CENTER ON POVERTY and INEQUALITY
GEORGETOWN LAW

Re-Envisioning Medicaid & CHIP as Anti-Racist Programs

AYAN GORAN, LAURA TATUM,
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JUNE 2023

Georgetown Center on Poverty and Inequality

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Contents

Introduction

Racial and ethnic disparities in the American health care system have long impeded our nation's health and well-being. For everyone in the United States to achieve their full potential—and for our nation to achieve its full potential—we must ensure that every person, regardless of racial identity or economic status, has equitable access to health care.

Medicaid and the Children's Health Insurance Program (CHIP)—government programs that provide health insurance for adults with low incomes and their children—have significantly decreased racial disparities in health and health care and have brought access and coverage to millions who would be otherwise uninsured or underinsured.[1] As of February 2023, over 93 million people—more than one-fifth of the U.S. population—are enrolled in these programs, making Medicaid and CHIP the largest health insurers in the country.[2] Medicaid and CHIP are the primary providers of health care for people with low incomes.[3, 4] Participants are disproportionately people of color, who are more likely to be employed in low-paid jobs that do not offer private health insurance.[5]

To create an effective, equitable health care system, policymakers must address stark racial disparities in coverage, racial disparities in quality of care and health outcomes, and unnecessarily burdensome application and re-enrollment processes and restricted eligibility.[6, 7] If the programs evolved to purposefully address structural racism, as discussed in this report, Medicaid and CHIP would help create a health care system that works for all.[i]

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i This report addresses selected racial inequity problems and proposes selected recommendations to advance racial equity within the Medicaid and CHIP programs. The report does not aim to be comprehensive.

This report, developed with the input of health equity experts and practitioners, puts forth an anti-racist re-imagining of Medicaid and CHIP that actively reckons with the racist history of the Medicaid program and offers recommendations that capitalize on the transformative potential of the programs. To transform Medicaid and CHIP into programs that work to redress racist harms and advance racial equity, program participants must be valued as co-creators of an anti-racist future. In addition to recommendations, this report also offers principles to guide anti-racist policy transformations. The principles center the voices and agency of program participants and prioritize direct community involvement at all stages of the policy process.

The Georgetown Center on Poverty and Inequality recommends re-envisioning Medicaid and CHIP to advance racial equity through policy changes that:

1. Address inequitable coverage;
2. Bridge racial disparities in quality of care and health outcomes; and
3. Expand eligibility and alleviate administrative burdens.

The need for this re-envisioning is particularly evident as the implications of the federal COVID-19 public health emergency (PHE) expiration in May 2023 become increasingly apparent. An estimated 18 million individuals could lose Medicaid coverage due to the expiration of the PHE and other temporary Medicaid policies.[8] This expiration, which coincides with the publication date of this report, will disproportionately affect children and young adult participants (ages 18-34), of whom 34 percent are Latinx and 15 percent are Black.[9] Policymakers should mitigate massive losses in coverage for an estimated 17 percent of Medicaid and CHIP-eligible individuals.[10, 11, 12]

Background

From inception, the full reach and impact of Medicaid and CHIP were curtailed by racialized political resistance to Medicaid and by limitations in the programs' policy designs. To re-envision Medicaid and CHIP as anti-racist programs, it is necessary to understand Medicaid's history, which is steeped in structural racism, and the programs' policy designs, which prevent them from fully addressing racial disparities in coverage, access, and outcomes.

Compromises With Southern States Curtailed Medicaid's Impact

Medicaid's design was the product of conflicting political sensibilities concerning how to address the health needs of people with low incomes, many of whom were people of color.[13] Medicaid's predecessor, created by the Kerr-Mills Act of 1960, was a poorly-funded, voluntary health coverage program. States were allowed to opt out and were granted wide discretion in setting eligibility standards. Many states—particularly Southern states with large percentages of Black residents—opted out or excluded people in need of coverage.[14] In fact, the often-called "Black Belt" states (Texas, Arkansas, Louisiana, Tennessee, Mississippi, Alabama, Florida, Georgia, South Carolina, and North Carolina) accounted for only 3.3 percent of all Kerr-Mills participants.[15, 16] During this period, the country's elderly population and medical costs were both on the rise, and a clear need for increased options for affordable health insurance emerged.[17] In 1965, in an attempt to meet this need, President Lyndon B. Johnson established both Medicaid and Medicare under the Social Security Act.[18]

