everybody has equal access to healthcare coverage or treatment. The Medicaid program is intended to provide support to people of low socio-economic status and those with certain conditions in order to ensure that those populations can receive necessary treatment. The program also covers a range of non-medical services including transportation to appointments and aid in Long Term Services and Supports. Unfortunately, within the United States health system people who belong to racial/ethnic minority groups often find it difficult getting coverage and accessing necessary care.

This inequity exists within Medicaid as well, and is increasingly becoming a priority for policymakers to address. The COVID-19 pandemic, which disproportionately affected non-White communities (Marshall, 2020), and the Black Lives Matter protests in the summer of 2020, which called attention to racial disparities in the United States, have catalyzed progress around addressing inequity in healthcare. Unfortunately, there is a severe lack of available data on race/ethnicity within Medicaid and therefore a lack of analysis to inform new policies and best practices.

There are barriers to accessing care that disproportionately impact non-White enrollees at every step in the healthcare process, and all of them need to be addressed, but this project will focus specifically on what can be done to make providers more available and equitable in their treatment of patients. This angle does not address issues with eligibility that are incredibly important to racial equity in healthcare but also very politically difficult to change. I focus on providers in part because of political feasibility but also because the Medicaid Directors have numerous options for direct intervention in provider networks through Managed Care Organizations that could very quickly impact how Medicaid operates. Also, making people eligible for healthcare coverage does not increase access to care if there are not available providers who accept Medicaid patients.

This policy analysis will cover the background of issues with equity in the Medicaid program, especially on the provider side. I will then examine some policy alternatives and evaluate them according to the criteria of cost, political feasibility, administrative feasibility, and effectiveness at reducing disparities based on the existing evidence.

Problem Statement

Non-White Medicaid enrollees face disproportionate barriers in access to providers and quality care.

Although there certainly are issues with equitable access to health insurance coverage, having coverage alone does not reduce racial/ethnic disparities in access to quality care or health

outcomes (Alegría et al., 2016). Hispanics, Blacks, and American Indian and Alaskan Native individuals are more likely to delay or go without needed care, and are less likely to have a usual source of care (Artiga et al., 2020). These same groups are at higher risk for certain health issues and have worse health outcomes. Issues of racial equity in healthcare are especially important for Medicaid to address because racial/ethnic minority groups are disproportionately represented among Medicaid enrollees. 21% of Medicaid enrollees are Black and 25% are Hispanic despite making up just 13% and 19% respectively of the US population (US Census Bureau, 2019). These populations face higher barriers to accessing care from eligibility and enrollment through treatment at the doctor's office. This report will focus specifically on the provider side of healthcare and how access to physicians and quality care can be improved for racial/ethnic minorities enrolled in the Medicaid program.

Client Overview

I am working jointly with the National Association of Medicaid Directors (NAMd) on this problem. NAMd is a membership association that represents the Medicaid Directors who oversee the Medicaid programs in each state. NAMd does research to support the Directors in achieving their policy priorities. They are beginning work on a project that will look forward to how Medicaid can adjust and improve coming out of the COVID-19 pandemic, and one of the areas they will be looking at is disparities. Medicaid has been gutted in many ways by the pandemic, and while this is a huge problem it also introduces the possibility to rebuild the program in new ways that will improve it for both the State Medicaid Agencies and enrollees. My project will provide initial research and analysis to inform NAMd's recommendations for addressing and narrow racial disparities. I worked primarily with Lindsey Browning on this project.

Background

The Medicaid Program

Medicaid is one of the largest sources of federal entitlement spending and provides health insurance coverage to millions of Americans. As of 2019, the program covered one in five Americans, most of whom are low-income. Income eligibility varied significantly at the state level prior to the Affordable Care Act raising eligibility for single adults to 138% of the Federal Poverty Line in states that chose to expand Medicaid (Rudowitz, Orgera, et al., 2019). In states that have not expanded, some other groups are categorically eligible for Medicaid coverage such as pregnant women, children up to a higher income level, and those with certain disabilities. Under the law, states have the authority to cover optional populations so some states cover incarcerated individuals and lawfully residing immigrants. Coverage differs so much at the state level based on expansion and state policy because, unlike Medicare, Medicaid is primarily a federal-state partnership (Rudowitz, Garfield, et al., 2019). The federal government imposes some rules and guidelines and matches state Medicaid funding at anywhere from 50%-83% but

states have a lot of authority to decide what, who, and how to cover their enrollees (“Matching Rates,” n.d.).

The Medicaid program is a crucial benefit for many people who otherwise may not be able to afford healthcare. The program covers almost half of all births, 83% of low-income children, 48% of children with special healthcare needs, and 45% of non-elderly adults with disabilities (Rudowitz, Garfield, et al., 2019). Coverage includes most preventive services and essential health benefits as well as varying degrees of other benefits for the four core populations of disabled individuals, low-income children, low-income adults, and seniors (dual eligibles) (Rosenbaum et al., 2019). Most of the population enrolled in Medicaid are low-income children and adults, but the majority of Medicaid expenditure is on seniors and disabled individuals who often receive long-term and complex care (Rudowitz, Garfield, et al., 2019). There are national standards for both eligibility and covered services, but states that have not chosen to expand Medicaid are not subject to nearly as many requirements. The majority of decisions at the state level are made by State Medicaid Agencies (SMAs) that are guided by the state Medicaid Director and the state legislature. The SMAs can submit plans and waivers for approval to the Centers for Medicare and Medicaid Services (CMS). Section 1115 Waivers that allow states to waive portions of the Medicaid law and the majority of innovative programs including the ability to contract with Managed Care Organizations are done through these waivers (*Contract Review | Medicaid*, n.d.).

