Chapter 6:

Medicaid's Role in Advancing Health Equity

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Key Points

- Medicaid can and should play an active role in advancing health equity, in particular addressing racial disparities in health care and health outcomes. More than half of all adults enrolled in Medicaid and more than two-thirds of children enrolled in Medicaid and the State Children's Health Insurance Program (CHIP) identify as Black, Hispanic, Asian American and Pacific Islander, American Indian and Alaska Native, or multiracial.

- Disparities in access and outcomes among Medicaid beneficiaries of color are the product of decades-long inequities, stemming from structural racism and explicit and implicit bias in health care delivery, and will require sustained institutional changes to overcome.

- There is also the need to address inequities and disparities experienced by Medicaid beneficiaries who are too often marginalized for other reasons. These include, for example, their age, disability status, sex, gender identity, sexual orientation, and geography as well as the intersection of these identities with race and ethnicity.

- While Medicaid alone cannot remedy societal health inequities, changes in its policies and processes have the potential to reduce disparities and inequities in access, outcomes, and the experience of care for its beneficiaries. The Centers for Medicare & Medicaid Services has committed to advancing racial health equity with the goal to improve measurement of health disparities for a core set of metrics and ultimately close the disparities in access, quality, and outcomes.

- States are taking a variety of approaches in their actions to address health equity. These include the following:

  - improving the collection and reporting of race and ethnicity data to ensure greater consistency, granularity, and completeness;

  - building and sustaining leadership and infrastructure within the state Medicaid agency to prioritize health equity;

  - engaging beneficiaries in the design, implementation, and assessment of policies;

  - examining application and renewal processes to reduce systemic barriers that prevent beneficiaries of color from gaining and keeping coverage;

  - using delivery system levers, including managed care contracting, payment approaches, and quality strategies, to address inequities and reduce gaps in access and outcomes; and

  - developing a workforce that is representative of the beneficiaries it serves and also provides care with cultural competence.

- The Commission has committed to embedding a health equity lens across all its work. The Commission will continue to examine federal and state efforts in Medicaid and CHIP to promote equity and address racial disparities in health care and health outcomes.

CHAPTER 6: Medicaid's Role in Advancing Health Equity

Medicaid can and should play an active role in advancing health equity, in particular addressing racial disparities in health care and health outcomes. More than 57 percent of adults enrolled in Medicaid and more than 67 percent of children enrolled in Medicaid and the State Children's Health Insurance Program (CHIP) identify as American Indian and Alaska Native (AIAN), Asian American and Pacific Islander (AAPI), Black, Hispanic, or multiracial (MACPAC 2022a).[1]

Health disparities have long existed between Medicaid beneficiaries of color and their white counterparts. In the historic 1985 *Report of the Secretary's Task Force on Black & Minority Health*, then Secretary of the U.S. Department of Health and Human Services (HHS) Margaret Heckler noted that since the beginning of federal record keeping, "there was a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation's population as a whole," and she called for efforts across the federal health department to reduce these gaps. Though the report did not focus specifically on Medicaid, it acknowledged the program's role in providing health insurance coverage to low-income individuals of color and its potential to help address certain disparities (HHS 1985). Since then, HHS and the Centers for Medicare & Medicaid Services (CMS) have continued their work to identify and reduce racial and ethnic health disparities, including among Medicaid beneficiaries. In 2020, the COVID-19 pandemic and racial justice protests underscored the importance of this work and created a new sense of urgency to address inequities in health care systems, programs, and policies, including Medicaid.

Medicaid alone cannot remedy societal health inequities or their causes, but its policies can be leveraged to reduce disparities and inequities in access to care, health care experiences, and health outcomes among the people it serves. Disparities in access to care and health outcomes among Medicaid beneficiaries of color are the product of decades-long inequities, stemming from structural racism and explicit and implicit bias in health care delivery, and will require sustained institutional changes to overcome. Correcting these inequities through Medicaid will require intentional efforts involving beneficiaries, federal agencies, states, managed care organizations (MCOs), providers, and other stakeholders all at the table to identify policy levers, change program policy and operations, evaluate progress, and make needed course corrections.

Action is needed at both the federal and state levels to address longstanding disparities and set priorities for health equity. At the federal level, HHS and CMS have made commitments to these efforts, but specific action steps are still under development. State Medicaid programs have also shared their intentions and initial steps to promote health equity, and many are examining their programs and policies to better serve beneficiaries of color.

MACPAC has committed to examining how it can best contribute to combating structural racism and addressing racial disparities in health care and health outcomes by embedding a health equity lens across all of its work. Over the past two years, the Commission recommended extending postpartum coverage from 60 days to a full year to address the unacceptably high rates of maternal morbidity and mortality, changing estate recovery policies to mitigate their disparate effects on the most vulnerable, and strengthening the role of Medicaid in serving both child and adult beneficiaries with behavioral health needs (MACPAC 2021a, 2021b, 2021c, 2020a). We have also expanded our analyses of disparities in access and barriers to care for beneficiaries of color in other publications, including our *Access in Brief* series (MACPAC 2022b).

This chapter focuses on advancing health equity on the basis of race and ethnicity. It represents the Commission's most substantial statement to

date on how Medicaid policy can be reshaped to focus on health equity. It draws from the research literature; interviews with consumer advocacy groups, state officials, researchers, and other stakeholders; and the Commission's discussions to describe opportunities to promote racial and ethnic health equity in Medicaid.

We recognize the need to address inequities and disparities experienced by beneficiaries who are too often marginalized for other reasons, such as their age, disability, sex, gender identity, sexual orientation, and geography. For example, rural residents have worse health outcomes and higher death rates than their urban counterparts. Individuals living in rural areas report poorer physical and mental health and have higher rates of smoking, obesity, and physical inactivity (MACPAC 2021d). Children and youth with special health care needs are more likely to have Medicaid coverage, yet compared with those with private coverage in 2016, children and youth with special health needs were less likely to have had a medical or dental visit in the past 12 months (MACPAC 2018). MACPAC is currently analyzing some of these populations and plans to share this work in future reports to Congress and other publications.

The chapter begins with an overview of key concepts related to health equity. Next, we describe the demographics of Medicaid beneficiaries of color and the disparities in access and outcomes they face. Turning to policy, the chapter then discusses the current and past efforts at the federal level to address health equity, followed by a section outlining some key areas for Medicaid policy development to advance health equity. These include the following:

- collection and reporting of race and ethnicity data;

- the role of state leadership in prioritizing a health equity agenda;

- beneficiary engagement in the policymaking process;

- enrollment, redetermination, and renewal processes;

- delivery system levers, including managed care contracting, payment approaches, and quality strategies; and

- development of a diverse and culturally competent workforce.

The chapter concludes with the next steps for MACPAC's health equity-focused work.

Key Concepts

Before describing past policy initiatives and future opportunities, we define several key concepts frequently used in discussions of health equity.

Health equity

Health equity is commonly defined as a concept in which "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care" (Braveman et al. 2017). It is important to note: "equity" and "equality" are often incorrectly used interchangeably. Equality means that everyone is given the same resources or opportunities, whereas equity acknowledges the differences in individual circumstances and allocates resources with the ultimate goal of having equal outcomes (Braveman et al. 2017). Medicaid health equity efforts focus on improving health care for Medicaid beneficiaries from historically marginalized groups.

Structural versus interpersonal racism

Structural racism is defined as "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing,

education, employment, health care, and criminal justice" (Bailey et al. 2017). Structural racism is expressed as a set of institutional, multifaceted, and systemic laws and policies that has cascading effects across institutions. These laws and policies result in more favorable outcomes for white communities and disadvantage communities of color. Race has been a central factor in shaping the policies, discourse, design, and implementation of the Medicaid program and shaping the public perceptions of it (Michener 2022).

