Underlying Factors of Medicaid Inequities: Conversations with Experts on Racism and Medicaid

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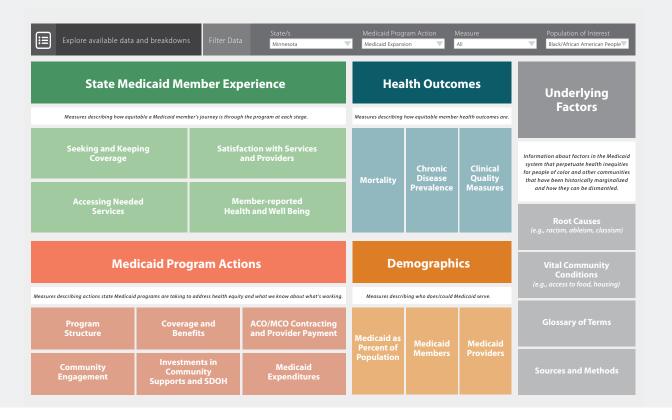
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INTRODUCTION

The Medicaid Equity Monitoring Tool (MET) project is a collaborative effort from the State Health Access Data Assistance Center (SHADAC) with support from the Robert Wood Johnson Foundation (RWJF) and partner organizations working to assess whether a data tool could increase accountability for state Medicaid programs to advance health equity while also improving population health. During the first phase of this project, a wireframe was created to organize the different sections of a potential tool.

SHADAC Medicaid Equity Monitoring Tool "Wireframe"
Detailed Example

Explore available data and breakdowns	Filter Data	State/s **Minnesota**	Medicaid Program Action **Medicaid Expansion**	Measure **All**	Population of Interest **Black/African American People**

State Medicaid Member Experience

Measures describing how equitable a Medicaid member's journey is through the program at each stage.

Seeking and Keeping Coverage	Satisfaction with Services and Providers
Accessing Needed Services	Member-reported Health and Well Being

Health Outcomes

Measures describing how equitable member health outcomes are.

Mortality	Chronic Disease Prevalence	Clinical Quality Measures

Underlying Factors

Information about factors in the Medicaid system that perpetuate health inequities for people of color and other communities that have been historically marginalized and how they can be dismantled.

- Root Causes *(e.g., racism, ableism, classism)*
- Vital Community Conditions *(e.g., access to food, housing)*
- Glossary of Terms
- Sources and Methods

Medicaid Program Actions

Measures describing actions state Medicaid programs are taking to address health equity and what we know about what's working.

Program Structure	Coverage and Benefits	ACO/MCO Contracting and Provider Payment
Community Engagement	Investments in Community Supports and SDOH	Medicaid Expenditures

Demographics

Measures describing who does/could Medicaid serve.

Medicaid as Percent of Population	Medicaid Members	Medicaid Providers

During discussions with our partners and an Advisory Committee, it was concluded that an understanding of underlying factors that lead to and perpetuate health inequities for people of color and other historically marginalized communities was a pivotal part of creating this tool. The "Underlying Factors" section of the wireframe aims to encompass this information.

Thus, in order to inform the Medicaid Equity Monitoring Tool (MET) project and the Underlying Factors section of the tool, SHADAC produced an annotated bibliography of resources to better understand the available academic and gray literature on those underlying factors of health inequities in Medicaid. While the bibliography covers a number of structural and systemic underlying factors of health inequities (e.g., ableism, sexual orientation and gender identity discrimination), most of the resources compiled in the bibliography address structural racism specifically. These resources discuss the history, policy context, and impacts of systemic racism on Medicaid recipients.

As a follow-up to the creation of the annotated bibliography, SHADAC's Health Equity Fellow held consulting conversations with authors of select resources cited in the structural racism section. Through these conversations, our goal was to:

1. Connect with experts in order to elicit feedback on key insights from SHADAC's annotated bibliography

2. Ask experts questions about what topics related to systemic racism need to be discussed within the tool

3. Discuss strategies on how best to convey and disseminate this important information

This brief summarizes these conversations, including specific examples and quotes from experts, for audiences interested in communicating about the effects of structural racism with the aim to dismantle it.

> Jump to:
>
> **Methods**
> **Key Findings**
> *What topics related to structural racism within Medicaid need to be discussed in a resource such as the Medicaid Equity Monitoring Tool?*
> *What strategies are helpful in communicating about structural racism across different audiences?*
> *How can the Medicaid Equity Monitoring Tool approach discussion of underlying factors with emphasis on progress?*
> **Conclusions**

METHODS

The experts involved in these conversations were selected from the list of authors whose works were included in the MET resource titled "Annotated Bibliography: Underlying Factors of Medicaid Inequities", specifically within the structural racism section. In the recruitment of these experts for these conversations, we prioritized diversity in both organization affiliation and geography. Eleven scholars were invited to participate in conversations, of which four accepted. Experts were offered appropriate compensation for their time.