Delivery Systems

Medicaid payment to healthcare providers is traditionally through a fee-for-service model but has increasingly shifted to Medicaid Managed Care. Over $\frac{2}{3}$ of Medicaid enrollees receive care through a Managed Care Organization (MCO) and these organizations receive 46% of Medicaid funding (Rudowitz, Orgera, et al., 2019). Notably, although the vast majority of enrollees receive care through an MCO, the majority of Medicaid funding goes to the elderly and those with disabilities who are often not covered by managed care. However, this is beginning to change and as of 2019, 25 states have started to cover Long Term Services and Supports (LTSS) through some type of capitated managed care (Gifford et al., 2019). Under Medicaid Managed Care, the State Medicaid Agencies contract with Managed Care Organizations run by private companies which are paid per-member-per-month for their enrollees to receive care from doctors in their network. The advantage of this capitated model is that it incentivizes providers to be cost-effective because if the costs of treatment are greater than the amount paid by the State, the MCO is responsible for covering the loss. The effect of the policy is that the risk for overtreatment or high costs is shifted from Medicaid to providers. Also, under managed care, SMAs can require certain activities or quality outcomes from MCOs which allows them to better target priority areas, including disparities (Hinton et al., 2020).

Disparities in Medicaid

Equity in access to healthcare is a nationally recognized issue. As of 2018, the uninsured rate for Black Americans was 14.4% and was 24.9% for Hispanic individuals. The disparity in

uninsured between Black and White Americans is 5.8 percentage points, and the disparity between Hispanic and White Americans is 16.3 percentage points (Baumgartner et al., 2020). Importantly, the percentage of uninsured in both cases is higher than the percentage of those racial/ethnic groups in the U.S. population, indicating that these groups are disproportionately uninsured (US Census Bureau, 2019). The coverage gap for both groups has decreased since the implementation of the Affordable Care Act, especially in expansion states, but progress has stalled since 2016 and the uninsured rate has subsequently increased (Baumgartner et al., 2020). However, even after being enrolled in Medicaid, racial/ethnic minorities often face additional barriers to finding a physician and receiving equitable care.

The delivery system of care (FFS or MCO) is an important determinant of how Medicaid enrollees access providers. There is conflicting evidence as to whether managed care improves the experiences of non-White Medicaid enrollees. One study by Bindman et al (2005) found that there was a 33% lower rate of hospitalizations for ambulatory care under mandatory managed care, and there was a greater effect for non-White racial/ethnic groups (Bindman et al., 2005). This finding suggests that managed care might be especially successful at improving care for those who have faced the highest barriers in the past. However, another study by Weech-Maldonado et al (2003) found that African Americans had more difficulty accessing care under managed care than fee-for-service, and their perceptions of care were worse. African Americans scored lower than whites on getting needed care, timeliness of care, and plan service. Linguistic minorities also faced more barriers and language determined the experience of Whites, Hispanics, and Asians with Asian non-English speakers having the lowest overall ratings of care (Weech-Maldonado et al., 2003).

Managed care can often include access to Patient-Centered Medical Homes (PCMH) that help provide primary care and coordinate care. While these services can be beneficial, African American and Hispanic children with a PCMH are not more likely to receive preventive services than their peers without one (white children with a PCMH are more likely to receive preventive services than White children without one). Also, one study found that African American diabetes patients with a PCMH were less likely to receive hemoglobin A testing, flu vaccines, and cholesterol management than their White peers (Adepoju et al., 2015). Conflicting research on the differential impact of managed care on racial/ethnic groups indicates that more research is needed on the subject and implementation of these policies should be accompanied by an eye towards the experiences of vulnerable groups.

After an individual is successfully enrolled in Medicaid, there may still be several barriers to receiving medical care. One well-recognized issue in the American health system as a whole that is especially prevalent in the Medicaid program is a lack of physicians in minority-dominated zip codes (*Access to Health Services*, 2020). Although it varies by state, Medicaid reimbursement is significantly lower than the payment that providers can receive from either Medicare or private insurance (*Access to Health Services*, 2020). On average nationally, Medicaid only pays 61% of what Medicare pays and this is still less than private insurance

(Mcaskill, 2014). As a result, many physicians do not accept Medicaid patients or if they do, only in limited amounts because they don't stand to make as much money and can sometimes even lose money (Greene et al., 2006). Racial/ethnic minorities are disproportionately represented in Medicaid, so they are also disproportionately impacted by the lack of physicians who accept Medicaid, creating higher barriers to accessing care for these populations.

Greene et al (2006) designed a study to test 3 hypotheses in order to understand why non-White Medicaid enrollees may have more difficulty finding a provider who accepts Medicaid: physicians are more likely to accept Medicaid patients in areas where the poor are White, physicians are less likely to accept Medicaid patients in areas that are racially segregated, and physicians are less likely to accept Medicaid patients in areas that are economically segregated. In their sample, 81% of physicians participated in Medicaid, although the number was higher for specialists than for primary care doctors. Counter to the economic expectation, physicians in urban areas were found to be less likely to accept Medicaid patients. They found a 16 percentage point difference in physician participation in counties where the poor were the most vs the least White. The difference was almost twice as large for specialists. When controlling for the other independent variables, reluctance to participate in Medicaid was concentrated in areas where the poor were non-White and where the non-White were segregated, providing evidence for the first two hypotheses. They found no evidence that participation differed as a result of economic segregation. The study is limited by being self-reported which may result in some bias and county-level geographic information may not be the most appropriate unit. However, it is the only study that directly tests whether the race of potential patients impacted physicians' decisions to participate in Medicaid.

Additionally, a study on primary care physician (PCP) access in Primary Care Service Areas (PCSAs) in Virginia found that there were lower shares of accessible PCPs in urban communities with a higher proportion of Hispanic individuals even when controlling for unobserved market traits (Daly and Mellor, 2018). They also found that PCSAs with a higher proportion of Hispanic or African American Medicaid enrollees had fewer accessible PCPs, which equally impacted the White enrollees in the areas suggesting that disparities are mostly between PCSAs with different populations rather than among different people within PCSAs (Daly and Mellor, 2018). The geospatial analysis from this study supports the findings from Greene et al (2006) and is important for policymakers because it goes beyond the proportion of physicians accepting Medicaid to look at the network of available providers within an accessible area.

