BRIEF

Disparities in Care for Safety Net Populations

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ADAPTATION HEALTH

Disparities in health care access, quality, and outcomes among racial and ethnic groups in the United States are long standing. Chronic diseases, as well as higher rates of adult and infant mortality, disproportionately impact populations of color more than their White counterparts. Disparities within cancer, cardiovascular-related disease, and HIV rates characterize the stark contrasts in health outcomes. Blacks, American Indians and Alaska Natives (AI/AN) report health conditions, including asthma and diabetes, more likely than Whites.[1] Although heart disease and cancer are the leading causes of death across race, ethnicity, and gender, Black people were 30% more likely to die prematurely from heart disease than Whites, and Black men, twice as likely to die prematurely from stroke. Furthermore, nearly 44% and 48% of African American men and women, respectively, are reported to have some form of cardiovascular disease.[2] Particularly, Black women are 60% more likely to have high blood pressure than non-Hispanic White women.[3] In 2018, Black people accounted for 42% of all new HIV diagnoses nationwide.[4] Overall, Black males have the shortest life expectancy compared to other groups, and higher infant mortality rates exist in Blacks and AI/AN populations compared to their White counterparts.[5]

Health inequities, like those aforementioned, are fueled by systemic, social, and environmental factors that disparately influence individuals' health and quality of life. While race/ethnicity is one of those factors, health disparities are also directly informed by place, or geographic location. For example, rural and urban community residents experience significant health differentials. Those living within rural communities generally have higher rates of preventable conditions, such as obesity, diabetes, cancer, injury, and of high-risk health behaviors than those in urban communities.[6] Rural-urban gaps in death rates over time have told the same story, widening from 0.4 years in 1969–1971 to 2.0 years in 2005–2009.[7] Place-based disparities highlight the significance of access to care as it relates to chronic disease burdens that challenge vulnerable communities. While the mean ratio of adults per primary care provider is approximately 1,075:1 in the United States, one study found that in urban centers, the ratio is closer to 3,500:1. Census data further supported that where 80% of the residents were African American, they had 28 times higher odds of falling into the lowest primary care access regions of the city. [8] The lack of primary care providers in racially diverse neighborhoods creates an additional barrier to care and leads to longer travel and wait times. Access to care barriers can also include lack of transportation, cost of care, healthcare distrust, lack of adequate healthcare facilities, and services, amongst other factors.

The Growing Role of Medicaid

Medicaid has displayed a continued ability to address identified barriers to care and health equity, as exemplified by results of Medicaid expansion. Medicaid expansion, implemented in 39 states

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[1] *Artiga, Samantha, et al. Disparities in Health and Health CARE: Five Key Questions and Answers. 1 Apr. 2020, www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.*

[2] *Weinstein, James N., et al. "The State of Health Disparities in the United States." Communities in Action: Pathways to Health Equity, by National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States, The National Academies Press, 2017, www.ncbi.nlm.nih.gov/books/NBK425844/.*

[3] *Office of Minority Health. Heart Disease and African Americans - The Office of Minority Health. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19.*

[4] *Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. (2021, January 20). HIV and African American People. Centers for Disease Control and Prevention. https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html.*

[5] *Weinstein, James N., et al. "The State of Health Disparities in the United States." Communities in Action: Pathways to Health Equity, by National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States, The National Academies Press, 2017, www.ncbi.nlm.nih.gov/books/NBK425844/.*

[6] *Downey, Laura Hall. "Rural Populations and Health: Determinants, Disparities, and Solutions." Preventing Chronic Disease vol. 10 E104. 27 Jun. 2013, doi:10.5888/pcd10.130097*

[7] *Singh, Gopal K, and Mohammad Siahpush. "Widening Rural–Urban Disparities in Life Expectancy, U.S., 1969–2009." American Journal of Preventive Medicine , vol. 46, no. 2, 1 Feb. 2014, pp. E19–E29., doi:https://doi.org/10.1016/j.amepre.2013.10.017.*

[8] *Brown, Elizabeth J., et al. "Racial Disparities In Geographic Access To Primary Care In Philadelphia: Health Affairs Journal." Health Affairs, 1 Aug. 2016, www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1612.*

and the District of Columbia, provides coverage to low-income adults, specifically non-elderly adults with incomes below 138 percent of the poverty line (safety-net populations); this population reports worse health status than higher income individuals.[9] Expansion has already resulted in Medicaid coverage for over 12 million adults, and could include an additional 4 million uninsured adults eligible for coverage in states that have not undergone expansion.[10] Of this potentially Medicaid eligible population, the majority are people of color, 29% Hispanic and 23% Black.