As noted by its architect, Wilbur Cohen, Medicaid originated from discussions about the need to provide medical insurance to key populations with low incomes to lessen the incentive to expand the federal Medicare program.[19] Southern states, Cohen anticipated, would be especially resistant to and wary of what they perceived as federal overreach due to recent civil rights legislation. As a compromise, Medicaid was designed to be a state-run program, granting states flexibility and control over their respective health care systems and limiting federal involvement.[20]

Cohen, and Medicaid's other founders, were concerned that Medicaid being state-run would curtail its ability to adequately meet the care needs of underserved people—understandably so, as Kerr-Mills, a state-run voluntary program, had an ineffective, limited reach.[21] Cohen envisioned a Medicaid program that would continue to expand, not a program that restricted access to a subset of the so-called "deserving poor."[22] In an effort to avoid the shortcomings of its predecessor, the Medicaid program included a provision that would require states to ensure that all individuals who met Medicaid's eligibility requirements would receive comprehensive care and services within 17 years. However, following pressure from New York Governor Nelson Rockefeller, this provision was removed in 1972, just seven years later.[23]

In Medicaid's early years, access was tied to the receipt of Aid to Families with Dependent Children (AFDC) and other existing federal benefits, including "Old Age Assistance" and "Aid to the Totally and Permanently Disabled," which would evolve into Supplemental Security Income (SSI).[24] From its very inception, Medicaid quietly inherited the racist, sexist narratives of deservingness that legislated eligibility for pre-existing public benefits programs.[25, 26]

CHIP's Temporary, Capped Funding Structure Limits Its Impact

The Children's Health Insurance Program (CHIP), a federal-state partnership program, was created in 1997 to provide a health insurance option for children in families with low and moderate incomes above the Medicaid eligibility threshold.[27] Far more people enroll in Medicaid than CHIP, but CHIP's targeted focus has made a considerable impact in reducing the number of uninsured children in the U.S.[28] From 1997 to 2018, the rate of uninsured children decreased from 14.2 percent to 5.5 percent.[29] By 2000, all states and the District of Columbia had implemented CHIP coverage systems, and by 2020, the number of uninsured children dropped precipitously from 10 million children to 3.6 million children.[30, 31]

Altogether, more than half of children in the U.S. receive their health coverage from Medicaid or CHIP.[32] The majority of Black, Latinx, and American Indian or Native Alaskan children access health care using Medicaid and CHIP as of 2020.[33] Many more children of color are eligible for CHIP but are not enrolled, often due to their families being unaware of the child's eligibility status or other obstacles, such as language barriers and complexities in the enrollment process.[34]

The funding structure of the CHIP program limits its ability to consistently support all eligible children. Medicaid is jointly funded by federal and state governments with no pre-set restrictions or enrollment caps; every individual who qualifies is entitled to coverage under the program.[35] In contrast, federal funding for CHIP is temporary (requiring periodic reauthorization) and has an annual cap. States can employ waiting periods and enrollment caps to restrict spending, and all eligible individuals are not entitled to coverage. This limits CHIP's ability to respond to changes in need, such as those brought on by economic and public health crises like the COVID-19

pandemic.[36] Participants are harmed by the limitations of this funding structure, as they—particularly participants of color—are more likely to shoulder the negative impacts of financial and health crises.[37, 38]

While the Affordable Care Act (ACA) limited CHIP waiting periods to fewer than 90 days and introduced federally required exemptions (such as job loss), nine states continue to employ CHIP waiting periods in some capacity.[39] The nine states with CHIP waiting periods as of April 2023 are Arizona, Arkansas, Florida, Indiana, Iowa, Louisiana, South Dakota, Texas, and Utah.[40] Waiting periods are a costly, inefficient, and ineffective use of state administrative resources, and they can harm children's health and development.[41]

Further, states that operate separate CHIP programs are allowed to "lock out" children from receiving benefits for a period of up to 90 days for nonpayment of premiums, contributing to periods of uninsurance for children in need of coverage.[42] The Centers for Medicare and Medicaid Services (CMS) noted the particular impact of lock-out periods on people of color in its proposed rule to streamline Medicaid and CHIP, writing "lock-out periods disproportionately affect non-White populations compared to White populations, which may further exacerbate existing disparities in health outcomes."[43]

Systemic Racism in Medicaid & CHIP

Ibram X. Kendi defines a racist policy as "any measure that produces or sustains racial inequity between racial groups."[44] Conversely, an anti-racist policy is "any measure that produces or sustains racial equity between racial groups."[45] It is impossible for a policy to be race-neutral; every law, process, and procedure functions to either uphold or combat racial inequity.[46] Systemic racism manifests in the Medicaid program in many forms, and the policy designs of the Medicaid and CHIP programs fail to fully address racialized issues of inequitable coverage, disparities in quality of care and health outcomes, and eligibility and administrative barriers.

