Guide to Equity in Medicaid

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ABOUT THIS GUIDE

This guide equips advocates and other changemakers with key information about Medicaid, including an overview of the system's inequities, and highlights the policy and accountability levers that can advance equity.

This guide is part of a larger project on inequities and policy levers in the US health care system. For the complete guide, visit urbn.is/4054rNQ.

The other topics covered include the following:

- behavioral health care system
- Children's Health Insurance Program
- health care for the uninsured
- Indian Health Service
- Marketplace insurance
- Medicare
- Medicaid-Medicare
- pharmacy services
- Veterans Affairs

OVERVIEW

Created in 1965, Medicaid is a federal and state public health insurance program providing physical, behavioral, and long-term services and support for people with low incomes. As the largest US health insurer, it covers millions of children, parents, pregnant women, seniors, and people with disabilities. Medicaid is an important source of coverage for people of color, who are more likely than white Americans to live in poverty due to systemic racism.

While Medicaid has improved health care access for the uninsured, nonwhite Medicaid enrollees tend to experience worse access, quality of care, and outcomes than white Medicaid enrollees. These inequities stem partly from historical racial politics that continue to shape the program's state-driven structure: because states can set their own eligibility rules, benefit packages, provider payments, and other aspects of the program, some state Medicaid policies disproportionately exclude people from racial and ethnic minority groups. States that resisted Medicaid creation tend to have very restrictive eligibility policies; many of these states also have not adopted the Affordable Care Act's (ACA) Medicaid expansion, perpetuating disparities.

For More Information

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POPULATION

Medicaid typically provides health care access to about one in five US residents. Enrollment rose sharply after the ACA's Medicaid expansion that began in 2014 and again during the COVID-19 pandemic when public health

emergency policies implemented between 2020 and 2023 required states to keep people enrolled during the pandemic.

- About a quarter of the US population was enrolled in Medicaid as of March 2023, or about 86.7 million individuals.
- Medicaid is a major insurance provider for pregnant women, covering about 4 in 10 births nationwide.
- It is the primary coverage source for long-term care services and supports, including nursing home care and assistance for older adults and adults with physical and behavioral disabilities living in their communities. About 8.8 million Medicaid beneficiaries received these services in 2019.
- While white people are the single largest group served by Medicaid, nonwhite people rely on it at higher rates. In particular, more than half of children who are American Indian/Alaska Native, Black/African American, Hispanic/Latinx, and Native Hawaiian or other Pacific Islander are covered by Medicaid.

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PROVIDERS AND SERVICE DELIVERY

Medicaid programs are legally required to ensure enrollees have equal access to covered health care services compared to the general population through sufficient provider payments. Yet, many providers hesitate to join Medicaid due to lower reimbursements and bureaucratic barriers, such as credentialing and complex billing.

Certain providers, including teaching hospitals, community health centers, and rural clinics, often serve as primary care providers for Medicaid patients. These "safety net" providers are often located in underresourced communities and tend to rely on health professional students and medical residents in training to provide health care services.

Some Medicaid programs directly contract with providers with a fee-for-service basis approach. Others contract with health plans known as managed care plans to serve members. Under managed care, states pay plans per enrollee, and plans contract and pay health care providers for services delivered. In 2020, almost three-quarters of Medicaid members were in managed care.

For More Information

- **Medicaid providers, delivery systems, and managed care:** "Provider Payment and Delivery Systems," MACPAC Medicaid 101, accessed October 30, 2023.
- **Provider participation in Medicaid:** Tiffany N. Ford and Jamila Michener, "Medicaid Reimbursement Rates Are a Racial Justice Issue," *Advancing Health Equity* (blog), June 15, 2022, The Commonwealth Fund.

- **Medicaid safety net providers:** Sara Rosenbaum, Peter Shin, Jessica Sharac, Caitlin Murphy, Rebecca Morris, Maria Casoni, and Morgan Handley, "Medicaid and Safety-Net Providers: An Essential Health Equity Partnership," *Improving Health Care Quality* (blog), April 6, 2022, The Commonwealth Fund.