To overcome challenges with transportation, telehealth, and physician availability, many non-White Medicaid enrollees rely on community health centers for care. The reliance on community-based providers is in part due to the lack of physicians in non-White areas (Taylor, 2019) and difficulties with transportation that make it easier for these groups to receive care from closer community sources. Minority groups, especially Black individuals, also have less trust in medical providers and are more likely to be comfortable in community-based settings (Gaskin et

al., 2012). Due to the reliance on and greater trust in community health providers among non-White racial/ethnic groups, it is important for Medicaid to reimburse this care. While 47 states and Washington DC have programs that actively encourage the use of community-based services, only 26 states explicitly reimburse Community Health Workers (CHWs) through Medicaid (NASHP, n.d.). When states do reimburse CHWs, minority groups are more able to receive care.

The final step to accessing care for Medicaid recipients is when they meet with a doctor. Unfortunately, discrimination while at the doctor's office prevents some people from receiving equitable diagnosis and treatment and often leads to frustration on the part of patients. Among Medicaid providers, discrimination and refusal to treat Medicaid patients are more common in areas that are majority non-White (Greene et al., 2006). The Georgetown University Health Policy Institute found that racial/ethnic minorities report less satisfaction with physicians, less participation in medical decision making, and lower levels of satisfaction with care. African Americans are most likely to report feeling as though they were treated disrespectfully during a healthcare visit (*Cultural Competence in Health Care*, n.d.). Audit studies have also found that physicians gave different treatment recommendations and assessments for Black patient-actors than for White patient-actors even when the symptoms were the same (Greene et al., 2006).

Physician access is especially challenging for chronic conditions or behavioral healthcare that often necessitate multiple visits. For example, Black Medicaid patients are less than half as likely to receive follow-up care within 30 days of inpatient discharge for depression-related care (Alegría et al., 2016). For these reasons, minority patients often prefer minority clinicians. Minority providers are also more likely than White providers to provide care in underserved areas (Alegría et al., 2016) and the race/ethnicity of a provider is one of the strongest indicators of willingness to accept Medicaid patients (Holgash & Heberlein, 2019). However, there are not enough non-White providers in the workforce. For example, only 12.9% of social workers and 7.8% of psychologists are non-White (Alegría et al., 2016). Fortunately, Black and some Hispanic enrollees in Medicaid have better care experiences than individuals with private insurance, but Medicaid providers must remain cognizant of potential discrimination and the cultural and linguistic needs of their patients (Martino et al., 2019).

Data Limitations

Important to any conversation on racial/ethnic disparities and Medicaid is the fact that data on race, ethnicity, and language (REL data) is not consistently collected, so it can be difficult to assess how policies impact specific subgroups. Currently, the Department of Health and Human Services (HHS) recommends using REL standardized categories developed by the Office of Management and Budget (OMB) (Lukanen & Zylla, 2020) but not all states or MCOs follow this recommendation. Incomplete data is a serious challenge to addressing disparities around access because it is difficult to determine the magnitude of the problem or what potential solutions might be (Ng et al., 2017). Lack of Medicaid quality data stratified by race/ethnicity is a well-recognized issue that many Medicaid policymakers are attempting to address. HHS has

defined the Child and Adult Core Sets as quality measures for states to report that are currently optional but will become required in 2024. Included in the Core Sets is a requirement to stratify the measures by REL data (Rosenbach et al., 2020). This is an important step that will improve the analysis of racial equity in Medicaid, but the current lack of available information means that my analysis must in places rely on information from smaller studies, comparable programs, and information about the US healthcare system as a whole.

Consequences of the Problem

When someone is not able to access appropriate or high-quality care, they often end up resorting to using the Emergency Department, even for non-emergency issues. Money spent on unnecessary ED visits is an important driver of high healthcare expenditure in the United States. One study using data from 2006-2009 found that 29% of ED visits from Medicaid enrollees were non-emergency visits. Of that 29% of non-emergency ED visits, 8.1% were by Black Medicaid enrollees, and 3.7% were by Hispanic Medicaid enrollees (Honigman et al., 2013). Total non-emergency expenditure in the ED amounts to \$32 billion per year (LaPointe, 2019), so the total cost of non-White Medicaid enrollees resorting to the emergency department for care is about \$3.8 billion.

In addition to the direct cost of not having health insurance, there is an opportunity cost to not being able to access a provider. Not having access to Medicaid care means that many people end up being sicker later in life, which means they are not able to be as productive and may not live as long so there is lost economic productivity. Also, good health is important for people to get an education or training so poor health results in lower incomes. In the United States, lost productivity due to illness or having to care for a sick family member is estimated to be \$260 billion annually (Mattke et al., 2007). Although Medicaid enrollees have health insurance, if there are barriers to care such as not being able to find a physician that an enrollee is comfortable with, enrollees may forego care resulting in a similar loss of economic productivity.

An underrecognized but important issue with underinsurance, especially for communities of color, is the impact on behavioral health which is often then transferred to costs to the criminal justice system and the medical system as a whole. As of 2017, there were 2.5 million Medicaid enrollees with unmet mental health needs (Zur et al., 2017). 60% of Medicaid enrollees belong to minority groups (“Distribution of the Nonelderly with Medicaid by Race/Ethnicity,” 2019), so that means roughly 1.5 million non-White Medicaid enrollees have unmet mental health needs. This number may be even higher if non-White enrollees have a disproportionately difficult time accessing mental healthcare. The lack of access to care has serious costs. For example, the societal costs of substance abuse exceed \$510 billion annually (*The Costs and Consequences of Disparities in Behavioral Health Care*, 2018). Research also shows that African Americans in particular are incarcerated more frequently but also have more difficulty accessing mental health services and are more likely to be undiagnosed or misdiagnosed (Johnson, 2020). The cost per inmate averages around \$33,274 in the United States (Hyperakt, 2020), so barriers that prevent

especially non-White Medicaid enrollees from accessing appropriate mental health services can become costly not just to individuals but to society if they are incarcerated.