State-Level Racism Blocks Millions From Coverage

The Affordable Care Act of 2010 (ACA) required states to expand their Medicaid programs and provide coverage to all non-elderly adults under 138 percent of the federal poverty line,[ii] but the Supreme Court effectively made expansion a state option with the *National Federation of Independent Business v. Sebelius* decision in 2012.[47] Prior to the ACA, the only non-elderly adults who could be eligible for Medicaid were pregnant people and people who had very low incomes and dependent children, though some states covered adults without children through demonstration projects.[48] The ACA expansion, funded with federal dollars, has allowed states to cover adults with low incomes without children as well as other adults with dependent children who had formerly been excluded by income eligibility thresholds.[49, 50] From 2014 to 2023, 40 states and the District of Columbia opted to expand their Medicaid programs,[51] helping an estimated 19 million people gain health coverage and leading to historic reductions in disparities in coverage between people of color and white people.[52, 53]

ii In 2022, 138 percent of the federal poverty line for an individual was $18,754; for a household of 4, it was $38,295. (U.S. Department of Health and Human Services).

As of March 2023, approximately 1.9 million adults with incomes below the poverty line but above their state's eligibility level are excluded from Medicaid in the 10 remaining non-expansion states. These adults exist in a "coverage gap" because their states have chosen not to expand Medicaid coverage.[54] These individuals earn too little to qualify for subsidized health insurance options through the ACA marketplace yet they also do not qualify for Medicaid. In states that have not expanded Medicaid programs, the eligibility criteria for adults are extremely limiting—the median income cap for parents in 2023 is 38 percent of the Federal Poverty Level (FPL) or an annual income of $9,447 for a family of three.[55]

People in the Medicaid coverage gap are disproportionately people of color. In 2021, 61 percent of the people in the coverage gap were people of color, though people of color only make up 41 percent of the adult, non-elderly population in non-expansion states.[56, 57] Individuals in the coverage gap were largely Black and Latinx, with each group constituting 28 percent of the total number of individuals in the coverage gap.[58]

Many Southern state legislatures have refused to expand their Medicaid programs. As a result, the vast majority—97 percent—of people in the coverage gap live in Southern states, and these states have the most severe racial disparities in access for people of color.[59, 60] For example, in 2019, over 70 percent of Asian adults in the coverage gap and 88 percent of Latinx adults in the coverage gap were living in Florida and Texas.[61] These racial disparities should be addressed by federal action.[62, 63]

FIGURE 1. Majority of Individuals in the Coverage Gap Live in Southern States

Number of Uninsured Non-Elderly Adults in the Coverage Gap, Based on 2023 Medicaid Eligibility Levels

All States Not Expanding Medicaid	Total Uninsured Non-Elderly Adults	Uninsured Non-Elderly Adults in the Coverage Gap
TOTAL	3,470,000	1,901,000
Alabama	219,000	128,000
Florida	726,000	388,000
Georgia	434,000	252,000
Kansas	82,000	44,000
Mississippi	147,000	88,000
South Carolina	166,000	94,000
Tennessee	218,000	124,000
Texas	1,435,000	772,000
Wisconsin	23,000	0
Wyoming	20,000	10,000

Note: Wisconsin's Medicaid program covers all non-immigrant and "qualified immigrant" documented non-elderly adults with incomes under the poverty level.

Source: Adapted from KFF analysis of 2023 Medicaid eligibility levels and 2021 1-year American Community Survey data.