Conversations took place over Zoom for 30-minute sessions; they were recorded and transcribed. Each expert was asked several questions related to their experiences and work at the intersection of Medicaid and structural racism. Answers to three main questions make up the content of this brief:

1. What topics related to structural racism need to be discussed in a resource such as the Medicaid Equity Monitoring Tool?

2. What strategies does the expert use in communicating about underlying factors and/or structural racism across different audiences?

3. How can the tool approach discussion of these topics with emphasis on progress?

Experts were also asked for any additional resources or articles that may be helpful in developing information for the tool; a list of resources is available upon request.

KEY FINDINGS

What topics related to structural racism within Medicaid need to be discussed in a resource such as the Medicaid Equity Monitoring Tool?

This question aimed to pinpoint what topics these experts feel are important to emphasize in providing a well-rounded picture of structural racism as a root cause of inequities in Medicaid.

Effects of laws and policies on specific groups

All of the interviewed experts discussed the importance of uplifting the impacts of specific laws and policies on certain groups, such as people with disabilities, American Indian and Alaska Native people, and the wide range of experiences across the many Asian ethnicities that exist. One expert specifically mentioned income and asset limits placed on those receiving disability benefits as an example – which can make saving money or pursuing work far more difficult.

Experts also mentioned how, historically in the U.S., public supports are intertwined with work and productivity with policies often centered in getting people into the workforce to contribute to society.

> "*...One of the things that I have reflected on a lot is how so many of our existing supports are tied to work. I think, as a society […] the primary goal of policy or social policy specifically is to get people to work. It's so deeply embedded in our thinking, and reflecting on that […] gaps have been created by this oftentimes single-minded focus on promoting market labor […] In terms of people who work within systems, I think, they, like all of us, hold many of those ideas and I think those ideas can lead to people being judgmental of the participants they engage with on a daily basis.*"

Emphasis on structural racism's universal impact

One expert suggested framing structural racism as something that impacts everyone universally by perpetuating inequities throughout the health care system. From limited access to health care to the quality of health care to how and where money is spent throughout the system, structural racism and its effects are felt by everyone. As opposed to expecting individuals to navigate an inequitable system themselves (oftentimes without the time or resources to do so effectively), addressing inequities at a structural level allows all to thrive.

These ideas and impacts go beyond public coverage: two experts discussed how the complexity of the U.S. health care system's structure overall (not just Medicaid) impedes the general public's ability to navigate health care effectively. These two experts felt it important to note that health care in the U.S. is organized as a business, rather than a social support system of essential care that everyone deserves equitable access to. This sets up the system to often prioritize monetary factors as opposed to equitable and accessible health care while also obfuscating the system itself to many who must interact with it.

Distrust

Distrust was the main emotion mentioned by all of the experts as an underlying factor of structural racism within Medicaid, particularly distrust in the government and/or public programs.

One expert discussed the differences between provider distrust and institutional distrust, where individuals seemed to be generally satisfied with provider experiences, but were distrustful of the medical system as a whole.

One expert spoke specifically to feelings of distrust in the overall landscape of Medicaid and the health care system on a national level:

> " *In addition to fixing gaps and barriers within Medicaid and the health care system, in general, there's a need for repair. That I don't think we're very far along in thinking about what that would even look like […] in this country in general, there's a sense of instability and unreliability that I think aggravates […] and filters all the way down. On a local level, it's the same kind of feeling that you're just constantly having things pulled out from under you. I think in the United States in general, we kind of feel that way about health care… it's always changing, insurance is changing, and doctors are changing […] what can we trust? I think that's a big deal.*"

Standard for comparison needs to reflect communities/populations

Experts discussed how using white people's health outcomes as the standard for comparison over showing how everyone is impacted places blame on Black and brown people. This is especially true when discussing Medicaid, considering how it disproportionately covers people of color. Focusing on population level research was more preferrable to these experts (as opposed to comparing health outcomes of white people to other populations).

What strategies are helpful in communicating about structural racism across different audiences?

While all of the experts expressed that communication is not their expertise, they all shared important approaches for connecting policy, structural racism, and health equity information with lay audiences, policymakers, as well as other experts in their field:

History

One expert spoke to the effectiveness of using history and historical policy context to communicate about structural racism with multiple audiences, particularly with legislators and key interest and advocacy groups. Experts explained that those audiences generally find history to be both interesting and contextualizing for current policies; **the expert who discussed history at length stated that history leads many people to the big picture "aha" moment due to its accessibility across audiences.**

They also mentioned that deeply rooted history spanning multiple generations can help folks shift from a mindset of personal blame or guilt about structural racism toward systems as the problem that needs to be addressed. This also links back to the idea of structural racism's universal impact: history is all of our history – using that shared story can help audiences unite as one community working towards solving these issues.

Providing specific examples

The experts varied in their perspectives on using specific examples or personal stories when discussing structural racism within Medicaid; a couple of experts favored demonstrating on how policies do not benefit everyone, while another expert uses personal stories and examples to help audiences better relate to how systems perpetuate inequities.