Since 2014, expansion has resulted in improved health outcomes, notably for racial and ethnic groups disproportionately affected by chronic disease. For example, Black women in states implementing Medicaid expansion experienced lower rates of infant mortality than those in non-expansion states, with 16 fewer deaths per 100,000 live births compared to their White counterparts at 4 fewer deaths.[11] A Journal of the American Medical Association study found reductions in 1-year mortality of non-elderly adults from end-stage renal disease in expansion states. Black patients, who are at higher risk for kidney failure, experienced the largest reductions in 1-year mortality.[12] Further, disparities in care and coverage have been reduced in expansion states. The gap between White and Black adults with low access to care due to affordability fell 3.4 percentage points between 2013 and 2018 (8.1 and 4.7 respectively).[13] Despite the impact of Medicaid on positive health outcomes, racialized and ethnic-based health disparities persist, and have been exacerbated amid the current COVID-19 pandemic. This places a growing burden on Medicaid to address the needs of current and future beneficiaries.

COVID-19 Impact on Medicaid

COVID-19 and the economic downturns accompanying it, have informed state projections of higher enrollment growth and Medicaid spending in FY 2021, compared to pre-pandemic estimates. In April 2020, the U.S. experienced 20.5 million job losses and the unemployment rate increased to 14.7 percent.[14] The Congressional Budget Office expects the unemployment rate in 2021 to be an estimated 6 percentage points higher than the 2020 projection.[15] Employment loss, resulting in loss of job-based health coverage motivates the aforementioned projections of Medicaid enrollment and spending. In a Kaiser Family Foundation survey of Medicaid Directors in all 50 states, nearly all states with available budget projections reported a budget shortfall as "almost certain" or "likely" for the upcoming fiscal year.[16] Many individuals at highest risk of exposure and death due to COVID-19 rely on Medicaid services; in states that have expanded Medicaid, 37 percent of essential and front-line workers are covered.[17] This year, an estimated 17 million people could be eligible for Medicaid when unemployment insurance benefits end.[18] As growth in eligibility for Medicaid coverage extends to marginalized populations experiencing job

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[9] Artiga, Samantha, et al. Disparities in Health and Health CARE: Five Key Questions and Answers. 1 Apr. 2020, www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/.
[10] Cross-Call, Jesse. "Medicaid Expansion Has Helped Narrow Racial Disparities in Health Coverage and Access to Care." Center on Budget and Policy Priorities, 21 Oct. 2020, www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and.
[11] Eliason, Erica L. "Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality." Women's Health Issues , vol. 30, no. 3, pp. 147–152., doi:https://doi.org/10.1016/j.whi.2020.01.005. Accessed 6 Feb. 2021.
[12] Swaminathan, S., Sommers, B. D., & Thorsness, R. (2018). Association of Medicaid Expansion With 1-Year Mortality Among Patients With End-Stage Renal Disease. JAMA, 320(21), 2242–2250. https://doi.org/doi:10.1001/jama.2018.16504
[13] Cross-Call, Jesse. "Medicaid Expansion Has Helped Narrow Racial Disparities in Health Coverage and Access to Care." Center on Budget and Policy Priorities, 21 Oct. 2020, www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and.
[14] Cross-Call, 2020
[15] Rudowitz, Robin, and Elizabeth Hinton. "Early Look at Medicaid Spending and Enrollment Trends Amid COVID-19." KFF, 15 May 2020, www.kff.org/coronavirus-covid-19/issue-brief/early-look-at-medicaid-spending-and-enrollment-trends-amid-covid-19/.
[16] Rudowitz, 2020
[17] Artiga, Samantha, and Wyatt Koma. "Low-Income and Communities of Color at Higher Risk of Serious Illness If Infected with Coronavirus." KFF, 7 May 2020, www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/.
[18] Rudowitz, Robin, and Elizabeth Hinton. "Early Look at Medicaid Spending and Enrollment Trends Amid COVID-19." KFF, 15 May 2020, www.kff.org/coronavirus-covid-19/issue-brief/early-look-at-medicaid-spending-and-enrollment-trends-amid-covid-19/.

loss and low socioeconomic status as a result of the pandemic, it is critical to meet the growing eligibility and need, and to ensure equity in care and outcomes.