Research has demonstrated that Medicaid expansion decisions are associated with state-level racism:[64, 65] lower levels of racial sympathy and higher levels of racial resentment are correlated with greater resistance to Medicaid expansion.[66] Governors who expand Medicaid are more likely to be praised by their constituents when the state's Medicaid program serves a larger white participant population.[67] Any equitable re-imagining of Medicaid and CHIP must account for the "racialized political realities" that prevent people of color from receiving necessary coverage and must address these realities with anti-racist solutions.[68]

The racist, negative effects of the coverage gap are made more acute during economic and public health crises, such as the COVID-19 pandemic. The reach of systemic racism goes beyond the health care system and affects access to employment, housing, transportation, and more. People of color faced higher risks of COVID-19 infection, hospitalization, and death than white people.[69] These risks are heightened by the racial disparities in the coverage gap.

Medicaid's Limitations Exacerbate Racial Disparities in Quality of Care & Health Outcomes

Low Medicaid reimbursement rates, racial segregation in nursing facilities, and limited maternal and infant coverage exacerbate well-established racial disparities in quality of care.[70, 71] These structural issues and unequal quality of care lead to poorer health outcomes experienced by people of color.

LOW REIMBURSEMENT RATES

Medicaid's low reimbursement rates mean that costs for health providers and institutions to care for Medicaid participants are often higher than the amounts they receive in reimbursement[72] which harms access to care for Medicaid participants—who are disproportionately people of color.[73] The Medicaid statute requires states to pay rates sufficient to ensure equal access for program participants, but Medicaid physician fees are well below Medicare[74] and private insurance fees.[75] On average, Medicaid fee-for-service physician payment rates are two-thirds of Medicare rates.[76] In turn, physicians are less likely to accept new patients insured by Medicaid (74.3 percent) than patients with Medicare (87.8 percent) or private insurance (96.1 percent).[77]

Low Medicaid reimbursement rates disproportionately harm people of color. According to research from Cornell University:

> "Disproportionality, or 'the way policies differentially allocate benefits and burdens to racial groups,' is apparent in current Medicaid reimbursement rates. Eight of the 10 most populous U.S. states are ranked in the bottom half of reimbursement rates nationally. Many of these states have considerably higher nonwhite populations enrolled in Medicaid and relatively lower reimbursement rates. In contrast, many of the states with the highest reimbursement rates have proportionally fewer residents of color (Vermont, Wyoming, Iowa, Idaho, Nebraska)."[78]

California's Medicaid reimbursement rates have been the subject of racial and ethnic discrimination litigation in recent years. In 2019, California had the 19th lowest reimbursement rate (out of 49 states and the District of Columbia)[79] and 77.7 percent of its Medicaid participants were non-white.[80] Several Medicaid participants in California joined with civil rights organizations to sue the state of California in 2017, arguing that inadequate benefits are a form

of discrimination against Latinx participants.[81] (The case was dismissed in June 2022 but is under appeal as of May 2023.[82])

Research has found that increasing physician reimbursement rates improves Medicaid participants' access to care and health.[83] A study analyzing changes in state payment rates estimates that a $10 increase in Medicaid payments reduces reports of doctors telling adult Medicaid participants they are not accepting new patients or their insurance by 13 and 11 percent, respectively.[84] The same study found that increasing Medicaid reimbursement rates by $45—closing the median payment gap between Medicaid and private insurers—would reduce disparities in access to care by 70 percent or more.[85]

RACIAL SEGREGATION IN NURSING FACILITIES

Under Title VI of the 1964 Civil Rights Act, programs that receive federal funding are prohibited from engaging in discriminatory practices.[86] When Medicare launched, the federal government made significant investments in desegregating hospitals. However, desegregation efforts in long-term care facilities—where Medicaid is the main funder—were not as strongly enforced.[87] More than 50 years later, nursing facilities remain heavily segregated.[88, 89]

Decades of research on nursing home health outcomes have shown deep disparities by race.[90] Black nursing home residents are much more likely than their white counterparts to live in nursing homes that deliver a poorer quality of care, have lower staff-to-patient ratios, and experience more financial precarity.[91] Research published in 2021 identified low Medicaid reimbursement rates as a key factor in ongoing racial segregation:

> "...Most long-term care users pay out of pocket if and while they have the funds to do so, but generations of discriminatory policies leading to lower levels of wealth among Black individuals mean that fewer funds are available to pay out of pocket. Persons who are impoverished can receive coverage from Medicaid, but Medicaid nursing home rates are much lower than those of other payers. This situation results in residential long-term care settings vying to admit non-Medicaid (disproportionately non-Black) patients, a situation that is inherently discriminatory."[92]

