

# Annotated Bibliography: Underlying Factors of Medicaid Inequities

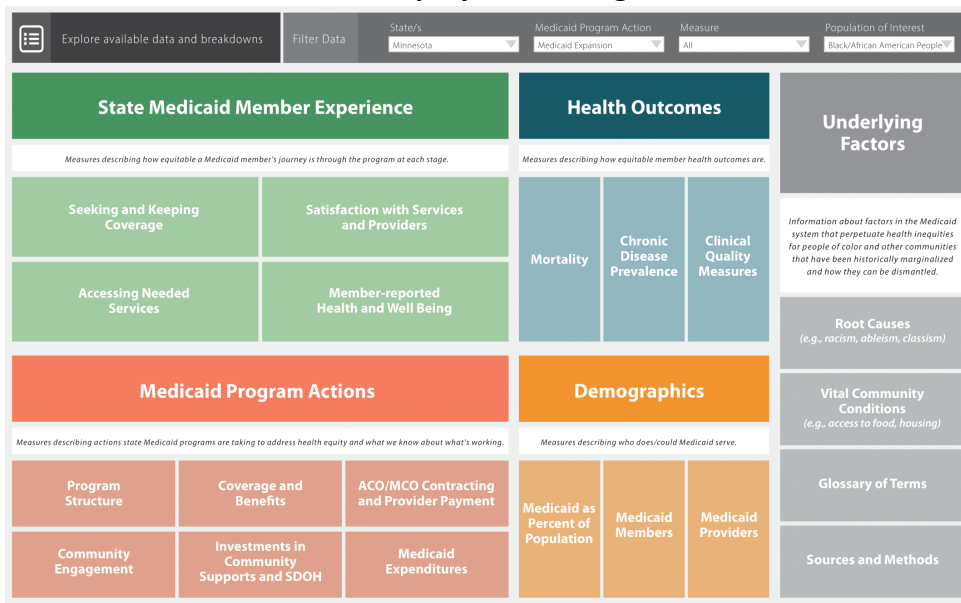
Last Updated April 4, 2024



The [State Health Access Data Assistance Center](#) (SHADAC), with support from the [Robert Wood Johnson Foundation](#) (RWJF) and in collaboration with partner organizations, is exploring whether a new national Medicaid Equity Monitoring Tool could increase accountability for state Medicaid programs to advance health equity while also improving population health. An [Advisory Committee](#) convened during the first project phase developed a high-level conceptual wireframe of a potential data tool that would track indicators of health equity in state Medicaid programs (Exhibit 1). In this second planning phase, the project team will explore whether a data tool as envisioned in the wireframe can be designed, developed, and maintained. A series of resources will shed light on the opportunities and gaps that exist in populating the different sections of a first iteration data tool that aligns with the wireframe.

Information in this specific resource is foundational for the section of the wireframe labeled “Underlying Factors.” This section of the tool (shown in grey in the image below) would include 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.

**Exhibit 1. Medicaid Equity Monitoring Tool “Wireframe”**



## **BACKGROUND AND PURPOSE**

The project team’s current scope of work includes assessing the feasibility of populating sections of the wireframe data tool to track indicators of health equity in state Medicaid programs. One section of the wireframe, labeled “Underlying Factors”, is a placeholder for resources and websites that explain how root causes of health inequities influence the current structure and functioning of Medicaid and the conditions where Medicaid members live. A ‘root

cause' is defined as *“the intrapersonal, interpersonal, institutional, and systemic mechanisms that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expression, and other dimensions”*, as well as *“the unequal allocation of power and resources—including goods, services, and societal attention—which manifest in unequal social, economic, and environmental conditions, also called the social determinants of health.”*<sup>1</sup> Common examples of root causes of health inequities include racism, ableism, and classism, amongst others. The Advisory Committee was firm in its belief that a future tool should include ways to inform users about root causes of health inequities in Medicaid. The vision is to have a section of the tool dedicated to research articles, white papers, and other publications regarding root causes, and to also have references to this information in other sections of the tool that help explain differences and trends seen in the data.

To this end, SHADAC conducted an initial scan of recent peer-reviewed articles and grey literature – regarding root causes and underlying factors that contribute to disparities in insurance coverage, access, utilization, and quality of health care in Medicaid; this annotated bibliography represents the findings from this initial scan.

The following annotated bibliography both identifies experts in Medicaid inequities and summarizes key articles and their findings. Through this work, our hope is that we can find and engage partners interested in collaborating to better understand the root causes of inequities in the Medicaid program that could be included as an integral component of a Medicaid equity tool.

This bibliography begins with a description of the methods used to conduct the literature review, followed by summaries of key resources. Resources are organized by topic areas most frequently addressed including systemic racism, systemic ableism, sexual orientation, gender identity, and gender affirming care discrimination, reproductive oppression in health care, and impact on vital community conditions.

## **METHODS**

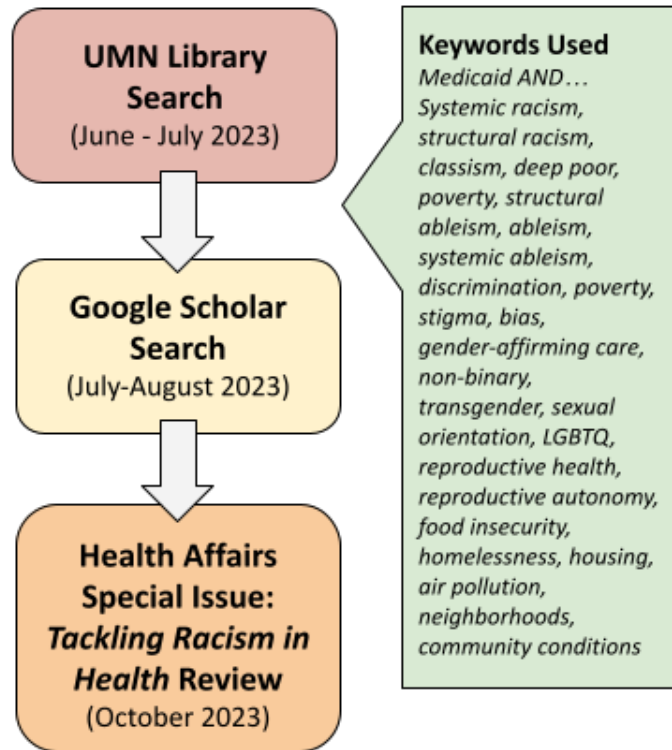
The scan, conducted between June and October 2023, reviewed resources published between January 2018 and October 2023. Resources were identified via keyword searches for specific root causes of health inequities, e.g., racism, classism, and ableism, etc., through the University of Minnesota Libraries database search (see Exhibit 2 below). Another search with the same

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<sup>1</sup> Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (2019). *The Root Causes of Health Inequity*. National Library of Medicine; National Academies Press (US). <https://www.ncbi.nlm.nih.gov/books/NBK425845/>

keywords was performed again through Google Scholar to accommodate any literature that the UMN Library system may not have access to.

**Exhibit 2: Approach to Identification of Resources for this Annotated Bibliography**



The first 250 resources for each keyword search were scanned by an initial reviewer to see if the abstract and/or the article contained any mention of Medicaid populations as well as for recency; articles and publications were omitted if they were published before 2018. If the article or resource included references to the Medicaid program or populations and fell within the chosen timespan (published in the last five years), those were pulled and reviewed in more detail by the project team. This resulted in 49 articles of potential relevance remaining to be reviewed in greater detail by the team for this project.

We then reviewed the 49 articles and selected those articles that provided the following: historical context of Medicaid inequities; information on how underlying factors continue to perpetuate inequities in accessing Medicaid coverage and services; and recommendations offered as solutions to alleviate inequities within the Medicaid program. Note: Articles that did not address historical context were excluded from this bibliography, but will be reviewed to inform future scans of evidence of state Medicaid program actions to advance health equity.

In order to address bias concerns with article selection, we considered the diversity of the scholar(s) who wrote the article, and we added keywords such as bias, stigma, and discrimination in select searches to expand our search beyond articles that use solely academic terminology for root causes (e.g., structural racism, systemic ableism, etc.). We also conducted reverse searches of select resources for additional published work by that author, in order to try to elevate the voices of the scholars working consistently in this space.

While this annotated bibliography covers a wide range of topics and populations of interest for the Medicaid Equity Monitoring Tool project, this was not a systematic or scoping review that is inclusive of all work at this intersection of Medicaid and underlying factors that contribute to health inequities. Books, dissertations, and master's theses were excluded entirely from the search, and only one commentary was allowed because of its discussion of structural issues in specialty care.

Based on the above criteria, we identified a final list of 33 resources and organized them into five topic areas. Each section begins with a short description of the topic area. The first resource listed in each section is the one that reviewers perceived to provide the best historical context on the topic (regardless of date). The resources that follow are in chronological order, with the most recent perspectives at the end of each topic section. Articles from the same year are ordered alphabetically by author, not by month of publication.