Persons with underlying health conditions and comorbidities have been impacted by COVID-19 with increasingly rapid and severe progression of the disease, often leading to death.[19] Hispanic and Black adults are more likely to suffer from diabetes, about 22% and 20% respectively, compared to 13% of their White peers. Furthermore, in 2015-2016, Black adults experienced underlying conditions of obesity and hypertension at higher rates than all other racial and ethnic groups, about 48% and 42% respectively.[20] Communities of color are more susceptible to contraction and death due to disparately higher prevalence of cardiovascular related diseases as well as overrepresentation in low-wage, essential, and frontline worker jobs with greater exposure risks. For example, African Americans account for 26% of the population in Milwaukee County and 32% in the state of Louisiana, however have made up 70% of COVID-19 deaths in both areas.[21] Populations with comorbidities are now challenged with maintaining effective chronic disease management, including access to care, provider visits, and medications or treatments, amid harmful COVID-19 effects.

Access to adequate care has been a prominent issue as a result of in-person restrictions and safety precautions, which place an undue burden on already vulnerable groups. An analysis conducted by Harvard University, the Commonwealth Fund, and Phreesia found that the number of visits to ambulatory practices declined nearly 60 percent by early April 2020 just after the pandemic began. During that time, telehealth visits rose rapidly, but in October 2020 outpatient visits rebounded to pre-pandemic levels. Visits for children ages 0 - 5, though, remain substantially below their pre-pandemic baseline, up to 18 percent lower. Additionally, visits to pulmonologists and behavioral health providers, which are critical services in this hour, also remain 20 percent and 17 percent below the baseline, respectively. However, Medicaid insured patient visits have rebounded to nearly the pre-pandemic levels, highlighting the importance of a specific focus on providing services and access to care for safety-net populations.[22]

Although increasing by 154% by March 2020,[23] telehealth measures were unable to provide all encompassing solutions for lack of care access during the pandemic. Within a New York City health system between March and May 2020, Blacks and Hispanics over 65 years old experienced the lowest predicted probability (11.3%) of using telehealth among all patients. Additionally, Blacks and Hispanics were most likely (60.1% and 48.2%) to use the emergency room (ER) than either telehealth (23.1% and 31.9%), or office visits (16.9% and 19.9%). Non-English speakers had a significantly lower predicted probability of using telehealth versus the ER (26.2% for Spanish speakers and 25.8% for other language speakers).[24] Technology gaps in

[19] *Sanyaolu, Adekunle et al. "Comorbidity and its Impact on Patients with COVID-19." SN comprehensive clinical medicine, 1-8. 25 Jun. 2020, doi:10.1007/s42399-020-00363-4*

[20] *National Center for Health Statistics. "Health, United States Spotlight Racial and Ethnic Disparities in Heart Disease ." Centers for Disease Control and Prevention, 23 Apr. 2019, www.cdc.gov/nchs/hus/spotlight/2019-heart-disease-disparities.htm.*

[21] *Thebault, Reis, et al. "The Coronavirus Is Infecting and Killing Black Americans at an Alarmingly High Rate." Washington Post, 7 Apr. 2020, www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killing-Black-americans-an-alarmingly-high-rate-post-analysis-shows/?arc404=true.*

[22] *Mehrotra, Ateev. "The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients." Commonwealth Fund, 15 Oct. 2020, www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels.*

[23] *Koonin, Lisa et al. "Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic - United States, January–March 2020." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 30 Oct. 2020, www.cdc.gov/mmwr/volumes/69/wr/mm6943a3.htm#:~:text=In%20February%202020%2C%20CDC%20issued,through%20virtual%20means%20such%20as.*

[24] *Weber, Ellerie, et al. "Characteristics of Telehealth Users in NYC for COVID-Related Care during the Coronavirus Pandemic ." Journal of the American Medical Informatics Association, vol. 27, no. 12, pp. 1949–1954., doi:https://doi.org/10.1093/jamia/ocaa216.*

internet or device access and literacy, language and cultural barriers, amongst others, influence these disparities in care utilization.

Providers are already seeing the aggravated impact of disparities on preventative utilization due to COVID-19. The University of Nebraska Medical Center reported their weekly volume of new cancer patients to be approximately half of normal levels. Similarly, New York's Mount Sinai Tisch Cancer Center reported a 30-50% drop in new cancer patients. Nationally, preventative cervical, colon, and breast cancer screenings dropped by 86-94%.[25] However, virtual visits are not appropriate for special conditions requiring physical examination or diagnostic testing, negatively impacting vulnerable populations at a greater scale. To this point, Dr. J. Leonard Lichtenfeld, Deputy Chief Medical Officer at the American Cancer Society, noted "You can't screen for cancer over telemedicine." [26] According to a study of the Veterans Affairs health care system, the largest integrated health system in the United States serving 6 million people annually, there were 93% fewer colonoscopy procedures in April 2020.[27] As a result, there is a realistic possibility for new cancer cases and other serious conditions to be undiagnosed or diagnosed at more dangerous stages. Additionally, up to 40% of child vaccination scheduled appointments have been missed, and when extended to "teenagers and vaccinations for human papillomavirus (HPV), it climbs as high as 80%."[28] This will likely lead to continued disparities and expanding gaps in health equity for communities of color, low-income, and other marginalized populations.