Interpersonal racism, by contrast, is seen in biases and discriminatory behaviors of individuals. It may be overt or implicit bias, the latter being defined as "unconscious or unacknowledged preferences that can affect a person's beliefs or behaviors, and in particular, an unconscious favoritism toward or prejudice against people of a certain race, gender, or group that influences one's own actions or perceptions" (O'Kane et al. 2021). In a Medicaid context, interpersonal racism may affect the experiences of Medicaid beneficiaries at enrollment and renewal, in accessing care, and while interacting with the overall health care system (Nguyen et al. 2022).

Health disparities versus inequities

The Centers for Disease Control and Prevention identifies health disparities as "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (CDC 2020a). Such disparities may result from implicit and explicit bias on the part of providers, lower concentration of providers and health care facilities in neighborhoods where people of color reside, transportation barriers, lack of provider willingness to accept Medicaid patients, and lack of culturally competent care or outreach strategies, including insufficient interpretation and translation services for those with limited English proficiency (ASPE 2022, 2021a, 2021b, 2021c). Complete and accurate data can both identify and shed light on disparities in care and outcomes

between Medicaid beneficiaries of color and their white counterparts, across different subgroups, and between those covered by Medicaid and other sources of insurance.

Although the term "health disparities" focuses on differences between groups, a focus on health inequities concentrates on identifying and addressing the root causes of these unjust differences, such as structural racism in the health care system (Everette 2021). An analysis of use of non-emergency transportation might first look to see whether there are differences in use between white and Black beneficiaries. If found, policy solutions might consider how the historical segregation of Black neighborhoods and resulting lack of public transportation affects the ability of beneficiaries living in those neighborhoods to access the care they need (Everette 2021).

Intersectionality

Intersectionality, a term coined by legal scholar Kimberlé Crenshaw, describes how race, socioeconomic status, age, gender identity, and other individual characteristics intersect and overlap (Crenshaw 1989). Other characteristics include sexual orientation, disability status, and geographic residence. Intersectionality provides a framework for considering how Medicaid beneficiaries who have multiple identities experience the health care system differently, including having worse health outcomes, compared with those who do not share similar identities or have not been affected by systems of oppression (e.g., racism, sexism). For example, higher rates of COVID-19-related morbidity and mortality among Black and Hispanic individuals may occur because they are more likely to be essential workers in lower-paying jobs that cannot be done from home. Once infected, they are also more likely to encounter unequal treatment from providers due to implicit bias compared with white individuals (CDC 2021a). Adults with disabilities from underserved racial and ethnic groups are more likely to report having poorer health outcomes generally, compared with people without disabilities

in the same racial and ethnic groups and with white, non-Hispanic people with disabilities (Magana et al. 2016, Gulley et al. 2014, CDC 2008).

Social determinants of health

Discussion of health equity and the effects of structural racism often turn to the social determinants of health (SDOH), defined as "the conditions in the places where people live, learn, work, and play that affect health and quality of life" (CDC 2021b).[2] They include, for example, a person's economic stability, level of education, housing status, and physical and social environment (CDC 2021b). Due to unjust laws and policies as the result of structural racism, people of color are more likely to live in impoverished communities with degraded environmental conditions and lack of healthy food options, work in low-wage occupations that do not offer employer-sponsored health insurance, and be predisposed to poorer health outcomes. Medicaid predominantly serves low-income people of color, often with high levels of health-related social needs (Yearby et al. 2022). It is important to note that health-related social needs are of concern for all Medicaid beneficiaries, who, by definition, have low incomes and are more likely to live in communities with substandard housing and experience other challenges to health.

Disparities among Medicaid Beneficiaries

More than half of the adults and two-thirds of children enrolled in Medicaid and CHIP are individuals of color. In 2019, adult Medicaid beneficiaries were more likely than the total adult population of the United States to identify as Hispanic (23.1 percent compared with 18.5 percent, respectively) or Black, non-Hispanic (22.5 percent compared with 12.4 percent, respectively). Similarly, in 2019, a disproportionate percentage of child beneficiaries identified as Hispanic compared with the total U.S. child population (37.5 percent compared with 25.6 percent, respectively) or Black,

non-Hispanic (20.8 percent compared with 12.7 percent, respectively) (MACPAC 2022a).[3]

In 2020, most of the 7 million adults and children who were uninsured but eligible for Medicaid and CHIP were people of color: 40 percent were Hispanic and 16 percent were Black, non-Hispanic (Orgera et al. 2021).[4] In addition, many non-elderly adults of color remain uninsured because they live in states that have not expanded Medicaid coverage to the new adult group; this includes 1,338,400 who are Hispanic, 957,000 who are Black, and 173,000 who are AIAN individuals (ASPE 2022, 2021a, 2021b).[5] Black people are more than twice as likely as those who are white or Hispanic to fall into the coverage gap (Cross-Call 2020).

Having Medicaid coverage improves access to screening and preventive care, permits earlier diagnosis of chronic conditions, and improves mental health outcomes (MACPAC 2021e). However, disparities in health outcomes and access between beneficiaries of color and their white counterparts remain. For example, although Medicaid coverage decreases maternal mortality for Black women, they are 79 percent more likely to experience severe maternal morbidity and mortality than their white counterparts. AIAN, AAPI, and Hispanic pregnant women also have increased odds of having such poor outcomes compared with white women (MACPAC 2020b).[6] In 2020, Medicaid beneficiaries who identified as Black, Hispanic, and Asian American experienced higher rates of infection, hospitalization, and death due to COVID-19 compared with those who are white (Thielke et al. 2021). Moreover, one study of Medicaid beneficiaries enrolled in managed care found that Black, Hispanic, and AAPI beneficiaries report having worse patient experiences than white beneficiaries (Nguyen et al. 2022). Disparities persist for children of color as well; one study found that they were less likely to have reported good health outcomes, less likely to have had a usual source of care, and more likely to have delayed or forgone care compared with white children (CAHMI 2014).

There are also racial disparities in use of services. A prior MACPAC analysis found that from 2015 to 2018, Hispanic adults were significantly more likely to report unmet or delayed care due to cost than white adults. Black and Hispanic Medicaid beneficiaries were less likely than white beneficiaries to have received primary care or mental health care in the prior 12-month period. Hispanic and AIAN children were significantly less likely than white children to have had a well-child checkup in the past 12 months. Health screening rates among adult Medicaid beneficiaries also differed by race and ethnicity. For example, beneficiaries who identified as Asian American, Black, or Hispanic were less likely to have ever had a colonoscopy or receive a cervical cancer screening test in the last three years (MACPAC 2022b).

Federal Health Equity Actions

For more than three decades, federal health agencies have focused on reducing health disparities, with the more recent goal of advancing racial health equity (Box 6-1). In 2021, HHS and CMS renewed their commitment to advancing racial health equity, although specific Medicaid efforts remain nascent. Broad HHS activities include, for example, the creation of a COVID-19 health equity task force, under the auspices of the HHS Office of Minority Health. This task force made recommendations that, if enacted, could benefit Medicaid beneficiaries of color, such as by ensuring the continuity of Medicaid coverage after release from incarceration, reducing the closure of health care facilities that primarily serve Medicaid beneficiaries, and assessing payment parity for behavioral health providers (OMH 2021).