There are a number of other externalities associated with healthcare access that are not quantifiable. The Institute of Medicine (IOM) recognizes some of these external costs including diminished social capital, unfulfilled social norms of caring, and decreased quality of life (Miller et al., 2004). As one example, uninsurance can contribute to tension and mistrust within a community. According to IOM, health insurance and caring for those who are sick make up an important part of the social contract of American society (Miller et al., 2004). When people cannot access care either due to uninsurance or other barriers, community bonds are eroded and trust is lost. This is especially true of racial and ethnic minorities many of whom already lack trust in the American medical system due to historical evils such as the Tuskegee Syphilis Trials.

There are numerous financial and societal costs that result from people not being able to access adequate healthcare. Racial/ethnic disparities in accessing care, especially equitable and culturally competent care, contribute greatly to these costs.

Criteria for Evaluation

Cost

One of the most important criteria to consider is cost. The Medicaid program is very expensive but limited by the budgets of states. Most states have budget requirements that prevent them from being able to quickly invest additional funds into Medicaid to do things like providing financial incentives for specific activities. Especially during and after the COVID-19 pandemic, states are experiencing very high enrollment and costs at the same time that state economies are struggling, so Medicaid agencies will be very reluctant to begin any new high-cost initiatives (Forbes & Park, 2020). This criterion will be measured using existing programs that are comparable to proposed alternatives and the best available estimates. Because data on managed care rates are very difficult to find and is not clear about the cost of specific programs, alternatives are ranked according to expected additional costs, then ranked from most costly (receives the lowest numerical score of 1) to the least costly (receives the highest numerical score of 4).

Political Feasibility

Medicaid is always a controversial political subject, so the political feasibility of alternatives is important to consider. The NAMD supports its members, the state Medicaid Directors, who can have competing priorities or political ideologies. The Directors are usually appointed by Governors, so although they are professionals they will also be influenced by the politics of the state. Also, changes in Medicaid programming including managed care contracts must be approved by CMS. The Director of CMS is appointed by the President so the agency is strongly influenced by the politics of the current administration. The political views of those in

charge of implementing policies within the State Medicaid Agencies are also important to consider because they may resist fully implementing a new policy that they do not agree with. The political feasibility of any alternative would likely vary between states, but all of the proposed alternatives would be implemented nationally by the Medicaid Directors. Political feasibility will be measured on a scale from 1 to 5 (1 is not feasible, 5 is very feasible).

Administrative Feasibility

Administrative feasibility is especially important to NAMD as they represent the Medicaid Directors and their SMAs. Medicaid struggles with having a large enough workforce to run programs, and the administration of the program, especially at the state level, is extremely complex. SMAs are already spread very thin and may not have the capability to introduce complex new changes. Workforce capacity will be a limiting factor to any alternative that requires the implementation of a new program or a significant amount of increased work (Shin & Larson, 2016). Especially in the wake of COVID-19, I will be very sensitive to the limits of the SMAs. Administrative feasibility will be measured on a scale from 1 to 5 (1 is not feasible, 5 is very feasible) according to the expected amount of increased work for SMAs.

Effectiveness at reducing disparities

The final and most important criterion is how effectively an alternative reduces racial/ethnic disparities in access to Medicaid providers. This criterion encompasses equity as equity is the primary goal of the project. The lack of available data on previous interventions to reduce racial disparities in healthcare, especially among the Medicaid population, means that there are no common measures of outcomes to compare. As a result, my analysis uses existing best practices and comparable programs to estimate the effectiveness of the alternatives compared to one another. Importantly, all the proposed alternatives would be implemented by MCOs meaning that they will only impact the 40 states and DC that use MCOs. Other states may be encouraged to implement comparable programs, but any policy I recommend is limited in efficacy by the fact that not all Medicaid members are covered through MCOs. Alternatives will be assigned an effectiveness score from 1 to 5 (1 is not effective, 5 is very effective) based on the existing literature.

Policy Alternatives

Alternative #1: Provide a financial incentive through MCO contracts for MCOs to have more diverse provider networks.

Studies suggest that White providers are significantly more reluctant to participate in Medicaid in areas where the Medicaid members are majority non-White, but there is no such discrimination found when the providers themselves are non-White. Recruiting, supporting, and

maintaining a more diverse workforce is an often-recommended step to reducing health disparities (Weech-Maldonado et al., 2003), but this cannot be addressed without understanding the demographics of the current workforce. This policy alternative would leverage contracts between states and MCOs to provide a financial incentive for MCOs that have more diverse provider networks and/or are actively working to increase the diversity of their networks. More than half of MCO states currently use financial incentives for MCOs to address state objectives including birth outcome measures and behavioral healthcare (Clark et al., 2017). These measures address plan performance and use capitation withhold or pay-for-performance incentives. This alternative would use a positive financial benefit to set a target percentage for non-White and bilingual or multilingual providers in MCO networks. The specific percentage will be determined by each state according to their own data on the availability of non-White providers. The incentive would offer bonus payments at 1.5% of revenue to MCOs that meet the diversity goal. While most pay-for-performance incentives involve withholds or penalties, this alternative offers a positive incentive to not penalize MCOs for the lack of minority providers in the US healthcare system as a whole.