The COVID-19 pandemic clearly demonstrated how poor quality of care contributes to poorer health outcomes—and increased likelihood of death from preventable causes—for Black older adults in predominantly Black nursing homes.[93] During the first year of the pandemic, 63 percent of nursing homes with a high share of Black residents reported at least one COVID-19 death, compared to 40 percent of nursing homes with a lower share of Black residents.[94]

LIMITED MATERNAL & INFANT COVERAGE

Medicaid's limited coverage of maternal and infant health care fuels racial disparities in pregnancy outcomes. Nearly half of all births in the U.S. are covered by Medicaid, and around two-thirds of Black women have births covered by Medicaid.[95] While most pregnant people in the coverage gap become eligible for Medicaid once they are pregnant, being uninsured before pregnancy is associated with a higher prevalence of risk factors that can lead to poorer pregnancy outcomes.[96] Additionally, under current law, states are only required to provide pregnancy-related Medicaid coverage for the first 60 days after delivery.[97]

The U.S. has the highest rate of maternal mortality among developed countries, and Black women die at significantly higher rates than other racial and ethnic groups.[98] In 2020, 24 mothers

died for every 100,000 live births in the U.S., more than three times the rate observed by other high-income countries.[99] Black women are approximately three times as likely as their white counterparts to die of pregnancy-related complications; American Indian and Alaska Native women are roughly twice as likely.[100] The majority of these deaths—roughly 80 percent—could be prevented by one or more care or systems changes.[101]

Although disproportionate rates of Black maternal and infant mortality are in part due to racist and discriminatory practices that are endemic to the health care system at large, access—greatly impacted by Medicaid policies—to continuous and attentive care before becoming pregnant and during the prenatal, delivery, and postpartum stages is critical to saving lives and ensuring healthy outcomes for mothers and their babies.

Medicaid & CHIP Policies Create Unnecessary Eligibility & Administrative Barriers for People of Color

Medicaid and CHIP applicants and participants face systemic obstacles to eligibility, enrollment, and renewal, significantly affecting access to coverage. These barriers block millions of people, particularly people of color, from being eligible for coverage and place unnecessary pressure on eligible people who navigate a web of Medicaid and CHIP program requirements and a complex health care system.

ELIGIBILITY BARRIERS

For several decades, eligibility for Medicaid was tied to eligibility for AFDC, a program with a history of restrictive policies based on racist and sexist conceptions of the "deserving poor" that continue to affect access to cash assistance.[102] Particularly for Black and other single mothers of color, access to AFDC was limited by targeted morals- and conduct-based exclusion policies.[103] Furthermore, states determined their own AFDC income eligibility limits and benefits levels; states with large Black populations tended to set lower income eligibility limits and benefits levels.[104] Some states implemented policies stopping Aid to Dependent Children (precursor program to AFDC) benefits during planting and harvesting seasons in an effort to compel Black parents to work in agriculture.[105] This connection to AFDC resulted in Medicaid eligibility requirements that were also rooted in harmful, conflicting stereotypes that portray people of color—particularly Black people—as both lazy (when it comes to participation in the labor force) and exceptionally industrious (when it comes to abuse of public benefits programs).[106] Another consequence of determining eligibility for Medicaid using AFDC policies was that adults without dependent children were not eligible for Medicaid, a restriction present in 2023 in nine states (every non-expansion state except for Wisconsin, which has a waiver program for such adults).[107, 108]

In 1996, the Personal Responsibility and Work Opportunity Act (PRWORA) officially decoupled Medicaid from eligibility for Temporary Assistance for Needy Families (TANF, which replaced AFDC) cash assistance. However, PRWORA resulted in an application process and new restrictions for Medicaid that made participation less accessible to immigrants; many of those restrictions remain in place.[109, 110] PRWORA restrictions included the introduction of a five-year waiting period on enrolling in Medicaid for many immigrants who are documented and a complete ban for people who are undocumented.[111, 112] CHIP, created in 1997, largely incorporated these same barriers.[113]

The policy choice to exclude many immigrants from access to benefits was rooted in racism.[114] It was the culmination of decades of policy debates in which policymakers, think tanks, and the

media vilified and scapegoated immigrants—particularly Latinx immigrants—for the nation's ills. These restrictions accelerated a radical process of exclusion that began shortly after immigration law opened the U.S. to more non-European immigrants in 1965.[115]