In November 2021, CMS announced a strategic vision to apply a health equity lens across all of its programs to achieve equitable outcomes through high-quality, affordable, person-centered care (Brooks-LaSure and Tsai 2021). For example, the Center for Medicare and Medicaid Innovation (CMMI) announced it will embed equity in its work by including models with more providers serving populations that have low and moderate income, are racially diverse, and are from rural regions. CMMI will also focus on increasing the number of beneficiaries from underserved communities who receive care through value-based payment models (Brooks-LaSure et al. 2021). To inform these new activities, CMMI will use key learnings from the Accountable Health Communities Model, which tested different approaches for meeting the health-related social needs of Medicare and Medicaid beneficiaries, such as screening, referral, and community navigation services (CMS 2022a).[7]

CMS leadership has also committed to a strategic plan based on six pillars; the first pillar is advancing health equity and addressing the underlying issues that result in health disparities. This will be accomplished by working with states to improve measurement of health disparities for a core set of metrics and closing the gap in disparities in access, quality, and outcomes (Brooks-LaSure and Tsai 2021). In April 2022, CMS released its framework for health equity, which outlines five priorities for the agency's efforts over the next decade to achieve health equity and eliminate disparities:

- expand the collection, reporting, and analysis of standardized data;

- assess causes of disparities within CMS programs and address inequities in policies and operations to close gaps;

- build capacity of health care organizations and the workforce to reduce health and health care disparities;

- advance language access, health literacy, and the provision of culturally tailored services; and

- increase all forms of accessibility to health care services and coverage (CMS 2022b).

The CMS Office of Minority Health is examining policies and programs to mitigate unintended consequences that affect underserved

communities and the safety-net providers who serve them. The CMS Office of Minority Health has convened an advisory council on equity with leaders from across the agency, including the Center for Medicaid and CHIP Services (CMCS) and Medicare-Medicaid Coordination Office, to operationalize equity priorities across all programs and policies. It developed a technical assistance program for states and organizations working to advance health equity (CMS 2021a). The CMS Office of Minority Health is also partnering with CMCS to conduct an equity assessment pilot on quality of care in the postpartum period among pregnant women covered by Medicaid and CHIP (CMS 2021b).

CMCS has identified three key priority areas for Medicaid and CHIP.

- improve measurement of racial and ethnic disparities to uncover inequities;

- identify promising practices for expanding access to coverage and care for historically marginalized populations; and

- address SDOH (CMS 2022b).

CMCS has also identified objectives for quality improvement initiatives focused on underserved Medicaid beneficiaries. These objectives are to:

- disseminate information about promising practices in reducing health disparities in Medicaid and CHIP to public and private stakeholders, state partners, community-based organizations, and underserved communities;

- identify vulnerabilities and areas of opportunity in Medicaid and CHIP for quality improvement and reducing health disparities among enrollees; and

- identify and collaborate with states and external organizations to develop partnerships to reduce health disparities in Medicaid and CHIP (CMS 2021c).[8]

CMCS has also issued guidance to state Medicaid programs on ways to adopt strategies that address SDOH, including through Section 1115 demonstrations (CMS 2021d). At the end of 2021, CMS approved the California Medicaid's combined Section 1115 demonstration and Section 1915(b) waiver that will help address beneficiaries' health-related social needs and strengthen access to care (CMS 2021e).[9] CMS has also set priorities for outreach to communities of color in its most recent outreach and enrollment grant opportunity (CMS 2022c). Specifically, the notice encouraged states and other applicants for outreach and enrollment grants to consider strategies that bridge racial and demographic coverage disparities.[10] In addition, CMS encourages outreach strategies that use parent mentors and community health workers (CMS 2022c).[11]

CMCS has noted key actions it has taken to address health equity thus far. CMCS is encouraging all states to adopt the option to extend postpartum coverage to 12 months.[12] It is considering how to make investments in key populations with especially large disparities in health outcomes, such as individuals involved in the justice system and individuals experiencing housing instability. For example, it is working with states to identify ways to connect justice-involved individuals with community-based services upon release. CMCS has also made changes to policies that it views as creating additional barriers to access to coverage and care and has been working to implement the home- and community-based services provisions of the American Rescue Plan Act (P.L. 117-2) (CMS 2022d).

The Commission is encouraged by the commitment of CMS to set priorities for health equity. We look forward to learning about the specific actions that will be taken and how CMS will set expectations and create opportunities for states to be full partners in this work. We encourage the agency to obtain input from states, beneficiaries, and other stakeholders as its work moves forward. MACPAC will continue to monitor the release of more targeted guidance from CMS to states, especially around Section 1115 demonstrations.

BOX 6-1. Prior Federal Efforts to Address Health Disparities

Medicaid's history is intimately connected to changes in federal policy to provide equal rights and equal treatment for people of color. Because the 1964 Civil Rights Act barred discrimination on the basis of race in programs receiving federal funding, the creation of Medicaid (and Medicare) in 1965 led to desegregation of hospitals and nursing homes (Barton Smith et al. 2007).

Since then, federal agencies have focused on racial and ethnic disparities at various times. For example, after the 1985 *Report of the Secretary's Task Force on Black & Minority Health*, the first federal report focused on the health of racial and ethnic minority groups, the U.S. Department of Health and Human Services (HHS) established the Office of Minority Health (HHS 1985). Over time, HHS agencies, including the Centers for Medicare & Medicaid Services (CMS), created their own offices of minority health.

Federal government efforts intensified in the 1990s, when goals were established to eliminate racial and ethnic disparities in infant mortality, diabetes, cancer screening and management, heart disease, and immunization by 2010 (Brooks 1998). In 2000, the HHS Office of Minority Health released national standards for culturally and linguistically appropriate services, and efforts were taken to improve services provided by federal agencies for individuals with limited English proficiency; these are still in use by the Medicaid program (OMH 2000, DOJ 2000). In 2003, the Agency for Healthcare Research and Quality released the first of what is now known as the National Healthcare Quality and Disparities Report, which measures trends in effectiveness of care, patient safety, timeliness of care, patient centeredness, and efficiency of care (HHS 2022). Further emphasis on eliminating disparities was reflected in Healthy People 2010, the decennial effort to set goals for improving the nation's health and well-being. Subsequently, Healthy People 2020 and 2030 also included explicit goals to eliminate health disparities and achieve health equity (CDC 2020b).

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) increased the number of people of color eligible for Medicaid. Under Section 4302 of the ACA, HHS issued implementation guidance on data collection standards for race and ethnicity (HHS 2011). In 2011, HHS also released an action plan to reduce racial and ethnic health disparities with four key priorities to:

- assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities;

- increase the availability, quality, and use of data to improve the health of minority populations;

- measure and provide incentives for better health care quality for minority populations; and

- monitor and evaluate the department's success in implementing the plan (ASPE 2015).

Specific Medicaid goals and actions included improving language access for applicants with limited English proficiency or low literacy and implementation of targeted asthma initiatives (ASPE 2015).

In addition, through the Health Equity Technical Assistance program, CMS has assisted state Medicaid agencies, health plans, providers, health systems, and others on matters such as approaches to achieve health equity among the individuals their programs serve and how to assess the effect of their programs on disparities (CMS 2021a).

Opportunities for Medicaid Action

There are multiple opportunities for state Medicaid programs to advance racial health equity. States are taking different approaches in the actions they will take to address equity, the expectations and accountability for state staff and contractors in participating in such activities, and the resources they are devoting to these efforts. The following sections highlight some current state activities and point out opportunities for others. We also note where CMS and others could provide additional support or direction.

Data collection and reporting

The Commission has discussed the need for improvements in collection and reporting of data on race and ethnicity to ensure greater consistency, granularity, and completeness. Improved data collection and reporting is foundational to the ability of CMS, states, and MCOs to identify disparities and priority areas for equity efforts.[13] This includes data collected by states at application and renewal and data collected as part of federal household surveys.[14] Both data sources are important for assessing racial disparities, and each has benefits and limitations when assessing use of services by and care experiences of Medicaid and CHIP beneficiaries. Administrative data can be used to analyze use of services but cannot capture unmet need or care experience. Federal household surveys can be helpful in examining different aspects of health care use and experiences, but none supports comprehensive federal or state-level analyses of coverage and access by race and ethnicity (Johnson et al. 2010). Additionally, the survey sample size for many racial and ethnic groups from federal surveys are often too small to provide reliable estimates. Poor data quality and limited collection of data at the subgroup level can lead to aggregating data as one race or ethnicity, which can obscure variation in access to care, health status, and health outcomes (Nguyen 2022).