Analysis

Cost: This alternative has the highest cost and receives a **cost score of 1**. In 2019, premiums paid by Medicaid to MCOs totaled \$279 billion (“Total Medicaid MCO Spending,” 2019). If all MCOs were able to meet the provider diversity requirement set by their state, the highest potential cost for a 1.5% pay-for-performance incentive would be **\$4.18 billion**. It is unlikely that the cost would be this high because not all MCOs will be able to meet their state’s requirement and therefore would not receive the financial incentive, so this represents the upper limit of the potential cost.

Political Feasibility: This alternative receives a **2 for political feasibility**. In the fiscal year 2019, 24 of 40 (more than half) MCO states reported using capitation withholds or some type of pay-for-performance incentive in their MCO contracts. This indicates that financial incentives are a common practice to promote state Medicaid priorities, including health equity (Hinton et al., 2020). There is also some indication of bipartisan support for a more diverse healthcare workforce. H.R. 3637, the Allied Health Workforce Diversity Act, was introduced in the House of Representatives in 2019 by both Democratic and Republican members, and then got taken up and included in the bipartisan EMPOWER for Health Act of 2019 (Schakowsky, 2019). The bill included funding for grants to provide scholarships or stipends for students from underrepresented groups in the healthcare industry. The bill stalled in the Senate, but the bipartisan introduction and inclusion of the workforce diversity provision indicate that focusing on workforce diversity may be politically feasible. However, the high cost and explicit focus on rewarding MCOs for choosing their providers based on race/ethnicity lower the political feasibility of this alternative.

Administrative Feasibility: This alternative receives an **administrative feasibility score of 2**. Capitation rates for MCOs are set by the SMA. Also, to require MCOs to spend money in a certain way SMAs need special permission from CMS for directed payments. As a result, SMAs may be unwilling to adopt a policy that requires additional oversight and work. This alternative would require SMAs to set a target diversity percentage, evaluate their MCOs for whether they meet that requirement, then administer the incentive payment. The extra work required by already stressed SMAs lowers the administrative feasibility of this alternative.

Effectiveness at reducing disparities: This alternative has an **effectiveness score of 4** because there is evidence that increasing provider diversity can lead to more providers accepting Medicaid patients and a better experience for non-White enrollees (Alegria et al., 2016), but the policy may be difficult for MCOs to implement due to a shortage of non-White providers. Even the most proactive MCO could have difficulty finding enough new providers to make a meaningful change, reducing the effectiveness. A study on physician availability found that non-White physicians are the only group equally likely to take on Medicaid patients regardless of the racial makeup of the county (Weech-Maldonado et al., 2003). As of 2018, 56% of physicians identified as White, 17% identified as Asian, 5.8% identified as Hispanic, and 5% identified as African American, and less than 1% identified as American Indian or Alaska Native (13% unclassified) (*Percentage of All Active Physicians by Race/Ethnicity, 2018*, 2018). The race/ethnicity of providers is one of the strongest indicators of willingness to accept Medicaid patients (Holgash & Heberlein, 2019), so provider network diversity is an important element of improving minority access to Medicaid care. This alternative may also encourage MCOs to contract with Community Health Workers who provide care for many non-White Americans (Gaskin et al., 2012).

Alternative #2: Risk-adjusted payments for providers based on the members they serve.

Many physicians choose not to accept Medicaid patients or only accept a very limited number of Medicaid patients as a result of low reimbursement rates. Additionally, a study by Greene et al (2006) demonstrated that providers disproportionately choose to not participate in Medicaid when the majority of their Medicaid patients would be non-white. This discrimination contributes to difficulty finding providers for non-White or language minorities enrolled in Medicaid. This alternative would leverage risk-adjusted payment increases to providers who serve a higher proportion of racial/ethnic or language minorities. This policy would incentivize more providers to accept Medicaid patients, especially in historically underserved areas where the Medicaid members are predominantly non-White.

The alternative is modeled after Massachusetts's social determinant of health risk-adjusted payments. The model uses neighborhood stress scores which incorporate factors such as poverty, percentage of residents receiving public assistance, and education level (Ash & Mick, 2016). These factors are correlated with race/ethnicity so neighborhood stress scores can be used as a proxy for race/ethnicity to deliver a more targeted intervention (Firebaugh & Acciai, 2016). This alternative is more direct to the providers themselves and therefore to the enrollees.

However, state Medicaid budgets are already under a lot of stress and provider reimbursement rates are often one of the first cuts when states need to curb spending. Therefore, states that choose to implement this incentive would receive an increase in federal matching funds to cover the reimbursement increases for the first 5 years which would then decrease over the course of the next 5 years as states can adjust and implement other cost-cutting strategies.

Analysis

Cost: This alternative has a **cost score of 2**. In the Massachusetts model, each 1 SD increase in the Neighborhood Stress Score resulted in a \$50 increase in the reimbursement per patient (Ash & Mick, 2016). About 65 million people live in areas with a shortage of primary care physicians (Harrah, 2020), so if all of these people receive Medicaid (Medicaid enrollees often are a medically underserved population) then the **additional cost is \$3.25 billion**. The policy would also seek to address access issues with specialists, so this is likely a low estimate of the necessary cost. One option to reduce this cost would be to try to redistribute provider reimbursement funds and spend proportionally more on historically underserved areas to encourage more physicians to accept Medicaid in those areas. It is unlikely that every person would be enrolled in Medicaid, but some providers in areas with a neighborhood stress score greater than 1 standard deviation may see higher payments.

Political Feasibility: This alternative has a **political feasibility score of 3**. Massachusetts has come the closest to implementing a similar program by using Neighborhood Stress Scores to help determine risk-adjusted payments to providers. This is only one state but means that there is precedent for this type of program. Also, in Fiscal Year 2020, 43 states implemented some type of provider rate increases (Gifford et al., 2019). However, increasing state spending on Medicaid is always politically difficult. Also, COVID-19 has put state budgets and therefore legislatures and SMAs under extreme stress, so the federal match is crucial to make this alternative even moderately politically feasible.