FINANCING

Medicaid is financed by both federal and state governments. The main sources of Medicaid funding include the following:

- **Federal medical assistance percentage (FMAP):** Medicaid receives joint funding from states and the federal government. The federal contribution, known as matching funds, ranges from a minimum of 50 percent to a maximum of 83 percent based on state income (e.g., states with lower per capita income receive higher federal matching rates). It can reach 90 to 100 percent for some populations and programs.
- **State matching funds:** States choose funding sources for Medicaid's nonfederal share (e.g., general funds, health care provider taxes). These funds can fluctuate based on state priorities and revenues, affecting access, coverage, and benefits.
- **Disproportionate share hospital (DSH):** DSH payments offer federal financing to hospitals serving many Medicaid and low-income uninsured patients. DSH payments often stabilize "safety net" hospitals' finances.

For More Information

- **FMAP:** "Matching rates," MACPAC, accessed October 30, 2023.
- **State matching funds:** "How Do States Pay for Medicaid?" Peter G. Peterson Foundation, June 2, 2023.
- **DSH**: "Disproportionate share hospital payments," MACPAC, accessed October 30, 2023.

BARRIERS TO ACCESSING MEDICAID COVERAGE

Eligibility and enrollment policies can hinder Medicaid enrollment and continued coverage.

Enrollment Barriers

Enrollment barriers include the following:

- difficulty finding information about Medicaid in plain language and languages other than English
- complex application processes and required documentation, like income or immigration papers
- requests for extra information or action to obtain or keep coverage, like periodically verifying family income
- requirements to qualify for Medicaid, such as participating in job search or job training activities (also known as work requirements)

State Income Limits

States that have expanded Medicaid under the ACA offer coverage for people with incomes up to 138 percent of the federal poverty level, or about $41,400 for a family of four in 2023. Nonexpansion states may set limits as low as 18 percent of the federal poverty level, or about $5,400 a year for the same family size. As of March 2023, 10 states haven't adopted Medicaid expansion, leaving about 1.9 million people without access to affordable health coverage, with around 60 percent from racial and ethnic minority groups.

Federal Immigration Policies

Most lawfully present immigrants who meet Medicaid program requirements, such as income and state residency, can't enroll until they've been in the United States with qualified status for over five years. Anti-immigration policies proposed or enacted by the Trump administration and previous administrations have heightened fears among immigrant families about using public benefits, including Medicaid. Some states allow quicker access for pregnant people and children who are immigrants, and a few states use their funds to cover residents without documentation. All states must provide limited emergency medical coverage to immigrants without documentation, such as for trauma treatment or hospital birth, but complexity or delays in paperwork may leave the patient facing medical bills.

For More Information

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BARRIERS TO ACCESSING QUALITY HEALTH CARE SERVICES IN MEDICAID

State decisions on benefits and provider payments can affect access to health care for Medicaid enrollees.

Covered Benefits

State Medicaid programs must cover mandatory benefits like physician services, prenatal care, and hospitalizations, but optional benefits such as dental services, prescription drugs, and physical therapy might be missing. States can impose measures or limits on covered benefits like prior authorization or asking members to pay a small amount for getting care or filling prescriptions. These policies can delay or make it more difficult for members to access care.

Limited Provider Participation

Finding Medicaid-accepting providers can be hard. Complex processes, low and delayed payments, and bureaucracy deter providers. Access to specialty care services is more difficult than primary care services, partly due to low reimbursement. In states with Medicaid-managed care, enrollees are automatically assigned to a primary care provider if they don't pick one independently, often because of limited access to full culturally and linguistically appropriate information, which can sometimes lead to undesired assignments. Limited primary care access may cause delayed care or reliance on emergency departments, which are not designed to provide ongoing chronic care management.