## **RESOURCES BY TOPIC AREA**

### **SYSTEMIC RACISM**

The modifiers 'structural', 'institutional', and 'systemic' are often used interchangeably, and *"describe how racism is embedded across systems, structures and institutions and how these work in concert to perpetuate racial inequity."*<sup>2</sup> The articles summarized in this section describe historical implications of the Medicaid program that have perpetuated disparities, discrimination, provider bias, and institutional racism throughout the health care system for Medicaid eligible individuals who identify as people of color. Many sources in this section also discuss how to disentangle inherently systemically racist practices from the Medicaid program and move toward equitable policies that can positively impact Medicaid coverage, access, and care quality.

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<sup>2</sup> State Health & Value Strategies (SHVS). (2021). *Talking about anti-racism and health equity: Discussing racism*. <https://www.shvs.org/wp-content/uploads/2021/08/Talking-About-Anti-Racism-Health-Equity-1-of-3.pdf>

*Keywords: Medicaid and racism, Medicaid and systemic racism, Medicaid and structural racism, Medicaid and stigma, Medicaid and bias, Medicaid and discrimination, Medicaid and poverty, Medicaid and deep poor, Medicaid and classism*

**Yearby, R. (2018), Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism. Am J Econ Sociol, 77: 1113-1152. <https://doi-org.ezp1.lib.umn.edu/10.1111/ajes.12230>**

**Author(s):** Ruqaiyah Yearby, Professor of Law at Ohio State University<sup>3</sup>

**Article Type:** Peer-reviewed journal

This article discusses the historical context and implications of Medicaid’s origins. For example, Title VI of the Civil Rights Act of 1964 was designed to support hospital-level integration but did not apply to individual-level providers, which allowed for racism to persist especially directed toward Black people. The racist conduct of providers persisted beyond Title VI, creating mistrust and deterring Black people from seeking health care even today. Yearby connects key aspects of systemic racism to health inequity, such as housing discrimination, the wealth gap, and employment discrimination. She goes on to discuss ways in which these issues are not permanent – that they can be resolved through multifaceted solutions aimed at holding institutions accountable for racial disparities in their health care, such as further diversity training for health care staff at all levels, emphasis on cultural humility over cultural competency, and, on the federal level, implementation of new anti-discrimination laws that hold institutions (such as health care systems) accountable for vast or increasing disparities among their patients.

**Korenman, S., Remler, D. K., & Hyson, R. T. (2019). Medicaid Expansions and Poverty: Comparing Supplemental and Health-Inclusive Poverty Measures. Social Service Review, 93(3), 429–483. <https://doi.org/10.1086/705319>**

**Author(s):** Sanders Korenman, Dahlia Remler, City University of New York Graduate Center; Rosemary Hyson, City University of New York, Baruch College

**Article Type:** Peer-reviewed journal

Authors explain how a newly constructed measure of poverty, called the “Health-Inclusive Poverty Measure,” that accounts for both health insurance needs and resources to meet them, builds on the research related to the impact of Medicaid expansion on poverty. The premise for

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<sup>3</sup> Another article of interest by Ruqaiyah Yearby: Yearby R. and Mohapatra S. (2021). Systemic Racism, The Government’s Pandemic Response, and Racial Inequities in COVID-19. Emory Law Journal, 70(7), 1418–1473.

this new measure is that health insurance is a basic necessity and should be incorporated into how poverty is measured. The Census Bureau’s supplemental poverty measure, another common measure of poverty, accounts for *indirect* effects of health insurance on poverty. Comparatively, the new Health Inclusive Poverty Measure adds insurance needs, does not deduct out-of-pocket spending on premiums, adds health insurance benefits, and caps other deductions, such as deductibles and copays. Using this new measure, the authors explain that Medicaid can move a family out of poverty when their resources are above the measure threshold or keep them from falling into poverty due to out-of-pocket expenses. Authors conduct logistical regressions and show that the poverty rate as defined by the new health-inclusive measure is lower in expansion states than non-expansion states; the deep poverty rate is lower, too, in expansion states versus non-expansion states. Differences were generally smaller and not statistically significant when using the supplemental measure. Thus, the authors conclude that any rollbacks in Medicaid expansion would not only hurt public health, but also increase poverty as well.

**Snowden, L., & Graaf, G. (2019). The “Undeserving Poor,” Racial Bias, and Medicaid Coverage of African Americans. *Journal of Black Psychology*, 45(3), 009579841984412.**

<https://doi.org/10.1177/0095798419844129>

**Author(s):** Lonni Snowden, Health Policy and Management, University of California Berkeley; and Genevieve Graaf, School of Social Work, University of Texas at Arlington

**Article Type:** Peer-reviewed journal

This article elevates the structural determinants of African American individuals’ physical and psychological well-being, namely stereotypes and biases that deny these individuals much-needed health insurance coverage and treatment. Authors attribute greater African American-White disparity in coverage to African American individuals’ disproportionate residence in states that declined to expand Medicaid. Authors build on earlier research by Colleen Grogan and Sung-geun Ethan Park documenting the association between state’s acceptance of Medicaid expansion and representation of African American people and White peoples’ willingness to accept expansion.<sup>4</sup> In addition, while stigma associated with Medicaid coverage has lessened for some population groups, it has not for the “non-deserving” poor, i.e., nonelderly, nondisabled adults. In fact, studies suggest that negative attitudes towards Black people explains opposition to welfare spending and public health insurance coverage. Authors call on additional research documenting both the benefits of expansion and how biases act as a

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<sup>4</sup> Grogan, C. M., & Park, S. (Ethan). (2017). The Racial Divide in State Medicaid Expansions. *Journal of Health Politics, Policy and Law*, 42(3), 539–572. <https://doi.org/10.1215/03616878-3802977>

barrier. The authors also encourage Medicaid administrators and providers to offer culturally sensitive care.

**McGregor, B., Li, C., Baltrus, P., Douglas, M., Hopkins, J., Wrenn, G., Holden, K., Respress, E., & Gaglioti, A. (2020). Racial and Ethnic Disparities in Treatment and Treatment Type for Depression in a National Sample of Medicaid Recipients. *Psychiatric Services*, 71(7), 663–669. <https://doi.org/10.1176/appi.ps.201900407>**

**Author(s):** Brian McGregor, Glenda Wrenn and Kisha Holden, Department of Psychiatry and Behavioral Sciences & The Satcher Health Leadership Institute, Morehouse School of Medicine, Atlanta, Georgia; Chaohua Li and Peter Baltrus, National Center for Primary Care

**Article Type:** Peer-reviewed journal

This article explores disparities in uptake and modality of treatment for depression for those who are enrolled in Medicaid and seeking mental health care. Authors analyze data from a nationally representative sample of Medicaid claims (in 28 states and the District of Columbia) from 2008-2009. The study identified that African American Medicaid enrollees diagnosed with depression were about half as likely to have received treatment compared to white Medicaid enrollees diagnosed with depression; Hispanic Medicaid enrollees diagnosed with depression were about three-quarters as likely to have received treatment compared to white Medicaid enrollees diagnosed with depression. Additionally, African Americans who received treatment for their depression were “...less likely to receive medication alone...”, but more likely to only be in therapy (without medication) compared to whites. These findings stood when controlled for medical comorbidities, neighborhood income inequality and poverty, and neighborhood educational context. The authors attribute these disparities partially to cultural differences and stigma of receiving mental health care, as well as provider implicit and explicit bias and structural factors that perpetuate inequities. The authors recommend integrated care models as a way to overcome stigma and improve mental health care access.

**Minoff, E. (2020). The Racist Roots of Work Requirements. Center for the Study of Social Policy (pp. 1–33). Center for the Study of Social Policy. <https://cssp.org/wp-content/uploads/2020/02/Racist-Roots-of-Work-Requirements-CSSP-1.pdf>**

**Author(s):** Elisa Minoff, Senior Policy Analyst at Center for the Study of Social Policy

**Article Type:** Report

This resource, written by a policy analyst in an advocacy organization, provides a detailed history of work requirements in the U.S. and how these policies are based on a bias that certain

people, i.e., Black people, do not want to work. This report also argues that these policies were written to coerce people, primarily Black people, into certain forms of labor thus inflating the standing of White people and putting any assistance available to non-White people at risk. Despite a lack of evidence in favor of these policies for the well-being of all, they continue to be promoted. For example, the Medicaid work requirements under the Trump Administration proved harmful to families; evaluation of the policy in Arkansas' showed that the Medicaid work requirement led to coverage losses and no employment gains).<sup>5</sup> The author argues that in order to stop the creation of policies rooted in structural racism, it is important to understand "how we got here." Beginning with slavery and White enslavers perpetuating racist stereotypes about Black people, the author discusses how this has evolved to public assistance policies requiring primarily Black families to work in low-wage, insecure jobs. "Work requirements not only deny families much-needed assistance, but they also discount much of their labor, ignoring the caregiving work that people provide to their loved ones...." The author advocates for the abolishment of work requirements and the promotion of policies, e.g., higher minimum wage, child care, and paid family leave, that value all work, no matter the setting or wage.