The quality of Medicaid data on the race and ethnicity of its beneficiaries varies by state. MACPAC has assessed data available in the Transformed Medicaid Statistical Information System (T-MSIS) in terms of its completeness and validity. Consistent with problems reported in CMS's Data Quality (DQ) Atlas, our assessment found that 9 states had data of low concern, 21 states had data of medium concern, 17 states had data of high concern, and 4 states had unusable data. In total, only 30 states (those with low and medium data quality concerns) meet the minimum data quality standards necessary for conducting analyses with race and ethnicity data.[15] When comparing T-MSIS data to external benchmarks, such as the American Community Survey, MACPAC analysis found that data reported on T-MSIS are not always consistent with other data sources, raising concerns about validity (MACPAC 2022c).[16]

Poor quality or missing race and ethnicity data in T-MSIS may reflect difficulties in how states transform data when reporting to CMS, but they may also reflect inconsistencies or lack of attention to these data elements at the time of application. In 2021, the State Health Access Data Assistance Center reviewed how 33 states are collecting data on race and ethnicity from paper and online Medicaid applications. They found that many states used inconsistent race and ethnicity categories on their paper and online applications.[17] Although providing write-in responses and allowing applicants to select multiple races and ethnicities can improve accuracy, use of these methods is inconsistent across states and between paper and online applications.[18]

It is also important to note that those applying for or renewing their Medicaid coverage cannot be required to report their race and ethnicity, as this is not a condition of eligibility. People of color may hesitate to report this information because they do not understand why they are asked to provide it or how the data will be used. They may also have concerns about privacy and potential discrimination (James et al. 2021, Shimasaki

2013, AHIP 2004).[19] State instructions and explanations for collecting this information vary considerably, although there are known strategies for improving response rates.

Although insufficient and inaccurate data make it difficult to assess disparities, develop appropriate interventions, and monitor progress, the absence of complete data should not prevent the work of promoting equity and reducing disparities from progressing. The Commission has urged CMS to place a higher priority on these fields in its data validation activities and support states in gathering these data. This includes providing technical assistance to states on proven methods that both improve data collection and build trust with beneficiaries regarding the use of such data (MACPAC 2021f). As noted previously, CMS recently announced that it plans to issue revised guidance on how to improve the quality and completeness of data collection as well as guidance to improve measurement of health disparities across a core set of stratified metrics (CMS 2022b).

In the year ahead, the Commission will examine steps that CMS and states can take to improve the collection of race and ethnicity data from Medicaid beneficiaries to ensure greater completeness of these data. This work will also explore beneficiary experience in reporting these data to understand concerns and barriers.

Leadership and infrastructure

State-level leadership and infrastructure are critical to the success of Medicaid health equity activities. In some states, this leadership is coming from the top with governors declaring racism a public health crisis and directing all state agencies to assess policies and actions from a racial equity lens (APHA 2021).[20] In other states, leadership and commitments have been initiated by the secretary of health and human services or the Medicaid director. Such leadership makes a statement that this work is a priority and provides authority for agency staff to engage in (and be held accountable for) equity work.

Some states have established infrastructure to support their health equity work, designating a health equity advisor and developing health equity plans with medium- and long-term strategies and actions to reduce health disparities. Some states are designating a dedicated Medicaid health equity official, who is tasked with coordinating and leading efforts that ensure equity is embedded in all policies and practices across the Medicaid agency.[21] In some states, equity plans apply statewide or at the department level, and in others, there is a specific Medicaid equity plan (Box 6-2). The content of these plans varies.[22] Initiatives often focus on maternal health, such as extending Medicaid postpartum coverage or providing coverage of doula services. States also describe plans to improve collection of race and ethnicity data.

BOX 6-2. State Spotlight: Louisiana

The Louisiana Medicaid health equity plan is a component of the equity initiative of the Louisiana Department of Health (LDH). The LDH Office of Community Partnerships and Health Equity leads this work. All LDH agencies, including Medicaid, have a health equity action team (HEAT), which reports to LDH leadership. The role of the HEAT is to create a Medicaid-specific repository of health equity-related data and conduct a needs assessment for vulnerable populations. This information will be used to inform future policy (LDH 2020). The HEAT developed a tool that helps staff systematically review existing and new agency policies with a health equity lens. For example, the tool includes a checklist that staff can use to assess whether the language used in a policy is person centered. The staff leader of the Medicaid HEAT reports progress on the equity initiatives to the Medicaid director, who in turn reports to departmental leadership.

States are also looking internally at agency processes and taking steps to equip staff to engage in equity initiatives. For example, the Illinois Department of Health developed a health equity checklist for all state officials to integrate equity-based principles in the design and implementation of programs (Thoumi et al. 2021). Some Medicaid agencies are facilitating implicit bias and antiracist trainings for all staff members to be more aware of how privilege and prejudices can manifest in their work (Everette 2021). In addition to such training for all staff, some states are working to ensure the Medicaid agency workforce is diverse and representative of the populations it serves.

States may face several challenges in their work to set priorities for health equity in Medicaid. Staff may have taken on these initiatives without additional resources. Moreover, changing political landscapes and policy priorities, as well as budgetary constraints, create uncertainty for the longevity of equity initiatives.

Beneficiary engagement strategies

Medicaid beneficiaries are often left out of discussions of the policies that affect their health and coverage (Coburn et al. 2021). Beneficiaries have much to offer in the development of policies and can also provide valuable feedback on how well the policies and programs are serving them as well as areas for improvement. Beneficiary engagement strategies can help build trust between the community and the state Medicaid agency and promote accountability to beneficiaries. But this work must be sustained over time to do so (Chomilo 2022).

Efforts to improve beneficiary participation should be mindful of historic mistrust of health care systems and the factors that affect beneficiaries' ability to provide feedback. Lack of trust and uncertainty as to whether feedback will be heard may discourage beneficiaries from sharing their views (Musa et al. 2009). Tailoring engagements to smaller groups with common backgrounds may help participants feel more comfortable sharing

their experiences with state Medicaid program and plan officials. For example, after acknowledging the current and historical structural racism that contributes to racial health disparities in Minnesota, the state's Medicaid program specifically engaged U.S.-born Black beneficiaries to identify policy priorities and administrative changes that could improve racial equity. Meeting participants informed and guided a Medicaid agency report, recommending specific changes and actions to advance racial health equity. The state is now examining how to integrate voices from the U.S.-born Black community into routine policy, budget, and administrative activities (Chomilo 2022).[23]

Although all state Medicaid programs are required to have a medical care advisory committee (MCAC) to provide input on state policies and practices, the power dynamics and structure of such committees may affect beneficiary engagement (§ 1902(a)(4) of the Social Security Act, 42 CFR 431.12). MCACs must include (at a minimum) board-certified physicians and other health professionals who are familiar with the medical needs of low-income population groups, Medicaid beneficiaries and members of other consumer organizations, and the director of the public welfare department or the public health department (42 CFR 431.12(d)).[24] Given the makeup of these boards and the use of jargon that can occur at the meetings, many advocates note that beneficiaries report that these meetings can feel tokenizing and intimidating. Some states are coordinating with community-based organizations that can provide beneficiary representatives with technical support and preparation that enables them to feel more confident participating (Allen et al. 2021). Others are convening members-only advisory councils to make the engagement opportunities more accessible. For example, Colorado Medicaid has created member experience advisory councils that consist of members, their families, and caregivers to advise on what is working and what is not in the state's Medicaid program (HCPF 2022). Arkansas Medicaid is also developing a members-only beneficiary advisory council (AR DHS 2021).