Outcome-Based Reimbursements

The trend toward paying providers for value or improving health outcomes may discourage providers from accepting Medicaid patients due to their often greater complexity and social risk factors (such as unstable housing or food insecurity), increasing the risk of poor health. Safety net providers may be penalized for serving patients with complex care needs.

Structural Barriers

Medicaid members may have limited access to reliable transportation, sick leave, and paid time off, making it difficult to access health care.

Stigma and Discrimination

Negative rhetoric, biases, and stereotypes about Medicaid enrollees have led to discriminatory behaviors by providers and others, affecting access and outcomes. Medicaid enrollees often feel like "second-class citizens" when receiving health care.

How Health Care Access Barriers Affect Medicaid Patients

A 15-month-old baby with Medicaid coverage is brought to her pediatrician because her parents have noticed she is not doing everything "other 15-month kids are doing." She does not clap, uses only the word "mama," and can cruise but not walk independently. The primary care pediatrician observes developmental delays during assessments and refers the family to the hospital developmental specialist. Unfortunately, there is a six-month waiting period for an appointment, and no other nearby developmental specialists accepting Medicaid patients are available. The delay in accessing specialist care will likely have long-term negative effects on the health and well-being of this baby.

For More Information

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DISPARITIES

Research shows nonwhite Medicaid enrollees face more barriers than white enrollees. Racial and ethnic disparities persist in Medicaid coverage, health care access, service use, preventative and chronic care, maternal and infant health services, quality of care, and spending. Gaps in state data on Medicaid members' race/ethnicity and other demographics limit our understanding of these disparities.

For More Information

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- **Data issues in Medicaid**: "Availability of Race and Ethnicity Data for Medicaid Beneficiaries," MACPAC, 2022.

OVERSIGHT AND ACCOUNTABILITY

The federal government oversees state Medicaid programs. By federal law, Medicaid members have a right to appeal state agency or managed care plan decisions.

Federal

- **Centers for Medicare and Medicaid Services (CMS):** CMS oversees and guides Medicaid programs under the US Department of Health and Human Services. States need CMS-approved plan amendments for Medicaid funding. These amendments detail eligibility, services, and provider payments. CMS must also approve state program changes through a process known as waivers.
- **Government Accountability Office (GAO)**: Dubbed "the investigative arm of Congress" and "the congressional watchdog," GAO aids Congress in improving the performance of federal programs, including Medicaid, by conducting independent research and providing recommendations.
- **The Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC):** MACPAC is a nonpartisan federal partner that analyzes Medicaid and CHIP policies and data, providing updates and recommendations to the federal government on improving the programs.

State

- Each state has an agency that administers its Medicaid program, sometimes with state-specific names (such as Medi-Cal in California). These agencies often contract with other public or private entities for functions like data systems for claims, eligibility, and administrative tasks. Other state and local agencies, such as social services, child welfare, and mental health agencies, often coordinate with Medicaid.

Individuals

- **Medicaid appeals:** States must allow enrollees to appeal enrollment and coverage denials. Appeals procedures vary by state and can be confusing and complex. State and local legal aid organizations offer free or low-cost assistance for Medicaid appeals. Specialized lawyers often influence Medicaid through lawsuits and advocacy.
- **Medicaid ombudsman programs:** Some states have a special office to help members navigate Medicaid and address complaints and issues.

For More Information

- **Medicaid appeals**: MaryBeth Musumeci, 2012, *A Guide to the Medicaid Appeals Process*, Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- **Legal aid**: "Find a Lawyer and Affordable Legal Aid," USA.gov, accessed October 30, 2023.

POLICIES AND ACTIONS THAT COULD LESSEN BARRIERS AND DISPARITIES

It is important to note that health disparities result from entrenched structural racism that affects equitable access to education, employment, health care, housing, and other resources that improve the financial security and well-being of individuals and families. Eliminating health disparities, therefore, requires broader policy, program, and practice shifts beyond the health sector.