**Nolan, L.T., Beckman, A.L., & Sandoe, E. (2020). "How Foundational Moments In Medicaid's History Reinforced Rather Than Eliminated Racial Health Disparities", Health Affairs Forefront. <https://www.healthaffairs.org/content/forefront/foundational-moments-medicaid-s-history-reinforced-rather-than-eliminated-racial-health>**

**Author(s):** LaShyra T. Nolen, Founding Executive Director of We Got Us and Current Student Harvard Medical School; Adam L. Beckman, Medical Student at Harvard Medical School and Harvard Business School; Emma Sandoe, Associate Director of Strategy and Planning at North Carolina Medicaid and Adjunct Professor at Duke University

**Article Type:** Peer-reviewed online brief

The authors examine foundational moments in the history of the Medicaid program—the creation of Medicaid (1965), welfare reform (1996), the ACA Medicaid expansion (2012), and the COVID-19 pandemic (2020)—that led to inequities in access to care as well as the racial disparities and disparate health outcomes that resulted. The authors call for policy changes in Medicaid that focus on: improving access to care for marginalized communities; prioritizing clinical care to address diseases and conditions that have disproportionately affected Black Americans; diversifying the health care and nursing facility workforce; and incentivizing nursing

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<sup>5</sup> Sommers, B. D., Goldman, A. L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2019). Medicaid Work Requirements — Results from the First Year in Arkansas. *New England Journal of Medicine*, 381(11), 1073–1082. <https://doi.org/10.1056/nejmsr1901772>



facilities to provide minority patient access to care while also address disparities minority patients often face.

**Shafer, P. R., & Ndugga, N. (2020). Fighting the Institutionalization of Racism in Medicaid. American Journal of Public Health, 110(12), 1790–1791.**

<https://doi.org/10.2105/AJPH.2020.305946>

**Author(s):** Paul R. Schafer, Professor at Boston University School of Public Health; Nambi Ndugga, Policy Analyst at the Kaiser Family Foundation’s Racial Equity and Health Policy Program

**Article type:** Peer-reviewed journal perspective

This American Journal of Public Health Perspective written at the height of the COVID-19 pandemic by scholars at Boston University raises concerns about some states using flexibilities offered in the Medicaid program to exacerbate inequities. The authors cite the Trump Administration initiatives restricting benefits and spending (such as converting Medicaid to a block grant, work requirements, and restrictions on retroactive eligibility) as having a disproportionate negative effect on Black Americans and people of color. The authors move on to caution decision makers against promoting rather than reversing institutional racism in initiatives like these. These initiatives, regardless of if they were established with racist intent or not, demonstrate that inequities are still built into Medicaid’s policies and practices today – and that we need to replace them with equitable policies that benefit those most in need.

**Jaramillo, E. T., & Willging, C. E. (2021). Producing insecurity: Healthcare access, health insurance, and wellbeing among American Indian elders. Social Science & Medicine, 268.**

<https://doi.org/10.1016/j.socscimed.2020.113384>

**Author(s):** Elise Trott Jaramillo, Associate Research Scientist at the Pacific Institute for Research and Evaluation (PIRE-Southwest); Cathleen Willging, Center Director and Senior Research Scientist II at the Pacific Institute for Research and Evaluation (PIRE-Southwest)

**Article Type:** Peer-reviewed journal

This peer-reviewed article provides a qualitative perspective on the experiences of Native American elders in the health care system across the United States. Native American people have experienced significantly higher rates of mortality from heart disease, higher rates of diabetes and mental health concerns, and have the lowest life expectancy of any aggregated race in the country. This is attributed to the lack of sufficient funding for the Indian Health Service, a separate health system that is meant to serve enrolled members of federally

recognized tribes. While the expansion of Medicaid and other provisions under the Affordable Care Act (ACA) improved access to health insurance coverage for American Indian people, concerns of inadequate services sparked this research study, which consisted of semi-structured interviews with 95 elders between June 2016 and March 2017. The study found the elders lacked confidence in three main aspects of the health care system: interactions with providers (e.g., lack of trust, accessible communication, and/or coordination); identification of health insurance coverage and health care costs (e.g., confusion); and federal policy for American Indians. The authors conclude with a call to action to address health care hesitancy in a way that does not increase the complexity that Native people already face in navigating the health care system, but instead focuses resources on systemic and provider-centric changes that can build confidence for American Indian people seeking care.

**Alio, A. P., Wharton, M. J., & Fiscella, K. (2022). Structural Racism and Inequities in Access to Medicaid-Funded Quality Cancer Care in the United States. *JAMA Network Open*, 5(7).**

<https://doi.org/10.1001/jamanetworkopen.2022.22220>

**Author(s):** Paula Amina Alio, Professor in the Department of Public Health Sciences at the University of Rochester; Mitchell J. Wharton, Associate Professor of Clinical Nursing and Associate Dean for Equity and Inclusion at the University of Rochester; Kevin Fiscella, Professor in the Departments of Family Medicine and Public Health Sciences at the University of Rochester

**Article type:** Commentary

Authors in this commentary share their perspectives on findings from a secret shopper study building off of the established association between having Medicaid coverage and a lower likelihood of scheduling specialty care appointments compared to those with private insurance coverage. In that secret shopper study from Marks et al<sup>6</sup>, researchers found that only two thirds of facilities accepted new patient appointments for cancer treatment for patients covered by Medicaid. Authors of this commentary suggest that downstream solutions, including improved reimbursement and adoption of new payment models, are not enough to help resolve these issues of access to care. They aim to raise awareness of structural racism in health care and promote equity-centered health care policies over those that only advantage white populations. Examples of the authors' suggested solutions include Centers for Medicaid Services (CMS) requiring facilities to make their Medicaid policies public as well as incorporating 'access to Medicaid' in managed care and accreditation organizations requirements and

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<sup>6</sup> Marks, V., Hsiang, W., Nie, J., Demkowicz, P., Umer, W., Haleem, A., Galal, B., Pak, I., Kim, D., Salazar, M. C., Berger, E. R., & Leapman, M. (2022). Acceptance of Simulated Adult Patients With Medicaid Insurance Seeking Care in a Cancer Hospital for a New Cancer Diagnosis. *JAMA Network Open*, 5(7), e2222214–e2222214. <https://doi.org/10.1001/jamanetworkopen.2022.22214>

standards. Improving data collection, gathering patient experience exit surveys, and establishing patient grievance processes were also proposed as possible solutions.

**Somers, S., & Perkins, J. (2022). The Ongoing Racial Paradox of the Medicaid Program. Journal of Health and Life Science (pp. 96–112). American Health Law Association.**

<https://healthlaw.org/wp-content/uploads/2022/05/The-Ongoing-Racial-Paradox-of-the-Medicaid-Program.pdf>

**Author(s):** Sarah Somers, Managing Attorney of the National Health Law Program’s (NHeLP) Chapel Hill, North Carolina Office; Jane Perkins, Legal Director of the National Health Law Program (NHeLP)

**Article Type:** Peer-reviewed journal

This resource discusses the history of Medicaid and makes key observations about the paradox of the Medicaid program – that while Medicaid has decreased disparities in health insurance coverage and access among the poor and people of color, the program was also founded on inherently racist premises. The authors point to three distinct Medicaid policies that shaped its weaknesses. First, the program’s beginnings were not federal; it was an optional state-level program. This resulted in disparities between states, as the authors say, “States in the South lagged. Thirty-two states had adopted Medicaid before even the first former Confederate state had adopted it.” The second major issue with Medicaid’s foundations that authors call out was its roots in the voluntary health coverage program under the Kerr-Mills Act of 1960, which had the stigma of a welfare program. The authors point out that in order, “to qualify, a person had to be poor and fit with a population group deemed worthy of coverage.” The third major concern with Medicaid’s history according to these authors is its fundamental coverage, delegation of decision making, and enforcement of covered services to states. Despite protections afforded under Title VI of the Civil Rights Act, extremely segregated facilities and disparities in both services and outcomes exist to this day. Authors discuss ways Medicaid can address systemic racism, including encouraging the expansion of Medicaid in states that have not yet made that decision, the addition of requirements to improve health equity in state contracts with Medicaid managed care plans, and the improvement of collection and reporting of disaggregated data.

**Wallace, J., Lollo, A., Duchowny, K. A., Lavallee, M., & Ndumele, C. D. (2022). Disparities in Health Care Spending and Utilization Among Black and White Medicaid Enrollees. JAMA Health Forum, 3(6), e221398. <https://doi.org/10.1001/jamahealthforum.2022.1398>**

**Authors:** Jacob Wallace, Professor at Yale School of Public Health, Anthony Lollo, Professor at Yale School of Public Health, Kate Duchowny, University of California – San Francisco, Chima Ndumele, Professor at Yale School of Public Health, Matthew Lavallee, Yale University.