Beneficiaries may face logistical barriers, such as the inability to take time off work, secure transportation, and procure child care, that limit their participation in advisory councils. For MCACs specifically, states must make financial arrangements, if necessary, to support beneficiary participation, but federal rules do not specify the type of expenses that can be reimbursed (42 CFR 431.12(f)).[25] State Medicaid agencies are also beginning to host more virtual advisory council meetings to eliminate transportation barriers and provide interpretation services to facilitate participation by those with limited English proficiency (Coburn et al. 2021). Other strategies to increase participation include hosting advisory council meetings outside of traditional work hours, providing food, or providing transportation to and from the meeting (Allen et al. 2021).

Given that managed care is now the predominant delivery system in Medicaid, MCOs can play a role in engaging beneficiaries in program design and implementation. States may require MCOs to have member advisory committees (Bailit Health 2022). For example, Oregon's Medicaid beneficiaries are enrolled in coordinated care organizations; each organization must have at least one community advisory council, and more than half of the council's voting members must be Medicaid enrollees (OEI OHA 2022). Medicaid officials can attend MCO beneficiary meetings to engage directly with beneficiaries. States can also solicit feedback from beneficiary surveys and promote transparency by publishing reports and seeking input on report findings.

Given the importance of and challenges in beneficiary engagement, we hope to learn more about current state practices for engaging beneficiaries of color (e.g., via advisory committees), including their accessibility, opportunities to promote greater participation, and the manner in which beneficiary input is being incorporated into program policies and operations.

Enrollment, redetermination, and renewal processes

Some states are examining enrollment and renewal processes to identify opportunities to reduce systemic barriers that prevent beneficiaries of color from gaining and keeping coverage. MACPAC's analysis of churn and continuous coverage in 26 states with reliable race and ethnicity data found that Black and Hispanic beneficiaries were more likely than white beneficiaries to disenroll and reenroll within 12 months. However, white beneficiaries were slightly more likely to be enrolled for fewer than 12 months (MACPAC 2021g).

Beneficiaries of color may be at greater risk of disruptions in coverage, particularly as states look to the return of routine redeterminations and renewals once the COVID-19 public health emergency (PHE) ends. Given that states could not disenroll beneficiaries, except in extremely limited circumstances, during the PHE if they accepted the 6.2 percentage point increase in federal match, the need to redetermine all beneficiaries once the PHE ends creates a high risk of disenrollment for procedural reasons (Boozang and Striar 2021).

Some states are taking steps to reduce systemic barriers at application and renewal. For example, in response to feedback from Black beneficiaries about the complexity of these processes, Minnesota Medicaid is exploring how to make renewal materials more easily accessible electronically and considering options for partnering with navigators and the community to ensure eligible Black Minnesotans gain and maintain Medicaid coverage. The state hopes to implement any such changes in time for the resumption of routine renewals (Chomilo 2022). In February 2022, Oregon applied for a Section 1115 demonstration waiver that requests federal match to provide continuous enrollment for children until their sixth birthday and then establish two-year continuous eligibility for children older than age six and adults to preserve the coverage gains during the PHE (OHA 2022).

MACPAC is concerned about the potential for disruption in coverage and care when the PHE ends, given the unprecedented volume of redeterminations. CMS's recent guidance and tools describe strategies states can use to mitigate these effects, such as adopting the state plan option to provide 12-month continuous eligibility, using sample social media messages to increase beneficiary awareness of actions they will need to take to maintain coverage, and partnering with MCOs to obtain updated beneficiary contact information (CMS 2022e, 2022f, 2022g). Moreover, it will be important for CMS and states to consider how to mitigate the effects on people of color, including, for example, by supporting beneficiaries with limited English proficiency and working with trusted community-based organizations.

Delivery system levers

Delivery system levers to advance health equity and address disparities in care and outcomes include embedding health equity requirements in managed care contracts, leveraging payment methodologies, and setting priorities for equity in quality initiatives.

Managed care contract requirements. Many state Medicaid programs require MCOs to address inequities and reduce gaps in access and outcomes, but the required activities vary and practices are evolving. One study of managed care contracts in 20 states found that most include definitions of health equity or health disparities and require MCOs to collect member race, ethnicity, and language data and stratify quality measures by those same demographics (Bailit Health 2022). For example, Michigan and Minnesota have required MCOs to collect such data for nearly a decade (MI DHHS 2021, MN DHS 2021).

Others require MCOs to develop health equity plans. For example, MCOs in North Carolina must develop a member engagement plan that engages historically marginalized populations and describes how they will incorporate health equity into external and internal policies and procedures (NC

DHHS 2021a). Louisiana's request for proposals for MCO reprocurement states that MCOs should have a health equity plan that is specifically tailored to address the cultural, socioeconomic, racial, and regional disparities that their beneficiaries face (LDH 2021).

Some states require MCOs to take steps to address some of the social determinants of health, such as housing, transportation, and access to healthy food. In fiscal year (FY) 2021, 33 of 37 states with MCOs reported that the COVID-19 pandemic prompted the development of more strategies to address SDOH, such as requirements for plans to address housing. Other SDOH initiatives include increasing social needs screenings, connecting beneficiaries to social services, and partnering with community-based organizations (Gifford et al. 2021). For example, in Nevada's current MCO procurement, vendors must describe how they will identify and address SDOH affecting their members (NV DHHS 2021).

States are also requiring MCOs to do the following:

- conduct internal staff health equity trainings;

- implement the national standards for culturally and linguistically appropriate services;

- hire a health equity director;

- report the race and ethnicity of contracted providers to assess cultural congruency with beneficiaries;

- report on health disparities and propose interventions to mitigate these disparities; and

- implement alternative payment models focused on reducing health disparities (Bailit Health 2022).

Some states work with MCOs as they develop contract requirements related to equity. By doing this, states can leverage MCOs' technical expertise (e.g., data collection) to assess feasibility and implementation considerations for new

requirements being considered as well as to gain MCO buy-in before formalizing them. For example, Michigan Medicaid worked with its MCOs before requiring them to report the Healthcare Effectiveness Data and Information Set (HEDIS) disaggregated by race and ethnicity to ensure they shared a mutual understanding of the methodology for such reporting and definitions of race and ethnicity. In addition to providing a transparent process, engaging the MCOs early on provided time for MCOs to make the necessary systems and policy changes for compliance (MACPAC 2021h).

Payment. Some states are starting to use payment policies to drive plan and provider action on health equity, such as requiring value-based payment arrangements or implementing alternative payment models that tie MCO performance targets to reducing disparities on certain measures (Bailit Health 2022).[26] Equity-focused value-based payment efforts may address the SDOH (Patel et al. 2021).

State Medicaid agencies are encouraging providers to work with high-need populations. For example, California's value-based payment program directs MCOs to address health disparities by making enhanced payments to providers that serve beneficiaries with behavioral health needs and beneficiaries experiencing homelessness (Gifford et al. 2021). North Carolina's Medicaid program worked directly with providers to pilot an enhanced payment initiative to better serve historically marginalized beneficiaries and to reduce disparities. Providers received enhanced per-member per-month payments based on a minimum beneficiary poverty score. This score is based on the average poverty rate where the beneficiary lives.[27] Providers had flexibility in how these funds could be used as long as they ensured beneficiary access to care with the goal of reducing health inequities. For example, providers could use these funds to enhance primary care medical home services, such as increasing telehealth access, conducting staff training on trauma-informed care, or engaging patients to close care gaps in maternal or child health. North Carolina is now evaluating the pilot, including surveying providers on how the funds were used (NC DHHS 2021b).