Universal health insurance that makes health care free and accessible to everyone could advance health equity. In Medicaid, the following steps could accelerate progress toward equity. They require implementation and evaluation with the goal of eliminating racial and ethnic disparities.

Expanding Access to Medicaid in All States and Territories

- States and territories can expand Medicaid by adopting the ACA's Medicaid expansion and eliminating barriers to enrolling and maintaining Medicaid coverage. This requires collaboration among health stakeholders (providers, consumers, hospitals, and insurers) to support outreach and engagement of eligible individuals and sustained federal funding to cover expanded populations at higher matching rates. An estimated 3.5 million people would gain access to Medicaid coverage if all states expanded Medicaid. Without states adopting the ACA's Medicaid expansion, the federal government could offer coverage options for 1.9 million people earning too little to qualify for Marketplace subsidies but ineligible for Medicaid coverage due to nonexpansion.
- All states could provide 12 months of postpartum coverage for pregnant and parenting people who would otherwise lose Medicaid 60 days after birth. About one in four uninsured women during the postpartum period would likely gain coverage and improved access to health care services.
- All states could opt for Medicaid access for lawfully residing immigrants without a five-year waiting period. States that expanded Medicaid coverage for immigrants saw reduced uninsurance rates, increased use of health care services, and improved health outcomes of immigrant populations.

Improving Access to High-Quality and Equitable Care

Improved access to health care could be achieved by raising Medicaid reimbursement rates and lessening the administrative burden for primary and specialty care providers, including the following:

- improving federal oversight of Medicaid requirements to ensure adequate provider participation and monitoring and reporting access to primary care, behavioral health, dental services, and other specialist care by members' race, ethnicity, language, geographic location, and other characteristics
- developing provider payment models that support and incentivize high-quality, coordinated, culturally effective, unbiased care that considers patients' social factors affecting health outcomes and allows flexibility to collaborate with social service organizations to address patients' unmet social needs

Improving Medicaid Administration and Operations

Medicaid operations could be improved by providing federal funding and technical assistance to states to improve data systems and effective policy development, including the following:

- holding Medicaid programs accountable for using members' demographic data (such as race, ethnicity, and language) to identify and eliminate health disparities in their programs
- revamping, diversifying, and empowering Medicaid advisory committees and patient advisory boards to meaningfully engage Medicaid members in program and policy development

For More Information

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GLOSSARY

Accountability is an assurance that an individual or organization is evaluated on its performance or behavior related to something for which it is responsible.

The **Affordable Care Act (ACA)** is a comprehensive health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, or "Obamacare"). The primary goals of the ACA are to make health insurance more affordable by providing financial assistance (also known as subsidies) to people to purchase health insurance and expand the Medicaid program to cover more people with low incomes.

An **appeal** is a request to a health insurer to review a decision that denies a benefit or payment for health care services or medications.

The **federal poverty level** is a measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance and Medicaid and CHIP coverage.

Federal subsidies are cash assistance available to purchase health coverage at reduced or no cost for people with incomes below certain levels. Marketplace insurance plans with premium tax credits are sometimes known as subsidized coverage.

Health disparities are preventable differences in disease, health status, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities.

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

Marketplace is a shopping and enrollment service for medical insurance created by the ACA in 2010. In some states, the federal government runs the Marketplace (sometimes called the "exchange") for individuals and families.

Quality measures are tools that help assess or quantify health care processes, outcomes, patient experiences, and organizational structures and/or systems associated with providing high-quality health care.

AUTHORS' NOTE

This guide was revised December 29, 2023. "Advocates'" was removed from the title to indicate that the audience for this work extends beyond advocates. Similarly, "advocates" was deleted or modified in the "About the Guide" section on page 1. In addition, the final item in the "For More Information" box on page 8 was deleted because it was irrelevant.

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