**Article Type:** Peer-reviewed journal

This article utilizes 2016 administrative records from three Southern and Midwest state Medicaid programs to compare whether there were differences in health care spending and utilization between nearly two million black and white Medicaid enrollees. Results indicated that spending on adult Black enrollees was less than adult white enrollees after adjusting for demographic characteristics and health status. Additionally, Black Medicaid adults and children utilized health care less, including primary care, but visited the emergency department more than white Medicaid populations. Regarding preventive care, Black enrollees had higher rates of measures of some screenings, e.g., breast cancer, cervical cancer, chlamydia, than white enrollees. However, Black enrollees with asthma, diabetes, and cardiovascular conditions filled fewer pharmaceutical prescriptions than white enrollees. The authors attributed these differences in part to the structural and interpersonal racism that racial and ethnic minority groups face when navigating the health care system, as well as reduced access to care despite coverage increases for racial minorities overall. The authors recommend improvements to Medicaid managed care risk adjustment practices as Black enrollees are currently undercompensated in coverage due to unmet need. In addition, authors suggest a need to align plan and provider incentives to address health equity in the Medicaid program.

**Goran, A., Tatum, L., Brumfield, C., & Carr, A. (2023). Re-Envisioning Medicaid & CHIP as Anti-Racist Programs. Georgetown Center of Poverty and Law.**

**<https://www.georgetownpoverty.org/wp-content/uploads/2023/06/Re-envisioning-Medicaid-CHIP-June2023.pdf>**

**Author(s):** Ayan Goran, Policy Analyst at the Georgetown Center on Poverty and Inequality (GCPI); Laura Tatum, Managing Director of Policy & Research at GCPI; Cara Brumfield, Director of Income and Work Supports at the Center for Law and Social Policy (CLASP); Aileen Carr, Interim Executive Director of GCPI

**Article Type:** Report

This report discusses how many aspects of the Medicaid and Children’s Health Insurance Program (CHIP) programs contribute to health inequities among enrolled people of color. The

report covers key historical factors, such as the low reimbursement rates to hospitals and clinics for services, continued racial segregation in nursing facilities, and limited coverage for birthing people and their newborns. The latter likely contributes to the United States' maternal mortality rate ranking highest among developed countries. The authors also specifically emphasize systemic and administrative barriers in the enrollment process, highlighting political and media narratives that have resulted in exclusionary policies directed toward single mothers of color, particularly black women, as well as immigrants. Work requirements were another key exclusionary factor, as well as a quick turnaround on verification processes that relied on paper mail to arrive at the correct address in a timely manner among other administrative burdens. This report provides multiple recommendations on how to address these issues within both Medicaid and CHIP, including taking action at the federal level to close the coverage gap both in states that have not expanded Medicaid and for certain populations, making CHIP funding permanent, increasing Medicaid reimbursement rates, and alleviating administrative burdens. Additionally, authors point to centering community voices and empowering program participants through partnerships with community advocacy organizations and community health workers, compensating these organizations and/or individuals for their time.

**Haeder, S. F., & Moynihan, D. P. (2023). Race and Racial Perceptions Shape Burden Tolerance for Medicaid and the Supplemental Nutrition Assistance Program. *Health Affairs*, 42(10), 1334–1343. <https://doi.org/10.1377/hlthaff.2023.00472>**

**Author(s):** Simon Haeder, Department of Health Policy & Management, Texas A & M University; Donald Moynihan, School of Public Policy, Georgetown University

**Article Type:** Peer-reviewed journal

This piece uses survey data to explore the relationship between racial resentment and public attitudes towards administrative policies in public programs such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP). A random sample of adults with either Medicaid or SNAP were surveyed about the effects of administrative burdens (i.e., requiring in person interviews, lack of presumptive eligibility, lack of express lane eligibility, more frequent renewals, work requirements, and lack of continuous coverage) on program enrollment; a treatment group received additional information on how administrative burdens affect certain populations or exacerbate racial inequities in the survey introduction, while a control group did not receive this additional information. Authors found no relationship between exposure to this information and support for state actions associated with each of the six types of administrative burden. However, authors did find a relationship between support for administratively burdensome policies and racial resentment. Based on an analysis of non-Hispanic white respondents who were asked about racial resentment toward Black people, those with higher

levels of racial resentment were more supportive of Medicaid-specific policies that would create burden. Implications for policy makers, according to the authors, include that the general public's views on how state actions affect different socioeconomic groups are very important to the legislative process, and these views have an impact on support for new or proposed policies. However, it is also important to note that the finding that the public is hesitant to reduce initial enrollment burdens (such as work requirements) may be due to concerns of program integrity and combating fraud in addition to racial resentment. Overall, the public is more supportive of policies that reduce burden *after* enrollment, such as less frequent renewals and elimination of in-person interview requirements.

**Ku, L. (2023). Medicaid And SNAP Advance Equity But Sometimes Have Hidden Racial And Ethnic Barriers. *Health Affairs*, 42(10), 1347–1350.**

<https://doi.org/10.1377/hlthaff.2023.00994>

**Author(s):** Leighton Ku, Professor and Director of the Center for Health Policy Research at the Milken Institute School of Public Health, George Washington University

**Article Type:** Perspective in peer-reviewed journal

The author provides the historical context for programs like Medicaid and SNAP, explaining how they fill a gap in services for individuals and households living in poverty and addressing disparities in access to health care and food. While progress has been made, these programs are currently operating in an environment that runs counter to their original goals. While not explicitly racist, certain administrative policies (such as work requirements and immigration status restrictions), can be implicitly so, as they often have a disproportionately negative effect on specific populations of color. The author recommends that agencies administering these programs should reconsider policies that hinder enrollment and benefits.

**Michener, J., & Ford, T. N. (2023). Racism and Health: Three Core Principles. *Milbank Quarterly*, 101(S1), 333–355. <https://doi.org/10.1111/1468-0009.12633>**

**Author(s):** Jamila Michener, Professor of Government and Public Policy, Co-Director of the Center of Health Equity at Cornell University;<sup>7</sup> Tiffany N. Ford, Brookings Institution at University of Illinois at Chicago

**Article Type:** Peer-reviewed journal

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<sup>7</sup> Other resources from Jamila Michener include her book, *Fragmented Democracy: Medicaid, Federalism, and Unequal Politics*, as well as [this Vox article](#) on the politics and policy of racism in American health care.

This article discusses the important context of racism and three core principles that the authors see as key to understanding and implementing policy changes related to health and racial equity. Those three core principles are described as: “interlocking systems of oppression”, “cumulative disadvantage”, and “power”. Racism operates both alongside and interlocked with other systems of oppression, such as patriarchy, structural sexism, ageism, sizeism, ableism, homophobia, and others, which have impacted society both historically and in the present day by shaping the ways in which people live. Racist and oppressive policies can have a cumulative negative effect (“cumulative disadvantage”) across systems (examples of such systems include “child welfare, public assistance, banking, incarceration, employment, housing”), and generally throughout one’s life course. The authors state that studying and addressing policies in these areas in isolation is not productive – “people and communities experience these policy arenas as overlapping aspects of daily life” just as they experience many “interlocking systems of oppression” at once. The authors also discuss the complex relationship between the concepts of power and race, arguing that power fuels racism. Race, the authors say, is not a biological fact, but rather a social construct based on appearances. And power, according to the authors, is based on where a group falls on a socially constructed racial hierarchy. Thus, power fuels racism, as groups in power will act to both construct and maintain systems that perpetuate inequities and keep themselves at the top of the hierarchy. The Medicaid program is discussed by the authors as having many policies that perpetuate these differences between races and create both cumulative disadvantage and power imbalances, with work requirements used as a prime example. The authors suggest that progress towards a more equitable future for everyone requires program design, policymaking, data collection, and research that both collaborates with and centers communities experiencing inequities. The authors also propose engaging professionals in various disciplines, such as public health, public policy, and urban planning, as well as different sectors of organizations such as academia, government, and non-profits, in the creation and revision of equitable policies and programs.

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## **SYSTEMIC / STRUCTURAL ABLEISM**

Systemic or structural ableism is defined as *“a complex system of hierarchical and discriminatory processes, policies, and institutions that privilege and prefer able-bodied people, fail to represent or meaningfully include disabled persons’ voices, and are grounded in a network of ableist beliefs and practices that maintain and reproduce unequal outcomes for disabled people and benefit able-bodied people.”*<sup>8</sup> The systemic ableism category of this resource aims to highlight the experiences, barriers, and inequities of Medicaid eligibles and

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<sup>8</sup> Valdez, R. S., & Swenor, B. K. (2023). Structural Ableism — Essential Steps for Abolishing Disability Injustice. The New England Journal of Medicine, 388(20), 1827–1829. <https://doi.org/10.1056/nejmp2302561>

recipients who have intellectual and/or physical disabilities. The articles in this section also provide implications for the greater health care system – that much of health care is oriented to the able-bodied and overlooks those with different mobility and accessibility needs. Community collaboration and consultation, allocation of funding toward resolving ableist policies and practices, and considering physical accessibility when designing new architecture are just a few of the many varied options that can be pursued to better represent and provide appropriate, accommodating care for those with disabilities.