State Medicaid agencies can develop alternative payment models that provide incentives for person-centered care and reduce disparities in quality, outcomes, and patient experience (HCPLAN 2022). Models, such as an accountable care organization or bundled payment for episodes of care, can adjust up-front payments to providers to support capacity-building efforts, such as building the data and analytics infrastructure needed to successfully carry out alternative payment models (McGinnis et al. 2022). Alternative payment models, however, are not typically designed to account for the effects of historical inequities in access to care and the health care system, which affect the health status and needs of individuals of color (Yearby 2022). Thus, CMS and states should consider whether certain models could inadvertently provide penalties for providers caring for historically disadvantaged and underserved beneficiaries who may have greater medical complexity stemming from unmet need (CMS 2021b).

A few states—Louisiana, Michigan, and Ohio—have begun using capitation withholds to advance health equity goals (Bailit Health 2022). For example, in Louisiana's request for proposals for MCO reprocurement, the state indicates it may withhold 2 percent of the monthly capitation payment to encourage quality, health outcomes, value-based payments, and health equity. MCOs may earn back this withhold based on their reporting and performance relative to health equity requirements, which will be established in the final contracts that will go into effect in July 2022 (LDH 2021). Michigan Medicaid has used capitation withholds to provide incentives for reductions in racial disparities since FY 2020 (Gifford et al. 2021). The Ohio Department of Medicaid noted in its current reprocurement request for proposals that it will determine the quality withhold payouts based on an evaluation of the reduction of racial disparities (ODM 2021).

There may also be opportunities to use rate setting processes to support health equity initiatives. Actuaries in some state Medicaid programs are in the early phases of exploring how this can be done, including how to incorporate social needs into risk adjustment models (Patel et al. 2021). However, because capitation rates are based on historical utilization, including underutilization of services driven by systemic inequities, current managed care capitation rate setting processes may build in inequities.

Quality. The processes for monitoring and ensuring quality of care can also be deployed to address disparities. These include state quality strategies, external quality review, quality measurement, MCO quality assessment and improvement projects, and accreditation. CMS has provided resources and guidance to states on how to incorporate a health equity lens into these activities, but state adoption remains somewhat limited.

All states contracting with MCOs must implement a quality strategy for assessing and improving the quality of care provided by managed care entities.[28] Although these can be used to advance health equity, one review found that such strategies lacked information on how states planned to address racial and ethnic disparities, in some cases providing only a paragraph about pertinent state actions or referring only to state data collection activities (Machledt 2021). CMS has created a toolkit to help states craft their strategies, recommending that they consider demographic data, including information on trends related to health disparities and SDOH and, if available, the state public health agency's disparities reduction plan. CMS also recommends that states consider selecting quality measures for which there are considerable health disparities (CMS 2021g).

Although it is not required, some states have incorporated health equity work into external quality review activities that assess the quality, timeliness, member satisfaction, and access to care provided by MCOs.[29] These activities are conducted by external quality review organizations (EQROs) under

contract.[30] For example, California's EQRO conducts focused studies on disparities based on age, gender, race and ethnicity, and primary language on a range of quality measures, including ones related to children's health, women's health, behavioral health, and acute and chronic disease management for racial and ethnic disparities (CA DHCS 2020).[31] Since 2018, Louisiana's EQRO has administered surveys to examine how MCOs are addressing disparities. The latest survey asked MCOs to describe efforts to identify and reduce disparities in outcomes, health status, and quality of care between Medicaid beneficiaries and those with other sources of coverage and among beneficiaries, including differences by race, ethnicity, and age (IPRO 2021).[32] The EQRO reports are posted on the state's website.

CMS has encouraged states to report measures in the Child and Adult Core Sets stratified by race, ethnicity, sex, primary language, disability status, and geography; it has also provided technical assistance to states (CMCS et al. 2019, CMS 2016). However, the extent to which states are doing this is unclear.[33] Some states stratify HEDIS measures by race and ethnicity and report on them for state-specific purposes (Machledt 2021). Creating more overlap between HEDIS measures (which MCOs routinely use) and the core sets could lead to greater reporting of stratified measures, but this is not required.

Some states are creating MCO requirements to address the quality of care received by beneficiaries of color as part of their comprehensive quality assessment and performance improvement programs (42 CFR 438.330(a)-(b)).[34] Other states are requiring that performance improvement projects (PIPs), a required element of quality assessment and performance improvement programs, focus on equity and disparities. For example, in 2017 to 2020, California required MCOs to conduct a health disparities PIP, such as testing blood sugar levels among Black men to monitor diabetes, controlling high blood pressure among Hispanic beneficiaries, and increasing childhood immunization among Black children (HSAG 2019). For the 2019 to 2021

PIP period, California required all MCOs to conduct two PIPs, including one related to an identified health disparity (HSAG 2021).

Finally, MCOs may also seek the newly established health equity accreditation from the National Committee for Quality Assurance.[35] This designation adds new requirements to the existing multicultural health care distinction standards that focus on organizational diversity, equity, inclusion and reducing bias, collecting gender identity and sexual orientation data, and stratifying HEDIS measures by race and ethnicity (NCQA 2021a).[36] It is unclear how many Medicaid MCOs will seek this accreditation, but currently 50 MCOs have already received the existing multicultural health care distinction (NCQA 2021b).[37]

Development of a diverse and culturally competent workforce

A workforce that is representative of the beneficiaries it serves and also provides care with cultural competence, regardless of cultural congruence, can drive improvements in equity for Medicaid beneficiaries. Several studies have shown that when patients and providers share the same race or ethnicity, preventive health screenings increase and patient perception of treatment decisions improves (Saha and Beach 2020, Wilbur et al. 2020, Penner et al. 2016). However, only 23 percent of Black, 26 percent of Hispanic, and 39 percent of Asian American patients have a physician who shares their race or ethnicity, compared with 82 percent of white Americans (Wilbur et al. 2020). Additionally, when provider-patient language is in concordance or interpreter services are available, patients report greater satisfaction (Nguyen et al. 2022).

Medicaid equity activities focused on the workforce include providing training in cultural competence, cultural humility, and trauma-informed care; recruiting a more diverse and representative Medicaid workforce; and covering the services of the non-clinical workforce, who have an in-depth

understanding of community needs.[38] Some states are already actively engaged in these activities. For example, a study of MCO contracts found that 6 of 20 states are requiring MCOs to have cultural competency or cultural humility trainings for all network providers (Bailit Health 2022). Louisiana's recent MCO reprocurement includes model contract language to ensure services are delivered by network providers in a culturally appropriate manner that promotes cultural humility (LDH 2021). Kentucky Medicaid requires MCOs to promote the delivery of services in a culturally competent manner and develop strategies that are respectful of culturally diverse backgrounds (KY CHFS 2021). Development of provider networks presents another opportunity to improve beneficiary-provider cultural congruence, but better data on the race and ethnicity of both providers and beneficiaries may be needed to do so effectively. Additional guidance may be needed to inform state and MCO practices and to address provider concerns about how the data will be used.[39]

Some state Medicaid programs are using non-clinical professionals, such as community health workers (CHWs), peer support specialists, and doulas, who share lived experiences with beneficiaries and can help support and connect beneficiaries to services. CHWs, who are either members of the community they serve or have close ties to it, act as a liaison between beneficiaries and the health care system (Moses et al. 2021). Currently, at least 21 state Medicaid programs cover CHW services (MACPAC 2022d).[40] Peer support specialists have lived experiences with substance use disorder, a mental health diagnosis, or both (SAMHSA 2022). Most state Medicaid programs cover peer support services for beneficiaries with mental health conditions or substance use disorder (MACPAC 2019). Given racial and ethnic disparities in birth outcomes, states may also choose to cover doula services to support mothers during pregnancy, including in making decisions about the birth process (Safon et al. 2021). Several states have authorized pilot or demonstration programs to require Medicaid

coverage of doula services (Robles-Fradet 2021).[41] MACPAC has also initiated new work to examine state coverage of doula services.