One expert offered an example about the role of employers in providing livable wages and health insurance benefits. Increases in a company's profits often do not get reflected in greater wages and benefits for employees, or that wages are kept low so that employees instead qualify for Medicaid:

> "…they're [i.e. employees] getting paid less than the living wage, and, oftentimes, their employer helps them fill out Medicaid instead of providing health insurance or the benefits they need, while [the company] is still making lots of money. Sometimes with health care workers […] venture capitalists or equity firms come in and buy up hospitals [or companies] and [talk about] how they are making lots of profit, but the workers don't actually get higher wages, benefits, or paid leave. […] I try to connect it [by] highlighting employers who I think could do more. Then, bring it back to health care, where you see the company, state, or nonprofit that is paying people less, which then causes them to be on Medicaid (or maybe they fall in the gap, and they don't even get Medicaid). Focusing on hard working individuals who are trapped in the system, to me, is key, not only for those who are impacted, but also sometimes for policymakers to begin to understand that it's not just people sort of "using the system", but it is people who are trapped in a system of inequality."

Data

Some of the experts noted that data acts as a springboard for discussion of both problems and solutions.

The presentation of data and data visualization was seen as effective in spotlighting specific aspects of the system that need to be addressed. Further, one expert suggested pairing data and the information we can glean from it with strategies that focus on system level change over individual level change (the latter of which may create adamancy toward action or perpetuate feelings of guilt, as we mentioned in the 'History' section above).

Experts emphasized the need, though, for **more disaggregated data:**

> " *If we don't have disaggregated data, so much data is lost. We don't know what the experiences are. We may understand oh, Asian people use Medicaid in this way. But we're losing so much rich data. We don't understand how Asian populations in the south, in the west, the United States uses [categories] that are different from demographic backgrounds in the Asian community. And we do know that there are differences in how these resources are used. So, I think just disaggregate, and being able to utilize disaggregated data and being able to communicate that is incredibly key.* "

Social media

Experts spoke to the clear shift in how the general public prefers to receive information today: through the internet and particularly through social media (e.g. LinkedIn, Instagram, Facebook). They went on to describe how academia needs to "catch up" in utilizing social media as a tool to share information with many people in a concise, engaging, and accessible way:

> " *It's a shift that we have to have within the academic spaces or these policy spaces of, rather than looking at social media as an entertainment space, it is a tool for the spread of information. And we have to be able to use it, have people to use it as that…because lay people are looking at this. But policymakers are also looking at this and people who have huge decision-making abilities are looking at these videos to inform, "Oh, this is something I should be looking at in my area." I do think as public health researchers, we should take social media a lot more seriously than we currently do.* "

How can the Medicaid Equity Monitoring Tool approach discussion of underlying factors with emphasis on progress?

The articles and resources in our Annotated Bibliography did not always offer clear solutions or interventions to the many problematic policies, historical issues, and major impacts on the Medicaid program being discussed – so the experts were asked how SHADAC can provide an understanding of these historical harms and issues while also uplifting what progress has been made and potential proposed solutions.

Pointing to specific policies that improved the system

Experts discussed the importance of pointing to specific policies, e.g., Medicaid expansion, and highlighting ongoing policy changes as a part of the tool.

One expert mentioned how Native Americans benefitted greatly from The Indian Health Care Improvement Act, which was passed as a part of the Affordable Care Act. Policies of this nature that target issues certain racialized groups face in health care were seen as highly beneficial by this expert. This also links back to one of the first points raised in this brief: talking specifically about policy impact on specific groups.

Experts also suggested creating a repository of Medicaid program actions by state to center equity, especially if they are associated with coverage, access, or quality improvements.

Experts spoke to the benefits of making a "living tool" that can be updated as states implement actions that are equity-centered, or as states release reports that demonstrate improvements in equitable health outcomes. This would also be able to spotlight progress: users would be able to see new policies and actions being implemented over time, and can then see how those actions may or may not have influenced equity indicators within the tool.

Talking directly with Medicaid enrollees

All of the experts spoke about the importance of consulting and working directly with the communities and people experiencing the inequities in Medicaid. This part of the project is already underway as we work alongside our partner Health Leads.

CONCLUSIONS

These conversations illuminate a couple of key takeaways for consideration for a potential tool.

Communicating about structural racism in Medicaid should be multi-modal and broad to ensure both accessibility for multiple audiences and to emphasize that Medicaid is one social safety net embedded within a larger system. The experts acknowledged that Medicaid members are affected by higher-level inequitable structures that span beyond the Medicaid program's policies and actions. **This underlines the importance of an Underlying Factors section for a potential tool, which must strike a balance between being data driven, historically informed, and systems focused.**

Additionally, the experts' suggestions for how to maintain an asset frame for this work aligned with current project activities. They noted the importance of monitoring and highlighting actions taken by state Medicaid agencies to advance health equity, which is consistent with the Program Actions component of the MET wireframe. Centering member voices was also recommended, which affirmed the important role of Health Leads, a MET partner leading community engagement work focused on Medicaid member experiences.

If you are interested in additional information about this work or the Medicaid Equity Monitoring Tool project, please contact MET's project lead Christina Worrall at cworrall@umn.edu.