*Keywords: Medicaid and ableism, Medicaid and structural ableism, Medicaid and systemic ableism, Medicaid and disability, Medicaid and bias, Medicaid and stigma*

**Valdez, R. S., & Swenor, B. K. (2023). Structural Ableism — Essential Steps for Abolishing Disability Injustice. *The New England Journal of Medicine*, 388(20), 1827–1829.**

<https://doi.org/10.1056/nejmp2302561>

**Author(s):** Rupa S. Valdez, the Departments of Public Health Sciences and Engineering Systems and Environment, University of Virginia; and Bonnielin Swenor, the Disability Health Research Center, Bloomberg School of Public Health, Johns Hopkins University

**Article Type:** Peer-reviewed journal perspective

This article discusses the details of systemic ableism and its effects on those with intellectual and/or physical disabilities. The authors maintain that this underlying factor of health inequities is often ignored in health care and research spaces. In addition, more attention is needed on the ways structural ableism interacts with other forms of oppression. The core purpose of this article is to highlight achievable and actionable solutions for alleviating bias and discrimination of those with disabilities. Proposed solutions include establishing measures of structural ableism within research and providing accessibility options within physical environments (e.g. streets & roadways, buildings, neighborhoods, and cities). The authors also emphasize a need for the adaptation of measures of structural racism plus the addition of new measurement domains. Of particular importance for the authors is measuring both the funding allocated for home and community based services within the Medicaid program as well as measuring the rate of violations of the Olmstead decision, which entitles those with disabilities to community integration and community-based services. Consideration of qualitative methods and community partnership in this work is also crucial for creating actionable and effective solutions to issues of systemic ableism.



**Friedman, C., & VanPuymbrouck, L. (2019). The relationship between disability prejudice and medicaid home and community-based services spending. Disability and health journal, 12(3), 359–365. <https://doi.org/10.1016/j.dhjo.2019.01.012>**

**Author(s):** Carli Friedman, Director of Research for The Council on Quality and Leadership (CQL) at the University of Washington; Laura VanPuymbrouck, Assistant Professor of Occupational Therapy at Rush University

**Article Type:** Peer-reviewed journal

This peer reviewed article summarizes findings from a quantitative study exploring the association between ableism in the U.S. and Medicaid spending on long term services and supports. It begins with historical context about deinstitutionalization of people with disabilities and the history of Medicaid as both a primary payer for long-term care and an insurer for people with disabilities. Despite research indicating community living has more benefits than institutions, investments in home and community-based services vary state to state; authors hypothesize that an association exists between stereotypical attitudes toward people with disabilities (i.e., as dependent, a drain, not capable) and state decision making. Using CMS expenditure data and survey data from the Disability Attitudes - Implicit Association Test, authors found a negative association between state prejudice scores and state funding of home health and community-based services. While causality cannot be assumed, authors conclude by stressing the importance of understanding how disability prejudice is embedded into our society, and how it may influence Medicaid and other policy decisions. These findings are a call to advocate for increased investment in community services and to promote advocacy for the health and well-being of people with disabilities.

**Earl, E. (2023). Promoting Health Care Equity: The Instrumentality of Medicare and Medicaid in Fighting Ableism Within the American Health Care System. Seton Hall Law Review: Vol. 53: Iss. 5 , Article 9. Available at: <https://scholarship.shu.edu/shlr/vol53/iss5/9>**

**Author(s):** Emmalise Earl, Seton Hall University, Judicial Law Clerk in New Jersey Court System

**Article Type:** Peer-reviewed journal

This article discusses long-standing systemic issues with having accessible health care tools and equipment for people with physical disabilities. Despite the passage of the American Disabilities Act in 1973, which requires hospitals and clinics to have physically accessible equipment for care for all individuals regardless of mobility status, the Act has gone loosely enforced for decades according to the author. Lack of accessible equipment for routine checkups, such as scales and exam tables, results in incomplete examinations, later and more severe diagnoses

due to inability to screen those with mobility related disabilities, as well as an exacerbation of current diagnoses due to incomplete or less effective treatment. The author states that “without more aggressive enforcement, these circumstances are not likely to change”. The author uses the Department of Veterans Affairs (VA) hospitals as an exemplar for what is needed to uphold accessibility standards. The VA requires all new medical equipment to be approved as accessible by their Access Board. The author also describes specific program actions that the Center for Medicare and Medicaid Services needs to take in enforcing equitable access to medical equipment. For Medicaid in particular, the author suggests that state Medicaid agencies adopt and enforce standards that facilities and providers must follow in order to participate in the Medicaid program. The authors also suggest leveraging tax incentives to overcome financial barriers to accessibility.

## **SEXUAL ORIENTATION, GENDER IDENTITY, AND GENDER AFFIRMING CARE DISCRIMINATION**

Sexual orientation is defined as “*inherent or immutable enduring emotional, romantic or sexual attraction to other people.*”<sup>9</sup> Gender identity is defined as “*one’s innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves.*”<sup>10</sup> Sexual orientation and gender identity (SOGI) discrimination can be experienced in many ways in the health care system, and is defined as unequal treatment of an individual based on their preferences of attraction, their assigned sex at birth, or their current gender identity and presentation. This topic covers the overlap of Medicaid coverage, access, and care utilization for those who identify within the LGBTQ+ community and especially those seeking gender-affirming care or services through Medicaid. Gender-affirming care can be defined as “a supportive form of health care that consists of an array of services that may include medical, surgical, mental health, and non-medical services for transgender and nonbinary people.”<sup>11</sup> These articles highlight some of the systemic barriers and discrimination that this group of people face when seeking care. Understanding and dismantling these barriers is important for ensuring LGBTQ+ individuals’ comfort in seeking care, and giving them equitable access to services they may need.

*Keywords: Medicaid and gender-affirming care or transgender or non-binary, Medicaid and LGBTQ, Medicaid and non-binary, Medicaid and transgender, Medicaid and sexual orientation*

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<sup>9</sup> Human Rights Campaign. (n.d.). Sexual Orientation and Gender Identity Definitions. Human Rights Campaign; HRC Foundation. <https://www.hrc.org/resources/sexual-orientation-and-gender-identity-terminology-and-definitions>

<sup>10</sup> Ibid.

<sup>11</sup> HHS Office of Population Affairs. (n.d.). Gender-Affirming Care and Young People. U.S. Department of Health & Human Services. <https://opa.hhs.gov/sites/default/files/2023-08/gender-affirming-care-young-people.pdf>

**Mallory, C., & Tentindo, W. (2022). Medicaid Coverage for Gender-Affirming Care. Williams Institute UCLA School of Law. <https://escholarship.org/content/qt4ng3j6st/qt4ng3j6st.pdf>**

**Author(s):** Christy Mallory and Will Tentindo, Williams Institute at University of California - Los Angeles

**Article Type:** Report

This report highlights key factors related to Medicaid coverage of gender affirming care. Emphasis is placed on the sheer number of individuals who identify as transgender or gender non-conforming that are covered by Medicaid – about one fourth of those who identify as transgender or gender non-conforming in the United States rely on Medicaid for their gender affirming care. Underlying factors contributing to inequities for this group include unclear language about what services are covered, and/or gender affirming care services are not covered at all in their state. Authors urge all states to fully expand their Medicaid program under the Affordable Care Act.

**Kempf, R., Elias, N., & Rubin-DeSimone, A. (2021). Transgender and Gender Non-Binary Healthcare Coverage in State Medicaid Programs: Recommendations for More Equitable Approaches. *Journal of Health and Human Services Administration*, 44(1), 86–108. <https://doi.org/10.37808/jhhsa.44.1.5>**

**Author(s):** Robin J. Kempf, Assistant Professor in the College of Public Service at the University of Colorado - Colorado Springs; Nicole M. Elias, Associate Professor in the Department of Public Management at John Jay College of Criminal Justice, City University of New York; Alonso J. Rubin-DeSimone, John Jay College of Criminal Justice, City University of New York

**Article Type:** Peer-reviewed journal

This peer reviewed journal article describes how transgender and gender non-binary individuals have been marginalized historically in U.S. society, including in terms of institutional or informal “erasure” as well as through isolation and “hypervisibility.” In health care, this discrimination translates into lack of access to qualified professionals and lack of coverage for a continuum of needed services. Authors chose to review state Medicaid program coverage policies to identify opportunities to build equity for all U.S. residents and noted that discrimination of individuals identifying as non-cisnormative gender can be compounded by the intersectionality of race, sexual orientation, socioeconomic status, and geographical location. They assessed comprehensiveness of state Medicaid coverage in accordance with the World Professional Association for Transgender Health (WPATH) standards. Authors found that the five states in

their sample varied widely in terms of health coverage to transgender and gender non-binary Medicaid beneficiaries, however, there were stand out states in terms of the continuum of services offered as well as opportunities for improvement. Authors recommend removal of barriers to needed care such as prior authorization requirements as well as additional training for providers and individuals making coverage determinations.