Administrative Feasibility: This alternative receives an **administrative feasibility score of 1** because it is very targeted. Although this option is cheaper and more targeted to the communities most in need, it would require a significant degree of data collection, analysis, and oversight by the SMAs to ensure that MCOs and providers are receiving the correct rates. Another important note is that Massachusetts has the benefit of partnering with multiple top universities to design models for their Medicaid program, and as a result has a higher degree of sophistication and more administrative capability for complex models and programs than many other states (L. Browning, Personal Communication, March 24, 2021). Without significant support, other states would have a difficult time implementing this alternative.

Effectiveness at reducing disparities: This alternative can be very targeted and has strong evidence that it could increase Medicaid access so it receives an **effectiveness score of 5**. Data

show that each \$10 increase in Medicaid reimbursement is associated with a 0.3 percentage point increase in the likelihood of an enrollee reporting a doctor visit in the last two weeks, and a decrease in the number of adults who were told that a provider was not accepting new or any Medicaid patients (McKnight, 2019). Additionally, a study by MACPAC found that a one-percentage-point increase in the Medicaid-Medicare fee ratio increased physician acceptance of Medicaid patients by 0.78 percentage points (Holgash & Heberlein, 2019). If these increases are targeted at historically underserved communities that are majority non-white, they could reduce disparities in access to providers. Also, these benefits have the potential to impact Medicaid enrollees who receive fee-for-service care but live in the same areas if more practices or providers are willing to take on Medicaid patients or are less cost-constrained overall.

Alternative #3: Use MCO contracts to require MCOs to track disparities within their networks and develop plans to address them.

Some states have already started to experiment with requiring or providing incentives for MCOs to develop programs targeting racial disparities. For example, Minnesota requires its Integrated Health Partnerships to develop health equities measures for their patients. 35 states also require their MCOs to address SDOH in some way (Gifford et al., 2019). This alternative creates a similar requirement specifically for racial/ethnic disparities. First, MCOs would be required to collect REL data according to OMB recommendations and report quality measures stratified by race/ethnicity. States will already be required to report their Core Set quality metrics by race/ethnicity starting in 2024, so this alternative builds off of that new requirement (Rosenbach et al., 2020). There are many barriers to effective care, and programs to address racial equity could take a variety of forms. MCOs could take this opportunity to develop a provider network that is more educated about the needs and cultures of their Medicaid patients or is better organized to meet those needs which will improve communication and care experiences for members. Plans could meet this requirement by providing cultural competency training, language training, targeted programs to increase member engagement, programs to include Community Health Workers, or any other programs that specifically address disparities identified by MCOs within their networks. These programs could be administered at the plan or hospital level.

Analysis

Cost: This alternative receives a **cost core of 3**. The costs of new MCO requirements including requirements to address racial and ethnic disparities would be built into the capitation rates that states pay MCOs. Rates are developed using actuarial standards from the American Academy of Actuaries and are not made public (L. Browning, Personal Communication, March 24, 2021). One example of a program is cultural competence training. 71% of providers in the US accept

Medicaid (Masterson, 2019) and there are 1,044,706 active physicians in the US as of September 2020 (“Professionally Active Physicians,” 2021) which indicates that there are about 741,741 physicians within Medicaid. One example of a cultural competency training provided by Quality Interactions costs \$299 per person for a 6-hour course (*LearnUpon*, n.d.). If every Medicaid provider took this training, the cost would be **\$221 million for one-time training**. The exact cost would vary by the course and the number of physicians who are part of MCO networks requiring the training. Importantly, this is just one example of a program and is likely to be lower cost than many others. **A program that seeks to make meaningful changes in the structure or delivery of Medicaid to target racial disparities would likely cost much more** but probably still less than alternatives #1 and #2.

Political Feasibility: This alternative receives a **political feasibility score of 4** because it does not create major spending increases and builds off of programs that already exist which makes it more politically feasible. As of 2020, 35 states are leveraging MCO contracts to address Social Determinants of Health (Gifford et al., 2019). Many non-MCO states are also working to address SDOH in Medicaid. Race/ethnicity and language are important factors that are strongly related to many SDOH, and programs that seek to address SDOH through Medicaid would see an additional benefit to explicitly addressing racial inequities. The fact that the majority of MCO states are explicitly targeting SDOH through MCO contracts indicates that they may be willing to address racial disparities through similar methods.

Administrative Feasibility: This alternative receives an **administrative feasibility score of 5** because of strong precedent and low involvement from SMAs. The main challenges to administrative feasibility for this alternative would be working with the MCOs to quickly update data collection and reporting and implementing the programs. However, these challenges would mostly fall on the MCOs themselves rather than the SMAs. Most MCOs already have initiatives targeted at SDOH, so they may be able to incorporate additional measures to address racial/ethnic disparities without having to develop entirely new programs. Because MCOs are private companies they also are not subject to the same degree of budget and personnel shortages as SMAs.

Effectiveness at reducing disparities: This alternative receives an **effectiveness score of 3** because the effectiveness would depend a lot on the success of programs developed by MCOs to target racial disparities. If non-White providers are not available, culturally adapted interventions have been shown to be high-cost but effective (Alegría et al., 2016). One study found that training programs do increase culturally competent behaviors which may result in enrollees becoming more comfortable with their providers as well as train providers to work more effectively with their enrollees. The study found that the average cost-effectiveness ratio was \$338 for every 1 unit increase in culturally competent behavior (Parker et al., 2020). However, the sample size was very small and only included one hospital so more research is needed to fully understand the causal impact of this type of training. There may also be a benefit to MCOs

specifically collecting data and monitoring for racial disparities so that programs can be more targeted to meet the needs of enrollees.