From 2016 through 2023, Congress made repeated attempts to institute restrictive work requirements as an additional barrier to Medicaid eligibility.[116] Proposed work requirements for Medicaid would disproportionately affect African American mothers and their families, and research shows that work requirements, which can cost a state hundreds of millions of dollars to administer, do not actually promote increased work and earnings.[117, 118, 119] The Department of Health and Human Services predicts that work requirements could result in at least 21 million individuals—most of whom are working or exempt from working—being at risk of care interruptions or loss of coverage altogether.[120]

ADMINISTRATIVE BARRIERS

Administrative burdens are concentrated in public benefits programs that serve a higher proportion of people of color, while universal programs that serve a comparatively much larger white proportion of participants, like Social Security, have little to no administrative burden.[121] In the Medicaid and CHIP programs, administrative burdens contribute to 7 million people being uninsured despite their eligibility for Medicaid or CHIP.[122, 123, iii] Nearly two-thirds of the people who are uninsured and eligible are people of color.[124]

In both Medicaid and CHIP, administrative burdens causing eligible participants to lose coverage include short response windows and reliance on mailed paper notices and forms.[125,126] In various states, participants lose coverage if they do not respond to a verification request within 10 days.[127] A study found that in Colorado, Louisiana, Tennessee, Missouri, Ohio, and Texas, large numbers of participants lost Medicaid or CHIP coverage because they did not respond to verification requests in time.[128] In Arkansas, total Medicaid and CHIP enrollment dropped from approximately 948,000 participants in December 2016 to 841,000 in June 2019 due to various policies, including a work reporting requirement and the state's policy to disenroll participants if any mail is returned as undeliverable.[129] Focus groups indicated that some participants were not receiving mail from the Department of Human Services (DHS) at their updated address despite having reported it to the state.[130] Beyond Arkansas, many state Medicaid and CHIP agencies do not follow up on returned mail but rather end eligibility for participants whose addresses no longer seem valid.[131]

Many states have failed to fully implement the ACA's requirements to reduce administrative burden in both Medicaid and CHIP.[132, 133, 134] For example, many states require applicants to submit their pay stubs, substantiate variations in income, and demonstrate the loss of a job or other modifications in employment status even though state data sources can confirm eligibility.[135] These tasks may be particularly challenging for part-time workers and people with precarious work schedules, who are more likely to be people of color,[136] as their income tends to fluctuate regularly.[137] Income volatility and having multiple jobs can increase the required amount of paperwork and make it harder to keep forms up to date.

iii In September 2022, the Centers for Medicare and Medicaid Services (CMS) proposed a rule that would simplify the process for eligible individuals to enroll in the Medicaid and CHIP programs. Among the measures included in the proposed rule are eliminating CHIP premium lock-out periods and waiting periods, creating timeliness requirements for agencies to communicate eligibility redeterminations to participants, removing barriers to enrollment for new applicants, requiring states to allow adequate time for participants to provide requested information, and establishing particpant protections related to returned mail. For more information, see "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes, Proposed Rule." Federal Register, vol. 87, 7 September 2022, pp. 54760-54855. Available at https://www.federalregister.gov/documents/2022/09/07/2022-18875/streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health-program-application

A New Vision for Medicaid & CHIP to Advance Racial Justice

Medicaid and CHIP can and must be vital pillars of a care infrastructure that promotes and protects the well-being of people without access to private health coverage. The following sections describe a vision and propose recommendations to reimagine Medicaid and CHIP as programs that meaningfully ensure racial equity in health care access, coverage, and outcomes.

The Georgetown Center on Poverty and Inequality recommends re-envisioning Medicaid and CHIP to advance racial equity through three broad strategies:

1. Address inequitable coverage;
2. Bridge racial disparities in quality of care and health outcomes; and
3. Expand eligibility and alleviate administrative burdens.

This section provides several recommendations that federal and state policymakers and program administrators should enact, including transformative federal actions and changes that utilize existing tools and policies within Medicaid and CHIP. Implementation of these recommendations should be guided by principles that center and empower program participants and their communities.[iv]

iv The recommendations and principles in this report are not meant to be comprehensive.

Address Inequitable Coverage

This section outlines two transformative measures to address inequitable coverage: closing the coverage gap and making CHIP funding permanent.

CLOSE THE COVERAGE GAP

Implement federal action to close the coverage gap.