**Yuan, N., Chung, T., Ray, E. C., Sioni, C., Jimenez-Eichelberger, A., & Garcia, M. M. (2021). Requirement of mental health referral letters for staged and revision genital gender-affirming surgeries: An unsanctioned barrier to care. *Andrology*, 9(6), 1765–1772.**

<https://doi.org/10.1111/andr.13028>

**Author(s):** Nance Yuan, Cedars-Sinai Transgender Surgery and Health Program, and member of the Urology and Plastic Surgery Divisions at Cedars-Sinai Medical Center; Theodore Chung, David Geffen School of Medicine, University of California, Los Angeles; Alma Jimenez-Eichelberger and Caitlin Sioni, Cedars-Sinai Transgender Surgery and Health Program and the Division of Urology at Cedars-Sinai Medical Center; Edward C. Ray, Division of Plastic Surgery, Cedars-Sinai Medical Center; Maurice M. Garcia, Departments of Urology and Anatomy, University of California, San Francisco

**Article Type:** Peer-reviewed journal

This peer reviewed article investigates and discusses insurance requirements for referral letters from mental health providers prior to genital gender affirming surgeries for trans and non-binary individuals. In this study, half of the participants had federally funded insurance, such as Medicaid. Most plans, both public and private, required at least two referral letters at every stage of surgery (there may be four to five stages depending on the operation). Authors state that it took office staff, “an average of 2.5 hours per patient, per surgery, dedicated to coordinating submission of updated referral letters”. Some participants had to cancel or reschedule an operation due to lack of coordination of care, and/or administration not receiving referral letters. This resulted in patients being forced to pay for surgeries out-of-pocket instead of using insurance coverage. The authors discuss how multiple letters for each stage of a surgery is unnecessary, when no participant was deemed mentally unfit for any previously performed procedure. Authors state that requiring updated letters for each year was also a point of stress for participants as these administrative burdens were “costly and burdensome” to patients and providers alike. The authors urge organizations such as the World Professional Association for Transgender Health (WPATH) to revisit their recommendations for referral letter requirements to alleviate the burdens on both administrators and patients alike.

**Mann, S. J., Carpenter, C. S., Gonzales, G., Harrell, B., & Deal, C. (2022). Effects of the affordable care Act's Medicaid expansion on health insurance coverage for individuals in same-sex couples. Health Services Research, 58(3), 612–621. <https://doi.org/10.1111/1475-6773.14128>**

**Author(s):** Samuel Mann, Christopher S. Carpenter, Benjamin Harrell, and Cameron Deal are all from the Department of Economics, LGBTQ+ Policy Lab, Vanderbilt University, Nashville, Tennessee; Gilbert Gonzales is also a member of the Department of Medicine, Health & Society, and Department of Health Policy at Vanderbilt University.

**Article type:** Peer-reviewed journal

This peer reviewed journal article analyzes how Medicaid expansion influenced health insurance coverage for individuals in same-sex partnerships. Using data from the American Community Survey, authors found that there was a significant increase in coverage between 2009 and 2018 for low-income adults who were in a same-sex relationship, especially for women. The authors attribute this to a much higher prevalence of children being in households of women same-sex couples compared to men. The authors also state that sexual minority women may have stronger social ties that reduce stigma surrounding Medicaid or public options compared to sexual minority men. This research has implications that are important for policymaking and underlying factors of inequity within Medicaid in terms of barriers to seeking health insurance coverage and accessibility of services for those individuals in same-sex partnerships.

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## REPRODUCTIVE OPPRESSION IN HEALTH CARE

Reproductive oppression is defined as *“the regulation and exploitation of individuals’ bodies, sexuality, labor, and procreative capacities as a strategy to control individuals and entire communities.”*<sup>12</sup> This topic includes articles about systemic racism within reproductive health care, and how systemic racism perpetuates health inequities for women and birthing people of color. These articles highlight the experiences of women and birthing people throughout their prenatal care visits, the stigma and discrimination they have faced, and ultimately the actions that can be taken to alleviate disparities in access and outcomes.

*Keywords: Medicaid and Reproductive health, Medicaid and reproductive autonomy*

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<sup>12</sup> Women's Leadership and Resource Center. (2023). Reproductive Oppression Against Black Women | Women's Leadership and Resource Center | University of Illinois Chicago. [wlrc.uic.edu](https://wlrc.uic.edu/reproductive-oppression-against-black-women/); University of Illinois Chicago. <https://wlrc.uic.edu/reproductive-oppression-against-black-women/>

**Crear-Perry, J., Correa-de-Araujo, R., Lewis Johnson, T., McLemore, M. R., Neilson, E., & Wallace, M. (2021). Social and Structural Determinants of Health Inequities in Maternal Health. *Journal of Women's Health (2002)*, 30(2), 230–235.**

<https://doi.org/10.1089/jwh.2020.8882>

**Author(s):** Joia Crear-Perry, National Birth Equity Collaborative, Washington D.C.; Rosaly Correa-de-Araujo, Division of Geriatrics and Clinical Gerontology, National Institute on Aging, National Institutes of Health; Tamara Lewis Johnson, Office of Disparities Research and Workforce Diversity, National Institute of Mental Health, National Institutes of Health; Monica R. McLemore, Family Health Care Nursing Department & Advancing New Standards in Reproductive Health, University of California San Francisco; Elizabeth Neilson, Office of Disease Prevention, Office of the Director, National Institutes of Health; Maeve Wallace, Department of Global Community Health and Behavioral Sciences, Tulane University School of Public Health and Tropical Medicine

**Article Type:** Peer-reviewed journal

The authors of this article make a distinction between structural and social determinants of health, describing structural determinants as the “cultural norms, policies, institutions, and practices that define the distribution (or maldistribution)” of social determinants of health. The authors explore these concepts in the context of social determinants of maternal health. They present a theoretical framework of determinants of Black maternal health called “Restoring Our Own Through Transformation” (created by Jessica Roach, 2016) to illustrate a “web of causation” between structural and social determinants of health and wellness. Crear-Perry et al. explore structural determinants of maternal health that are features of the U.S. health care system including financial barriers to care, a shortage of primary care providers, and gaps in quality, while also considering policy levers that might improve structural factors to support better maternal health outcomes, like paid family leave, access to affordable and comprehensive health care (which could be measured using exposure to Medicaid expansion, having Medicaid coverage through 12 months postpartum, etc.), access to culturally appropriate care (e.g., with clinicians that have received education on structural determinants of health and health inequities—i.e. “structural competency” education), and investments in community-oriented primary care for diverse women of reproductive age (e.g., midwifery maternity centers, nurse practitioner practices, maternal and child clinics, etc.).

**Morcelle, M.T. (2022). Reforming Medicaid Coverage Toward Reproductive Justice. *American Journal of Law & Medicine*, 48, 223–243. <https://doi.org/10.1017/amj.2022.27>**

**Author(s):** Madeline Morcelle, Senior Attorney in the National Health Law Program's (NHeLP) Washington, D.C. Office

**Article Type:** Peer-reviewed journal

The author of this journal article argues that while Medicaid presents a powerful vehicle for reproductive justice, especially for Black people and people of color, its structure allows for discriminatory eligibility and coverage policies that worsen health inequities for adults and their children. Historically, women and people of color have been advocating against reproductive oppression and advocating for “...universal, comprehensive, and affordable health coverage and access, with strong nondiscrimination protections, for everyone.” However, the author describes how voices of those experiencing oppression need to be centered or part of an “open source” framework rather than a “bottom to the top” engagement to dismantle oppressive systems. The author explains how Medicaid was designed by whites in power to only provide access to health coverage for some, “...the ‘worthy poor’,” and that these discriminatory practices continue today through policy decisions, like making Medicaid expansion a choice, for example. The author also describes the lack of adequate benefits for certain populations. While advances have been made recently, namely the Medicaid postpartum coverage extension opportunity and options to cover some immigrant groups, reproductive justice voices and frameworks should be at the center of Medicaid reform efforts to stop reproductive oppression and advance health equity for all.