Alternative #4: Status Quo

The final policy option is to maintain the status quo and choose not to implement any new programs. The COVID-19 pandemic has highlighted many of the disparities that exist in American healthcare and Medicaid, and especially in the wake of racial justice protests during the summer of 2020, there is already a significant amount of discussion about how to improve racial/ethnic disparities. Many proposals and articles have been written about how to address these issues in the Medicaid program, and some states have already begun implementing policies to target these issues including increasing postpartum coverage and prioritizing social determinants of health. These efforts may be effective without further intervention.

Analysis

Cost: This alternative receives a **cost score of 4** as the least costly option because it does not require any additional expenditure. However, it is important to note that although this alternative does not introduce new programs or changes, there are costs when people cannot access medical care. When Medicaid enrollees are unable to find a provider in their area or do not feel comfortable seeing the physicians that are available, they may forego medical care and end up needing to go to the Emergency Department, or they may just skip straight to the ED even for non-emergency issues. The estimated cost of non-White Medicaid enrollees resorting to the ED for non-emergency issues is \$3.8 billion annually (see analysis pg 9). This is not a direct cost and would not be eliminated by the other alternatives so it is not considered as part of the cost criterion, but is important for policymakers to consider.

Political Feasibility: Option #4 receives a **political feasibility score of 4**. This alternative does not require any legislation or change from states, but the COVID-19 pandemic, as well as the national conversation about racism in the wake of protests this past summer, have resulted in significant political pressure to address racial disparities in healthcare.

Administrative Feasibility: This policy alternative receives an **administrative feasibility score of 5** because it requires no additional work from the busy SMAs.

Effectiveness at reducing disparities: Policy option #4 would just let current trends continue, so without any intervention to reduce racial disparities it receives an **effective score of 1**. Racial equity is becoming a much more important and present part of the national healthcare conversation, so there may be enough momentum for states or MCOs to begin addressing disparities without additional intervention, but this is not guaranteed and is unlikely to happen uniformly across the country.

Outcomes Matrix

I used the scores assigned to the alternatives for each criterion to develop an outcomes matrix. This matrix gives equal weight to all four criteria in evaluating the alternatives, and averages the scores. Alternative weights and scores were used for a sensitivity analysis which can be seen in the Appendix. In the sensitivity analysis, alternative #3 either still receives the highest score or is tied with the status quo.

Criteria	Alternative 1: Provider Disverty	Alternative 2: Risk-adjusted pay increases	Alternative 3: MCO equity program	Alternative 4: Status quo
Cost	1 (high)	2 (medium)	3 (low)	4 (lowest)
Political Feasibility	2	3	4	4
Administrativ e feasibility	3	1	5	5
Effectiveness	4	5	3	1
Average	2.5	2.75	3.8	3.5

Recommendation

I recommend that the National Association of Medicaid Directors advocate for Alternative #3, requiring Medicaid MCOs to track racial/ethnic disparities in their access and quality metrics and creating a program to address these disparities. This alternative ranks well on both political and administrative feasibility because of the existence of similar requirements for programs targeted at Social Determinants of Health. This alternative will also be easier to implement for the Medicaid Directors because the bulk of the administrative work and program development will be done by the MCOs. Overall, the alternative is relatively low cost and has the highest average score in the other three criteria. The cost of Alternative #3 would depend a lot on the program that MCOs choose to implement, but similar programs like those for cultural competence training are relatively low-cost. Although this alternative is not the most effective because it does not specifically target a barrier to care, it will encourage MCOs to be more aware of disparities within their networks and require them to think about ways to improve access.

The cutbacks to State Medicaid Agencies and the additional stress to both the agencies and state budgets caused by COVID-19 make alternative #3 more appealing because the MCOs

will be tasked with developing and administering their own programs. The majority of MCO states already require their MCOs to address social determinants of health which are often correlated with other racial/ethnic disparities such as worse housing conditions, difficulty finding transportation, and language barriers among others. These programs could be adapted to monitor specifically for the needs of non-White enrollees within Medicaid networks to ensure that they get access to care.

Implementation

Stakeholders

Medicaid Managed Care Organizations (MCOs) are private companies that contract with State Medicaid Agencies to provide benefits for some Medicaid enrollees with their participating providers. The Centers for Medicare and Medicaid Services (CMS) administer the federal side of the program, including the approval process for Section 1115 Waivers that set up MCOs (*Contract Review | Medicaid*, n.d.). State Medicaid Agencies are run by Medicaid Directors, the majority of whom are appointed by the Governor of the state. NAMD supports the Medicaid Directors in achieving the policy goals of their states and administering the program in an efficient way (Cutler, 2019). The Medicaid Directors are some of the primary stakeholders in this analysis because they will be responsible for the development of MCO contract requirements. They will need to get approval from state governors and then work with the staff of the agency to develop the specific measures. CMS is also an important stakeholder because MCO contracts are submitted for review and approval by the agency. The head of CMS is appointed by the President, and President Biden's commitment to equity in healthcare indicates that his administration will be supportive of this policy (Mason, 2021).

The second primary group of stakeholders is the Managed Care Organizations themselves and their parent firms. States that utilize MCOs contract with between 2 and 22 organizations. These organizations belong to parent firms that commonly operate MCOs in multiple states ("Medicaid MCOs and Their Parent Firms," 2019). The MCOs will bear the majority of the financial and administrative costs of data collection, program development, and program delivery so they are likely to be the most resistant stakeholders. If states cannot show that the new requirements fall under existing provisions (about SDOH or other equity initiatives), then MCOs will likely request additional funding which could raise the cost of this alternative. However, MCOs have been vocally committed to supporting racial equity within Medicaid (AHIP, 2021). Racial equity is also a priority of healthcare research and innovation in general, so this will encourage MCOs to invest in the recommended policy alternative (Rudowitz et al., 2021). NAMD can use the momentum of the racial equity movement within healthcare to encourage support and innovative program design from the MCOs.