Some states have implemented modest workforce programs using Medicaid policy levers. Massachusetts, for example, incorporated workforce development initiatives into its Delivery System Reform Incentive Payment program.[42] Massachusetts used a portion of the program funds to provide loan repayment to reduce the shortage of providers in community-based settings, such as primary care physicians, nurse practitioners, CHWs, peer specialists, and recovery support professionals (CMS 2021h).[43] Massachusetts also used workforce professional development grants to support a range of activities to increase and enhance the capacity of the non-clinical workforce, such as awarding training grants to increase the number of training slots for CHWs and peer specialists, implementing a training program for CHW supervisors, and paying for supervisor training for recovery coaches (CMS 2021h). In addition, numerous federal and many state programs aim to recruit and retain primary care clinicians as well as other health professionals, such as dentists and behavioral health providers, to provide care in underserved areas and for underserved populations (Schwartz et al. 2019, Block 2018).[44] These strategies include scholarships, tax credits, and stipends to community-based groups to support recruitment and retention (Schwartz et al. 2019). We note that although these workforce programs are not specific to Medicaid, they can increase the workforce serving Medicaid beneficiaries.

The Commission has previously discussed the importance of diversity and cultural competence of the health workforce serving Medicaid beneficiaries (MACPAC 2022e, 2021i).[45] Efforts by CMS, other federal agencies, and states to address cultural competence and cultural humility among Medicaid participating providers and expand the use of professionals, such as CHWs, may promote greater trust in and connection to the health care system among Medicaid beneficiaries.

Next Steps

Looking ahead, the Commission will deepen its work on health equity and continue using a health equity lens throughout our work. For example, the Commission has work underway to examine strategies to improve the collection and reporting of race and ethnicity data, explore Medicaid's role in improving access for those with limited English proficiency, and leverage medical care advisory committees to increase beneficiary engagement. In addition to our focus on racial health equity, we plan to build our analyses of inequities for other beneficiaries who have been historically marginalized on the basis of age, geography, disability, sexual orientation, and gender identity as well as those at the intersection of these identities with race and ethnicity. We will continue to monitor federal and state efforts to promote equity to understand their effects.

Endnotes

[1] In its analyses, MACPAC uses the five racial categories required by the Office of Management and Budget (OMB) to report federal data: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and white. The OMB ethnic categories are Hispanic or Latino. OMB established minimum standards for race and ethnicity data in federally sponsored data collection efforts and administrative reporting to improve the consistency and comparability of these data across agencies (OMB 1997). We recognize that such terms have evolved over time and that people of color may prefer to use different terms when self-identifying their race and ethnicity (e.g., American Descendants of Slaves; Latinx or Latine; Indigenous).

[2] Some analysts are beginning to use the term "drivers of health," considering it more inclusive and descriptive of all the forces that perpetuate racial inequities in health care (Lumpkin et al. 2021).

[3] In 2019, compared with the total adult population in the United States, adult Medicaid beneficiaries were less likely to be Asian American, non-Hispanic: 6.3 percent of the

total population compared with 5.7 percent of Medicaid beneficiaries. Similarly, in 2019, compared with the total child population in the United States, child Medicaid or CHIP beneficiaries were less likely to be Asian American, non-Hispanic: 4.3 percent of the total population compared with 2.6 percent of Medicaid or CHIP beneficiaries. For all racial and ethnic groups, the differences for the Medicaid or CHIP population from the U.S. total population is statistically significant at the 0.05 level. MACPAC could not produce an estimate for the American Indian or Alaska Native (AIAN) population due to limitations of the 2019 National Health Interview Survey. Our analyses include all of the OMB racial and ethnic categories with the exception of Native Hawaiian or other Pacific Islander, as these responses are not included in the publicly available data (MACPAC 2022a). Analyses of the 2017 American Community Survey data found that more than 50 percent of all AIAN children were covered by Medicaid or CHIP (ASPE 2021b).

[4] The Kaiser Family Foundation analysis is based on 2021 Medicaid eligibility levels and the Annual Social and Economic Supplement of the Current Population Survey from the U.S. Census. Hispanic people may be of any race but are categorized as Hispanic; other groups are all non-Hispanic.

[5] We note that in these cited publications, the Assistant Secretary for Planning and Evaluation uses the term "Latino" to refer to all individuals of Hispanic and Latino origin.

[6] MACPAC uses the term "pregnant women" as this is the term used in the statute and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women.

[7] The majority of the CMMI payment and delivery system reform models have focused on Medicare, while only a few (e.g., Maternal Opioid Misuse Model) focus on Medicaid and CHIP (CMS 2022a).

[8] The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) required the Secretary of HHS to report to Congress periodically on approaches for identifying, collecting, and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status in Medicaid and CHIP; state, and CMS efforts; and to make recommendations for improvements for data collection and evaluation (Sebelius 2014).

[9] Targeted interventions and services that can improve health outcomes outside the traditional health care setting and prevent institutionalization will be provided as in-lieu-of services—that is, services provided as substitutes for traditional medical services. For example, managed care plans will be able to cover support services, such as housing supports, home modifications, and medically tailored meals. California's demonstration also seeks to transform the delivery system by building stronger collaboration and alignment between the needs of historically underserved communities, providers, and community-based organizations as well as improving the integration of physical and behavioral health services (CMS 2021e).

[10] CMS released a notice of funding opportunity for the 2022 Connecting Kids to Coverage HEALTHY KIDS program grants that "will make available $49.4 million, ranging between $500,000 to $1.5 million per awardee for a three-year period of performance, to fund efforts to increase the participation of eligible children, parents, and pregnant individuals in Medicaid and CHIP." This program is authorized under Section 2113 of the Social Security Act, as amended by Section 3004(a) of the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS Act enacted as part of P.L. 115-120). Section 50103 of the Advancing Chronic Care, Extenders, and Social Services Act (ACCESS Act included as part of P.L. 115-123) further extended the program, providing funding for future cooperative agreement awards (CMS 2022c).

[11] Parent mentors are parents with at least one child enrolled in Medicaid or CHIP who can assist other parents with the application and renewal process. These mentors also provide education about health insurance coverage, provide guidance on identifying medical and dental homes, provide assistance and referrals to address social determinants of health, and serve as a liaison between families and the state (CMS 2022c).

[12] A provision in the American Rescue Plan Act of 2021 (P.L. 117-2) gave states a new option to extend Medicaid postpartum coverage to 12 months via a state plan amendment. This new option took effect on April 1, 2022, and is available to states for five years (CMS 2022b).

[13] MCOs also collect race and ethnicity data for several purposes, such as identifying members in need of enhanced care coordination or support services and identifying disparities in access and outcomes (AHIP 2004). MCOs collect these data from member surveys, member outreach, and health and social risk assessments.

[14] In 2011, HHS published updated guidelines for collecting data on race, ethnicity, sex, primary language, and disability status. The revised guidelines expand on the minimum OMB standards and include more granular subcategories that roll up into OMB's five minimum race categories and two minimum ethnicity categories (HHS 2011). Although some states collect and report data that meet the more detailed 2011 HHS guidance, most states are still using the OMB standards (SHADAC 2021).

[15] MACAPC analyzed these data using methods from the DQ Atlas T-MSIS Analytic File (CMS 2021f).

[16] For example, in 13 states, reported enrollment among Hispanic individuals differed by more than 10 percentage points compared with those of the Medicaid population in the American Community Survey. In four states, this differed by more than 30 percentage points (MACPAC 2022c).

[17] CMS has issued guidance to states on how to collect more robust race and ethnicity data at application, but states are required to collect only the minimum OMB race and ethnicity categories. States can request approval to modify the application based on state needs.