**Thompson, T. M., Young, Y.-Y., Bass, T. M., Baker, S., Njoku, O., Norwood, J., & Simpson, M. (2022). Racism Runs Through It: Examining The Sexual And Reproductive Health Experience Of Black Women In The South. *Health Affairs*, 41(2), 195–202.**

<https://doi.org/10.1377/hlthaff.2021.01422>

**Author(s):** Terri-ann Monique Thompson & Yves-Yvette Young, Ibis Reproductive Health, Tanya M. Bass, North Carolina Central University, Stephanie Baker, Elon University, Oriaku Njoku, Access Reproductive Care–Southeast, Jessica Norwood, The Runway Project, Monica Simpson, SisterSong Women of Color Reproductive Justice Collective

**Article Type:** Peer-reviewed journal

This article details a community-based participatory research approach to focus groups with nearly 50 Black women living in both Georgia and North Carolina (states chosen for having relatively restrictive reproductive health policies) to understand their experiences interacting with reproductive health care. The research team focused on three aspects of the participants’ experiences: access to health care, use of health care, and experience in health care – and how these experiences were connected to structural (summarized here) and individual racism. In

terms of structural factors and access to adequate care, findings include that reproductive health clinics were often located outside of participants' communities, making accessing care difficult. Focus group participants covered by Medicaid experienced issues with copayment being too burdensome. Lack of abortion coverage in some states was also a major concern for participants. In terms of structural racism and service use, authors report inconsistencies in what services are covered by different plans (both private and Medicaid coverage are mentioned), which impacted utilization. Focus group participants also reported that being a Black woman or living in a predominately Black community and receiving public assistance (or being uninsured) negatively impacted their health care experiences. Further, there was a perception that facilities caring for primarily publicly-insured individuals were lower quality. The authors urge for policy actions that alleviate these structural barriers, such as expanding federally funded Medicaid coverage, requiring abortion coverage, increasing reimbursement for doulas and midwives, and investing in hospitals that provide uncompensated care.

**Ogunwole, S. M., Karbeah, J., Bozzi, D. G., Bower, K. M., Cooper, L. A., Hardeman, R., & Kozhimannil, K. (2022). Health Equity Considerations in State Bills Related to Doula Care (2015-2020). *Women's Health Issues: Official publication of the Jacobs Institute of Women's Health*, 32(5), 440–449. <https://doi.org/10.1016/j.whi.2022.04.004>**

**Author(s):** S Michelle Ogunwole, Department of Medicine, Johns Hopkins University School of Medicine & John Hopkins Center for Health Equity; J'Mag Karbeah and Katy Kozhimannil, Division of Health Policy and Management, University of Minnesota School of Public Health; Rachel Hardeman, Center for Antiracism Research for Health Equity & Division of Health Policy and Management, School of Public Health, University of Minnesota; Debra G Bozzi, Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health; Kelly M. Bower, Johns Hopkins University School of Nursing, & Johns Hopkins Center for Health Disparities Solutions; Lisa A. Cooper, Department of Medicine, Johns Hopkins University School of Medicine, Departments of Health Policy and Management, Health, Behavior, and Society, and Epidemiology, Johns Hopkins Bloomberg School of Public Health

**Article Type:** Peer-reviewed journal

This article presents findings from a landscape analysis of state legislation related to doula care, including Medicaid coverage and reimbursement, with specific attention to whether legislation addresses racial health equity. It is well known that disparities in birth outcomes disproportionately affect Black and Indigenous birthing people. And evidence suggests that doula care is associated with improved birth outcomes. Authors draw on reproductive justice and public health critical race praxis frameworks in formulating study questions and methods. Reproductive justice refers to women having autonomy over their own bodies and the right to



have and parent children safely and with access to community supports to realize optimal reproductive health. Public health critical care praxis theory acknowledges the legacy of white supremacy and racism as a root cause of health inequities in public health research. Authors draw on this theory to develop criteria for assessing whether doula care legislation is designed to address racial health equity. Criteria included reimbursement with plans to provide a living wage, collaboration with community-based doulas, training and certification requirements and funding, and emphasis on workforce diversity, promising practices, and metrics. Authors found that of the 73 bills introduced by 24 states between 2015 and 2020, just over half focused on Medicaid reimbursement for dual care. (Twelve bills in seven states became law.) However only two states that passed Medicaid reimbursement for doulas also met some of the authors criteria for racial equity in their laws. Authors conclude that while proposals for increased access to doula care have increased over time, a racial equity lens is lacking. Authors suggest engaging doulas and considering racial equity policy assessments in the legislative drafting process.

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## IMPACT ON VITAL COMMUNITY CONDITIONS

The vital community conditions category addresses how structural barriers affect the conditions in which communities live, work, play, pray, and age (i.e., the social determinants of health) that affect health and well-being.<sup>13</sup> State Medicaid programs play a role in improving community conditions in order to support people having the agency to make choices that benefit their health. For example, some State Medicaid programs have expanded access to health insurance coverage for certain populations, helped alleviate resource deserts, and created affordable housing and employment options. This category emphasizes that social and geographic contexts matter in assessing the effectiveness of policies to advance equity, health, and well-being.

*Keywords: Medicaid and Food insecurity, Medicaid and Housing, Medicaid and Homelessness, Medicaid and air pollution, Medicaid and neighborhoods, Medicaid and community conditions*

**Semprini, J., Ali, A. K., & Benavidez, G. A. (2023). Medicaid Expansion Lowered Uninsurance Rates Among Nonelderly Adults In The Most Heavily Redlined Areas. Health Affairs, 42(10), 1439–1447. <https://doi.org/10.1377/hlthaff.2023.00400>**

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<sup>13</sup> State Health & Value Strategies (SHVS). (2021). *Talking about anti-racism and health equity: Discussing racism*. <https://www.shvs.org/wp-content/uploads/2021/08/Talking-About-Anti-Racism-Health-Equity-1-of-3.pdf>

**Author(s):** Jason Semprini, University of Iowa, College of Public Health; Abinasir K. Ali, University of Iowa, College of Public Health; and Gabriel A. Benavidez, Department of Epidemiology and Biostatistics, University of South Carolina

**Article Type:** Peer-reviewed journal

While there has been ample research on the effect of Medicaid expansion on reducing individual-level racial and ethnic disparities in health insurance coverage, authors here attempt to fill the gap in research on how Medicaid expansion is affected by root causes of health inequities, such structural racism, as measured by the historically racist policy of residential redlining. The federal government's rating system for mortgage investments, which benefited white, upper middle-class families and penalized minoritized communities and the working-class, has had lasting effects even after it was outlawed in the late 1960s. These effects include substantial wealth gaps, under-resourced communities, and poorer health outcomes. The authors use data from national surveys and a difference-in-differences design to explore how exposure to historical redlining may have influenced the effect of Medicaid expansion on population-level insurance rates for non-Hispanic Black, non-Hispanic White, and Hispanic non-elderly adults. When comparing uninsurance rates in Medicaid expansion and non-expansion states before and after the passage of the Affordable Care Act, authors found that Medicaid expansion had the greatest impact on lowering uninsurance rates in areas with the highest level of historic redlining. Even though no statistically significant differences were observed by race and ethnicity within each redline category, authors conclude that "Medicaid expansion may have helped to reduce some of the negative consequences of structural racism..." and emphasize the importance of studying contextual factors when evaluating health programs and policies.

**Londhe, S., Ritter, G., & Schlesinger, M. (2019). Medicaid Expansion in Social Context: Examining Relationships Between Medicaid Enrollment and County-Level Food Insecurity. *Journal of Health Care for the Poor and Underserved*, 30(2), 532–546.**

<https://doi.org/10.1353/hpu.2019.0033>

**Author(s):** Shilpa Londhe, Department of Health Policy and Management, Yale School of Public Health; Grant Ritter, Heller School for Social Policy and Management, Brandeis University, Mark Schlesinger, Department of Health Policy and Management, Yale School of Public Health

**Article Type:** Peer-reviewed journal

This article studies the relationship between county Medicaid enrollment and food insecurity in over 350 counties. The authors acknowledge that food insecurity prevalence ranges widely across the country, from as low as 4 percent up to 39 percent in some states. The authors

observe that counties who expanded their Medicaid program in 2012 had significantly reduced food insecurity compared to their baseline year of 2009, and compared to counties that expanded later in calendar year 2014. While the authors acknowledge that food insecurity and lack of insurance coverage are likely related, they conclude that Medicaid likely offers greater financial security overall, which alludes to many improvements for low-income families, with overcoming food insecurity being one positive of many likely effects.

**Bowen, S., Elliott, S., & Hardison-Moody, A. (2021). The structural roots of food insecurity: How racism is a fundamental cause of food insecurity. *Sociology Compass*, 15(7).**

<https://doi.org/10.1111/soc4.12846>

**Author(s):** Sarah Bowen, Professor of Sociology at North Carolina State University; Sinikka Elliot, Associate Professor of Sociology at the University of British Columbia; Annie Hardison-Moody, Associate Professor of Agricultural and Human Sciences at North Carolina State University

**Article Type:** Peer-reviewed journal

This article, written by scholars in the US and Canada and funded by the US Department of Agriculture, provides a detailed overview of the patterns of food insecurity in the recent past. These patterns of food insecurity include that it's associated with lower income households, mostly cyclical as opposed to chronic, more prevalent in households with children and in households headed by women, and households headed by people of color and people with disabilities. Food insecurity also has negative effects on physical and mental health as well as academic performance and risk of hospitalization among children. Authors summarize evidence on the association between food insecurity and poverty, other forms of hardship, housing insecurity, and neighborhood support systems, but argue that there is a more fundamental cause for food insecurity: racism and persistent unequal access for people of color to opportunities and resources. To combat food insecurity, structural change is needed. While the article does not go into detail about specific recommendations for the Medicaid program, it references advocating for Medicaid expansion and against "...punitive and stringent policies that disproportionately harm people of color..." which can be the price for access to assistance.