The third group of stakeholders to consider are the Medicaid enrollees. These are the main participants in the Medicaid program and the people who will be most impacted by the

policy alternative. Of Medicaid enrollees, non-White members are a subgroup of special interest because the recommended policy seeks to improve their access to Medicaid care specifically. The effectiveness of the MCO's programs will be evaluated in terms of how they impact the experiences and care of Medicaid enrollees, especially racial/ethnic minorities. The enrollees have a strong interest in the successful implementation of the policy alternative and continued commitment to reducing disparities.

Challenges and Oversight

The implementation of this policy is modeled after state requirements for MCOs to address social determinants of health (SDOH). Although 35 states include SDOH in their MCO contracts in some way, the models vary widely (Gifford et al., 2019). I expect that state contract requirements for racial/ethnic disparities will also differ significantly from state to state so the Medicaid Directors will need to set consistent baseline expectations. One of these expectations must be for MCOs to collect race, ethnicity, and language (REL) data according to the recommended categories set by the Office of Management and Budget (OMB). 10 states and Washington DC already require MCOs to report Health Effectiveness Data and Information Set (HEDIS) measures by REL, so this can be expanded to the remaining MCO states (Bailit Health, 2021). Also, all states will be required to report Core Set quality measures stratified by race/ethnicity by 2024, so MCOs already need to begin collecting REL data (Rosenbach et al., 2020). This data collection and the ability to report on quality by race/ethnicity will allow for a better diagnosis of racial disparities within MCO networks. Modification of data collection will be one of the biggest administrative barriers to the implementation of this policy, but there is precedent with 7 states using MCO contracts to require providers to capture SDOH data (Gifford et al., 2019).

MCOs will have the option to design their own programs to address racial disparities within their networks. If states feel strongly about the efficacy of certain types of programs, they can include this in the contract requirements. Some states already require MCOs to train staff in health equity or develop a Health Equity Director position (Bailit Health, 2021). For SDOH, states require activities such as developing a directory of community resources, contracting with community health organizations, and referring individuals to appropriate community services. (Kartika, 2018). Programs that could be implemented include cultural competence training for all members of MCO networks or participating hospitals, the inclusion of community health workers in MCO networks, or audits of MCO providers to ensure that they are providing equivalent care and services for patients of different racial backgrounds.

Due to both the lack of existing research and the fact that the specific programs will be determined by MCOs, there will need to be a significant amount of oversight. First, SMAs will want to be sure that MCOs are collecting the necessary data and looking for disparities in their networks. This could be done by requiring an annual report starting in year 2 (give the MCOs time to implement data collection and analyze it). As part of this report, SMAs could require MCOs to detail their plans to address racial/ethnic disparities. In future years (starting year 5),

they could also require the report to include progress updates on the program. I recommend that SMAs reevaluate the success of the new requirement starting in year 5 and then every 3 years thereafter to ensure that the policy is encouraging MCOs to address racial disparities effectively. As the policy is implemented, programs are developed, and data begins to be collected and analyzed, this policy alternative may not be effective. The lack of data to quantitatively assess cost-effectiveness prior to implementation means that this will need to be addressed at a later stage.

For this policy to be effective, careful attention will be necessary to ensure the buy-in and support of stakeholders as well as the development of a way to monitor and evaluate the programs developed by MCOs. SMAs and the Directors that run them will need to support MCOs as they begin to collect data and then continue to evaluate the effectiveness of this policy at reducing disparities as data analysis becomes more possible. In order to secure the support of the agencies and MCOs, the Directors should emphasize the current push for racial equity in healthcare and the support for this initiative by the federal government.

Conclusion

Racial disparities are recognized as one of the top priorities for the US healthcare system and Medicaid (DeVore, 2021). The Black Lives Matter protests during the summer of 2020 and the disproportionate impact of COVID-19 on minority communities have opened the political window to explicitly target inequities within the Medicaid program. I recommend that NAMD take advantage of this momentum and advocate for MCO contract requirements for REL data collection and programs to address racial disparities now. One of the major advantages of this policy alternative is the opportunity to begin a better system of REL data collection and reporting. This data will help MCOs track disparities and the experiences of their non-White members as well as analyze the impact of the programs they design. Racial/ethnic disparities in access to adequate care and available physicians must be addressed to make the Medicaid program more equitable and effective.

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Appendix

Sensitivity Analysis

Due to the limitations of the available data, I ran a sensitivity analysis to test the robustness of my recommendation. In the initial analysis, I weighed all four criteria equally. One alternate way to weigh the criteria would be to give more weight to effectiveness at reducing disparities (30%) as the main priority, and less to political feasibility (20%) because the national conversation about racial equity may encourage states to take action now. I found that the recommendation still does not change.

Criteria	Alternative 1: Provider Diverty	Alternative 2: Risk-adjusted pay increases	Alternative 3: MCO equity program	Alternative 4: Status quo
Cost	1 (high)	2 (medium)	3 (low)	4 (lowest)
Political Feasibility (20%)	2	3	4	4
Administrative feasibility	3	1	5	5
Effectiveness (30%)	4	5	3	1
Average	2.6	2.85	3.7	3.4

The cost of the expected alternative is also extremely variable depending on the programs MCOs choose to implement and whether the states would have to increase their capitation payments. I examined one alternative analysis where this alternative is the second most expensive (would receive a cost score of 2). In this analysis, the resulting score is the same as the status quo. However, it is likely that if more money is spent, effectiveness would also increase making alternative #3 still the recommended option.

Criteria	Alternative 1: Provider Diverty	Alternative 2: Risk-adjusted pay increases	Alternative 3: MCO equity program	Alternative 4: Status quo
Cost	1 (high)	3 (low)	2 (medium)	4 (lowest)
Political Feasibility	2	3	4	4
Administrative feasibility	3	1	5	5
Effectiveness	4	5	3	1
Average	2.5	3	3.5	3.5