Medicaid expansion improves access to care and health outcomes, increases coverage, bolsters economic security, and advances economic and employment growth.[138, 139, 140] In contrast, being in the coverage gap prevents millions of individuals from exerting agency over their own health.[141] Closing the coverage gap supports the growth and well-being of our country. Yet, approximately 1.9 million people are uninsured (as of March 2023) in the coverage gap created by states that have not opted into expansion.[142] Adults in the coverage gap earn incomes too low to qualify for subsidized health insurance options through the ACA marketplace, but because they live in states that have failed to adopt Medicaid expansion, they also do not qualify for Medicaid. Individuals in the coverage gap—the majority of whom live in Southern states and are Black, Latinx, or other people of color—have been left especially vulnerable to public health crises, such as the COVID-19 pandemic and the Black maternal mortality epidemic.[143, 144]

Even with the financial incentives to adopt Medicaid expansion offered by the American Rescue Plan Act of 2021, most non-expansion states continue to refuse to take action, making federal action necessary to ameliorate the racial injustices perpetuated by the coverage gap.[145]

MAKE CHIP FUNDING PERMANENT

Congress should make CHIP funding permanent.

Unlike other federal health insurance programs, CHIP must be reauthorized by Congress periodically, and federal CHIP funding to states is capped. This structure creates uncertainty for states and the potential for lapses in coverage for children. When Congress missed its deadline to renew CHIP funding for fiscal year 2018, federal funding lapsed for several months, and states had to take extraordinary measures to maintain their programs while they waited for federal action.[146, 147] Several states posted announcements on their websites or directly notified families that their CHIP coverage could be terminated. Connecticut went so far as to institute an enrollment freeze on new applications.[148] States respond to budget limitations by implementing enrollment freezes and caps, and studies indicate that these measures have led to families experiencing coverage losses, delays in accessing needed medical care, difficulties obtaining prescription medications, and significant financial hardships.[149]

The certainty of permanent funding would protect children and families from future lapses in federal commitment to CHIP and would allow states to keep their programs running smoothly and make plans for program improvements.[150] Making CHIP funding permanent would help ensure participants' health and well-being.[151]

Bridge Racial Disparities in Quality of Care & Health Outcomes

This section outlines two key policy changes to help address racial disparities in quality of care and health outcomes: increasing Medicaid reimbursement rates and mandating extension of Medicaid coverage to at least one year postpartum.

INCREASE MEDICAID REIMBURSEMENT RATES

States should increase Medicaid reimbursement rates to reduce inequities in access and quality of care.

Although the Medicaid statute compels states to pay rates that ensure equal access for program participants, Medicaid's low reimbursement rates present a barrier to accessing quality care for many, often requiring health care providers to spend more on services for participants than those providers receive in program funds.[152] Therefore, some providers accept patients with private insurance while rejecting patients who are Medicaid participants.[153] Low Medicaid reimbursement rates disproportionately harm people of color.[154] Research indicates that increasing physician reimbursement amounts under Medicaid improves program participants' health care access and health.[155] A 2019 study showed that increasing the baseline Medicaid primary care rates by $45 per service—to close the gap in payments between private insurance and Medicaid—would reduce inequities in access to care by at least 70 percent.[156]

Aligning Medicaid reimbursement rates with Medicare reimbursement rates for nursing home care is particularly important to address deep racial disparities in quality of care and health outcomes. Research on systemic racism in nursing homes suggests that doing so would reduce incentives for nursing homes to reject Medicaid participants and would advance racial equity.[157]

Federal and state action is needed to support adequate Medicaid reimbursement rates.

EXTEND MEDICAID COVERAGE TO AT LEAST ONE YEAR POSTPARTUM

States should extend Medicaid and CHIP coverage to at least one year after the end of pregnancy.

The American Rescue Plan Act of 2021 provided an option for states to extend Medicaid and CHIP coverage from two to 12 months postpartum; the Consolidated Appropriations Act of 2022 made this option permanent.[158] (As of January 2023, seven states use CHIP funding to cover pregnant individuals.)[159] This change has immense potential to ameliorate racial disparities in postpartum health outcomes if fully operationalized nationwide, and all states need to take up this expansion in coverage. As of June 2023, 35 states and D.C. have implemented 12-month postpartum coverage, and another six states plan to implement the change.[160]

Expand Eligibility & Alleviate Administrative Burdens

This section outlines policy changes expanding eligibility and alleviating administrative burdens to help ensure equitable access to Medicaid and CHIP coverage for all, particularly people of color.