**Charania, S. (2021). How Medicaid and States Could Better Meet Health Needs of Persons Experiencing Homelessness. *AMA Journal of Ethics*, 23(11), E875-880.**

<https://doi.org/10.1001/amajethics.2021.875>

**Author(s):** Sana Charania, George Washington University's School of Public Health in Washington, DC

**Article Type:** Peer-reviewed policy reform brief

This peer-reviewed policy reform brief includes a list of strategies that state Medicaid programs can pursue with providers to alleviate health care stressors of those experiencing homelessness. The author remarks that in 2020, over half a million people experience homelessness on any given night in the United States. According to survey data from a decade earlier, about a quarter of “...sheltered persons experiencing homelessness had a severe mental illness and 35 percent had problems with substance use”. The author states that there is a need for better supportive housing options and discusses studies in several states that showed providing permanent housing and needed services (such as behavioral health care) to individuals who were previously homeless led to decreased inpatient or emergency department visits and lower health care costs. The author emphasizes that it is not entirely on state Medicaid programs to reach those experiencing homelessness; clinicians and hospitals have a role to play in resolving biases about this very stigmatized group of people and assessing the basic needs of their patients. The author does highlight the importance of Medicaid expansion under the ACA – citing the improved health conditions of those experiencing homelessness and an increase in coverage in expansion states.

**Dennett, J. M., & Baicker, K. (2022). Medicaid, Health, and the Moderating Role of Neighborhood Characteristics. *Journal of Urban Health*, 99(1), 116–133.**

<https://doi.org/10.1007/s11524-021-00579-2>

**Author(s):** Julia M. Dennett, Yale University School of Public Health, New Haven, CT; Katherine Baicker, University of Chicago Harris School of Public Policy, Chicago, IL and the National Bureau of Economic Research, Cambridge, MA.

**Article Type:** Peer-reviewed journal

This article is an analysis of whether key neighborhood characteristics, such as “socioeconomic deprivation (which is a score that reflects neighborhood ethnicity, education, employment, poverty, and housing/crowding), food access, park access and green space, attributes that promote active living, and land use” influence the effect of health insurance coverage on health outcomes. Using data collected in 2009 and 2010 about participants in the Oregon Health Insurance living in the Portland area, some of whom had access to Medicaid coverage and some of whom did not, authors found neighborhood characteristics played only a limited role in moderating the impacts of coverage on select health outcomes. The study’s null findings imply that Medicaid expansion benefited many across the board, regardless of neighborhood. Also implied is that the relationship between coverage and neighborhood characteristics and health outcomes is complex. Authors note several study limitations, including other factors to consider

in the definition of neighborhood characteristics and their inability to conduct subgroup analyses. They also call for future research to inform policy.

**Satcher, L. A. (2022). (Un) Just Deserts: Examining Resource Deserts and the Continued Significance of Racism on Health in the Urban South. *Sociology of Race and Ethnicity*, 8(4), 483–502. <https://doi.org/10.1177/23326492221112424>**

**Author(s):** Lacey Satcher, Professor of Sociology and Environmental Studies at Boston College

**Article Type:** Peer-reviewed journal

This peer-reviewed article summarizes research examining the relationship between resource scarcity (measured in terms of multiply-deserted areas (MDAs)) and health. The author goes on to discuss how this relationship varies according to race and class composition of urban neighborhoods in the South and its implications for public programs, including Medicaid. MDAs were constructed based on three types of resource deserts: food, green spaces, and pharmacy deserts. Health outcomes examined included adults with diabetes, obesity, asthma, and no leisure-time physical activity. Results show that, compared to less resource-scarce areas, MDAs are associated with higher disease prevalence as well as higher rates of inactivity. Co-occurring resource scarcity has more influence on outcomes and activity levels than single-resource scarcity resulting in greater stress and negative impacts on health. “While there have been efforts to increase food access or greenspace for low-income, predominantly Black neighborhoods via farmer’s markets and community gardens, understanding that these neighborhoods are experiencing compounded, co-occurring resource scarcity calls for a more comprehensive policy intervention or community initiative that increases access to healthy foods, greenspace, and prescription medicines.” The author explains further that, “reducing disparities in prescription access and adherence via expansion of Medicare Part D and Medicaid are important, but study findings suggest that policy efforts to reduce disparities should also increase spatial access to pharmacies.”

**Wei, Y., Qiu, X., Sabath, M. B., Yazdi, M. D., Yin, K., Li, L., Peralta, A. A., Wang, C., Koutrakis, P., Zanobetti, A., Dominici, F., & Schwartz, J. D. (2022). Air Pollutants and Asthma Hospitalization in the Medicaid Population. *American Journal of Respiratory and Critical Care Medicine*, 205(9). <https://doi.org/10.1164/rccm.202107-1596oc>**

**Author(s):** Yaguang Wei, Xinye Qiu, Mahdieh Danesh Yazdi, Longxiang Li, Adjani A. Peralta, Cuicui Wang, Petros Koutrakis, Antonella Zanobetti, are all from the Department of Environmental Health at Harvard T.H. Chan School of Public Health; Matthew Benjamin Sabath Francesca Dominici are from the Department of Biostatistics at Harvard T.H. Chan School of

Public Health; Kanhua Yin is from the Department of Epidemiology at Harvard T.H. Chan School of Public Health; and Joel D. Schwartz is associated with both the Department of Environmental Health at Harvard T.H. Chan School of Public Health as well as the Department of Surgery, Massachusetts General Hospital, Harvard Medical School.

**Article Type:** Peer-reviewed journal

This peer reviewed study analyzes inpatient claims of Medicaid beneficiaries from 2000 to 2012 by zip code in order to determine the effect of three common air pollutants (nitrogen dioxide, ozone pollution, and particulate matter) on asthma hospitalizations. The researchers found a positive relationship between short-term exposures and increased risk of asthma hospitalization for those with one asthma admission during the study period, but air pollutants appeared to be less of a factor for those with multiple asthma admissions during the study period. A community-level analysis found higher risk of asthma hospitalization for people living in low population density zip codes, people with higher average BMI, and people living a longer distance to the nearest hospital. There were no significant differences in risk of asthma hospitalizations by race or ethnicity. These results emphasize the importance of both individual and contextual factors in assessing the quality of health care for the Medicaid population, where the impact of air pollutant exposures on asthma susceptibility differed by severity and place characteristics.

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### Suggested Citation

Nelson, Q. & Worrall, C. (April 2024). Annotated Bibliography: Underlying Factors of Medicaid Inequities. *State Health Access Data Assistance Center (SHADAC)*. <https://www.shadac.org/Medicaid-Equity-Monitoring-Tool>

## About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation (RWJF) is committed to improving health and health equity in the United States. In partnership with others, we are working to develop a Culture of Health rooted in equity that provides every individual with a fair and just opportunity to thrive, no matter who they are, where they live, or how much money they have.

Health is more than an absence of disease. It is a state of physical, mental, and emotional wellbeing. It reflects what takes place in our communities, where we live and work, where our children learn and play, and where we gather to worship. That is why RWJF focuses on identifying, illuminating, and addressing the barriers to health caused by structural racism and other forms of discrimination, including sexism, ableism, and prejudice based on sexual orientation.

We utilize evidence to advance health equity. We cultivate leaders who work individually and collectively across sectors to address health equity. We promote policies, practices, and systems-change to dismantle the structural barriers to wellbeing created by racism. And we work to amplify voices to shift national conversations and attitudes about health and health equity.

Through our efforts alongside the efforts of others, we will continue to strive toward a Culture of Health that benefits all. It is our legacy, it is our calling, and it is our honor.

For more information, visit [www.rwjf.org](http://www.rwjf.org)

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## About SHADAC

This resource was prepared by SHADAC Research Assistant Quin Nelson and Senior Research Fellow Christina Worrall MPP. State Health Access Data Assistance Center (SHADAC) is an independent, multi-disciplinary health policy research center housed in the School of Public Health at the University of Minnesota with a focus on state policy. SHADAC produces rigorous, policy-driven analyses and translates its complex research findings into actionable information for states.

For more information, visit [www.shadac.org](http://www.shadac.org)

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## About the Medicaid Equity Monitoring Tool Project

The Medicaid Equity Monitoring Project is a multi-phased effort to explore whether a new national data tool could increase accountability for making actualized progress toward improving population health while also supporting state Medicaid programs in advancing health equity. The Robert Wood Johnson Foundation (RWJF) contracted with the State Health Access Data Assistance Center (SHADAC) and its subcontractor RACE for Equity to assess both tool need and feasibility. RWJF contracted with Health Leads to work collaboratively with the SHADAC team to engage community members in discussions of a potential monitoring tool. At the end of the current phase, SHADAC, RACE for Equity, and Health Leads will make recommendations about the feasibility of moving forward with designing and developing a Medicaid equity monitoring tool.

Resources developed throughout the multi-year project are available here: <https://www.shadac.org/MedicaidEquity-Monitoring-Tool>

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