Industry's Response to Growing Need

While gaps in access to services have recently widened, COVID-19 publicly exposed that these problems were indeed pre-existing and persistent in the nation. Racial disparities in rates of COVID-19 related death have highlighted not only the underlying health conditions but also their triggers, including inequitable social determinants of health such as housing, food, and transportation (among others). This has fueled a nationwide discussion on health inequities between groups who otherwise have not had a shared dialogue, which include healthcare providers, scientists, foundations, private corporations, government agencies, academic researchers, and community organizations. Research organizations, like the National Institutes of Health, have implemented funding initiatives for states to conduct community outreach and engagement specifically addressing inequities challenging African Americans, Hispanics/Latinos, and American Indians.[29] Health technology companies have committed to intentionally focusing on social determinants of health. For instance, AdvaMed, a medical device trade association, released a Health Equity Initiative noting that social determinants, access to healthcare, affordability of care, and underlying medical conditions contribute to disproportionate impacts.[30] The American Hospital Association (AHA) made a number of advocacy and education efforts to address racial health inequities in light of COVID-19's disparate impacts on communities of color. It joined with the American Medical Association and American Nurses Association in a letter to

[25] *Abdelmalek, Mark, and Lucien Bruggeman. "Dramatic Drop in Cancer Diagnoses amid COVID Pandemic Is Cause for Concern, Doctors Say." ABC News, ABC News Network, 14 May 2020, abcnews.go.com/Health/drop-cancer-diagnoses-concern-doctors/story?id=70682238.*
[26] *Abdelmalek, 2020*
[27] *Gawron, Andrew, et al. "The Impact of the Coronavirus Disease-19 Pandemic on Access to Endoscopy Procedures in the VA Healthcare System." Gastroenterology Journal , vol. 159, no. 4, 1 Oct. 2020, pp. 1216–1220., doi:https://doi.org/10.1053/j.gastro.2020.07.033.*
[28] *McCarthy, Moira. "COVID-19 Is Causing a Reduction in Child Vaccinations." Healthline, 18 May 2020, www.healthline.com/health-news/covid19-causing-decrease-in-child-vaccinations.*
[29] *National Institutes of Health. "NIH Funds Community Engagement Research Efforts in Areas Hardest Hit by COVID-19." National Institutes of Health, U.S. Department of Health and Human Services, 18 Sept. 2020, www.nih.gov/news-events/news-releases/nih-funds-community-engagement-research-efforts-areas-hardest-hit-covid-19.*

[30] *"Health Equity Initiative." AdvaMed, 2020, www.advamed.org/issues/principles/health-equity-initiative.*

the federal Department of Health and Human Services urging more emphasis on racial disparities within COVID-19, including by reporting disaggregated data by race. AHA also created resources and guidance for other hospitals to utilize in an effort to ensure their most vulnerable patients receive equitable care, and to examine and address social determinants of health for patients. They state, "even though Minority Health Month concluded at the end of April, every day, now more than ever, we recognize the significance in raising awareness and doubling down on efforts to achieve health equity in our nation."[31]

Urgent Need for Action

The uncovering of deeply rooted social and physical health inequities that have plagued communities of color and other marginalized populations in the United States for decades has been an important step. It has made clear that the previous efforts made to address poor health outcomes are not complete, but that more work needs to be done. Organizations have shown a new focus on the future of health equity as they seek to address not only COVID-19, but also the entrenched inequities exposed as a result of the virus. As a safety net to many of those disproportionately impacted by the pandemic, Medicaid has the opportunity to push back against the standards of inequity across racial and ethnic groups. If COVID-19 ceases, but the very inequities that enabled the disease to disparately affect these populations are not addressed, the nation can expect to see these historical injustices repeated in the next epidemic or pandemic.

[31] *Arespacochaga, Elisa. "New AHA Resources Spotlight Hospital Efforts to Address COVID." American Hospital Association , 1 May 2020, www.aha.org/news/blog/2020-05-01-new-aha-resources-spotlight-hospital-efforts-address-covid.*