[18] The U.S. Census Bureau conducted research to improve the data collection methods for the 2020 Census, finding that certain methods both increased response rates and improved the accuracy of the responses. These include using a combined race and ethnicity question, explicitly writing in the application that respondents should report all responses that apply, and including write-in options if the desired category or subcategory is not included. Another recommendation is to provide an option for individuals to choose a Middle Eastern or North African race or ethnicity as these groups are currently defined as white, non-Hispanic (SHADAC 2021).

[19] One study found that 28 percent of patients felt considerable discomfort reporting their race and ethnicity and that 58 percent were somewhat concerned that such information could be used to discriminate against patients (Shimasaki 2013).

[20] As of publication, the governors of Michigan, Nevada, New York, and Wisconsin have all declared racism as a public health crisis. The Centers for Disease Control and Prevention has also called racism a serious threat to the public's health (APHA 2021).

[21] Of the 34 states examined, 11 have designated Medicaid health equity officials: Arizona, California, Illinois, Indiana, Louisiana, Massachusetts, Minnesota, New York, Pennsylvania, Virginia, and Washington. Some states have a state-level equity policy advisor who coordinates Medicaid health equity efforts with those of other state agencies (e.g., Delaware (director of statewide equity initiatives) and Indiana (chief equity, inclusion, and opportunity officer)).

[22] There is no federal requirement for states or Medicaid agencies to have an equity plan.

[23] The Minnesota Department of Human Services is also considering beneficiary engagement efforts with other communities of color to promote health equity for Minnesotans who are AIAN, Hispanic or Latino, or AAPI individuals; immigrants; and new Minnesotans (Chomilo 2022).

[24] There are no federal requirements regarding demographic characteristics of Medicaid beneficiaries serving on MCACs. Some states have such requirements, however. For example, Texas requires the MCAC (but not specifically the beneficiary members) to be racially and geographically diverse. Texas also requires its MCAC to include beneficiaries with intellectual, developmental, or physical disabilities, or their advocates; advocates for children with special health care needs; and beneficiaries who use mental health services, or their advocates, among others (THHSC 2020).

[25] States receive a 50 percent federal match for expenditures on the committee's activities (42 CFR 431.12(g)). States vary in their policies for compensating members. For example, Arizona reimburses beneficiaries for necessary costs, such as transportation and child care (AHCCCS 2020). The Kentucky Department of Medicaid Services provides reimbursement for travel expenses (KY CHFS 2018).

[26] In a study of selected state MCO contracts, 7 of 20 contracts included value-based payment arrangements (Bailit Health 2022).

[27] The enhanced per-member per-month payment amounts were a $9 enhancement for practice locations identified as Poverty Tier I (poverty scores of more than 17 percent through 21 percent) and an $18 enhancement for practice locations identified as Poverty Tier II (poverty scores of more than 21 percent) (NC DHHS 2021b).

[28] The strategy must describe the state's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status (42 CFR 438.340(b)(6)). This requirement also applies in CHIP (42 CFR 457.1240(e)). States must also describe network adequacy standards, continuous quality improvement goals, performance metrics, performance improvement projects (PIPs), and arrangements for external quality review.

[29] Federal Medicaid rules require states to contract with independent external quality review organizations to conduct oversight and assess quality, timeliness, and access to care provided by MCOs, prepaid inpatient health plans, prepaid ambulatory health plans, or primary care case management entities (42 CFR 438.350).

[30] Mandatory activities include validation of PIPs, validation of performance measures, review of compliance with federal quality requirements, and validation of provider network adequacy. Optional activities include validation of encounter data, administration or validation of consumer or provider surveys, calculation of performance measures, conduct of PIPs, administration of focused studies on particular aspects of clinical or non-clinical services, and assistance of the quality ratings (42 CFR 438.358).

[31] The state disaggregates data on these quality measures by race and ethnicity where possible.

[32] Specifically, the external quality review survey asked each MCO about identification or analysis of the MCO's Medicaid population based on risk characteristics; identification of differences in health outcomes or health status that represent measurable gaps between the MCO's Medicaid population and other types of health care consumers; identification of gaps in quality of care for the MCO's

Medicaid members and Medicaid subgroups; identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations; and development and implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCO members with at-risk characteristics.

[33] Reporting on the core sets is voluntary, and states may report on different measures. However, beginning in FY 2024, reporting on the Child Core Set and the behavioral health measures of the Adult Core Set will be mandatory.

[34] Quality assessment and performance improvement programs must include, at a minimum, PIPs; collection and submission of performance measurement data; mechanisms to detect underuse and overuse; mechanisms to address quality of care for enrollees with special health care needs; and for MCOs, prepaid inpatient health plans, prepaid ambulatory health plans, mechanisms to assess quality of care for enrollees using long-term services and supports, and activities to prevent, detect, and remediate critical incidents (42 CFR 438.330(b)).

[35] The National Committee for Quality Assurance (NCQA) is transitioning its existing multicultural health care distinction to the health equity accreditation beginning in July 2022 (NCQA 2021c). MCOs that satisfy NCQA standards for providing culturally and linguistically sensitive services and efforts to address health care disparities earn this distinction.

[36] The health equity accreditation is distinct from the general health plan accreditation. Federal rules do not require MCOs to have a general health plan accreditation; however, 33 states do (NCQA 2020).

[37] For example, Pennsylvania became the first state to require all its MCOs to achieve the NCQA Multicultural Health Care Distinction; state officials have signaled that they will require all MCOs to have the health equity accreditation (NCQA 2021d).

[38] There is a difference between cultural competency and cultural humility. Cultural competency training enhances provider knowledge about the cultures and practices of social groups, including those who have been historically marginalized and underserved, to more effectively serve

them. States are also incorporating cultural humility into equity efforts. Cultural humility is the acknowledgment of beneficiaries' unique cultural experiences and the willingness to learn from them to ensure culturally appropriate care (Lekas et al. 2020).

[39] One study of health plans found that less than half (46.5 percent) collect provider race and ethnicity. This same study found that 67 percent of plans reported that they distribute the provider demographic data to beneficiaries via the plan website, and 27 percent distribute this information through provider directories (AHIP 2004).

[40] California, Illinois, Nevada, and Wisconsin plan to add CHWs as a Medicaid-covered service in FY 2022. Arizona, California, the District of Columbia, and Illinois reported they are establishing or planning to establish CHWs as a Medicaid provider type. Colorado and Oregon are incorporating CHWs into case management redesign and care coordination improvement efforts (Gifford et al. 2021).

[41] These include Minnesota, Oregon, New Jersey, Florida, Rhode Island, Indiana, Maryland, Washington, California, and the District of Columbia.

[42] CMS is no longer approving new Delivery System Reform Incentive Payment (DSRIP) programs or renewing existing DSRIP programs when they expire. Many states with existing DSRIP programs are exploring ways to continue to support delivery system reform efforts using other Medicaid authorities; however, it is unclear to what extent these efforts include the workforce initiatives.

[43] Loan repayment amounts generally range from $30,000 up to $50,000 depending on the type of provider, in exchange for a four-year service commitment (MassLeague 2021).

[44] The Health Resources and Services Administration designates health professional shortage areas, which include geographic areas, populations, and facilities with an inadequate supply of primary care, dental, and mental health providers and services. Population health professional shortage areas have a shortage of services for a specific population subset (e.g., low-income individuals) within an established geographic area.

[45] For example, Medicaid is the nation's primary payer for home- and community-based services, and the majority (59 percent) of those providing such services are people

of color (Campbell et al. 2021). The home- and community-based services workforce, comprised largely of women and often immigrants, also faces inequities (PHI 2021). These include, for example, wage disparities; within the direct care workforce, women earn less than men on average, and people of color earn less than white people (Campbell et al. 2021).

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