MAKE MEDICAID & CHIP ACCESSIBLE TO ALL IMMIGRANTS WHO MEET INCOME & STATE RESIDENCY REQUIREMENTS, REGARDLESS OF CITIZENSHIP STATUS & WITHOUT WAITING PERIODS

Federal and state policymakers should implement policies that remove immigration status as a barrier to accessing Medicaid and CHIP benefits.

Documented immigrants in the United States who meet income and state residency requirements are barred from accessing Medicaid or CHIP for five years after attaining "qualified status."[161] "Qualified" immigrant groups include documented permanent residents, asylees, and refugees.[162] Other "non-qualified" groups of documented immigrants, including those with temporary protected status, and people who are undocumented, cannot enroll in Medicaid or CHIP, regardless of how long they have resided in the country.[163]

These restrictions leave a significant number of U.S. residents without coverage. In 2021, approximately 20.8 million noncitizens—a category that includes immigrants who are documented and undocumented—were living in the U.S.[164] People without citizenship status are significantly more likely to go without health care coverage, reflecting barriers to access. A quarter of non-elderly immigrants who are documented and almost half of immigrants who are undocumented were uninsured in 2021, versus less than 8 percent of non-elderly citizens.[165] In 2019, 7.9 percent of uninsured children were ineligible for Medicaid and CHIP only due to immigration status, despite their families' incomes falling below state thresholds.[166]

Federal policymakers should end the five-year waiting period, or "five-year bar," for access to public benefits, including Medicaid and CHIP, and other anti-immigrant exclusions created by PRWORA.[167] Legislative proposals, such as the Lifting Immigrant Families Through Benefits Access Restoration (LIFT the BAR) Act of 2022, would remove barriers created by PRWORA, including the five-year waiting period for access to public benefits.[168] In addition to ending the five-year bar, federal legislation should ensure that state policymakers cannot create new barriers to benefits.

Recent state policies have already demonstrated the feasibility of extending coverage to previously uncovered immigrant groups. The Children's Health Insurance Program Reauthorization Act of 2009 provided states with the option to extend Medicaid and CHIP coverage to pregnant women and children who are documented without a five-year waiting period.[169] To date, 35 states and D.C. have taken up this option to expand coverage for one or both groups.[170, 171] Additionally, as of December 2022, nine states allow comprehensive coverage for all income-eligible children, regardless of immigration status.[172] A few states—including California, New York, and Illinois—have made great strides in expanding Medicaid coverage to adults regardless of their immigration status.[173] In January 2020, California extended state-funded coverage to young adults ages 19-26 regardless of immigration status; in May 2022, California extended coverage to adults 50 and older regardless of immigration status.[174, 175]

IMPLEMENT CONTINUOUS ELIGIBILITY FOR PARTICIPANTS FOR AT LEAST 12 MONTHS

States should protect Medicaid and CHIP participants from churn and interruptions in coverage by implementing continuous eligibility for at least 12 months for all participants.

Many Medicaid and CHIP participants temporarily lose coverage due to short-term changes in income.[176] Others may face obstacles in maintaining coverage despite remaining eligible due to complicated renewal procedures and frequent eligibility checks.[177] The resulting process of disenrollment and re-enrollment over the course of a brief period of time is referred to as "churn," which both limits participants' access to care and raises administrative costs.[178] Children of color are more likely than their white counterparts to experience periods of uninsurance during the year; 14 percent of Latinx children and almost 12 percent of Black children are affected by these gaps in coverage, compared to 7.3 percent of white children.[179]

States can protect Medicaid and CHIP-eligible individuals from administrative burdens and interruptions in their care by instituting 12 months or more of continuous eligibility for all participants. As of 2023, 24 states have adopted 12-month continuous eligibility for children through a state option.[180] Beginning in 2024, all states will be required to provide 12-month continuous coverage for children.[v, 181]

Several states have taken action to extend continuous eligibility beyond 12 months; other states should follow their lead. In September 2022, Oregon received approval from the federal government for a Section 1115 demonstration project that provides continuous eligibility for children participating in Medicaid from birth until the age of six, and two years of continuous eligibility for all participants six years and older.[182] New York provides 12-month continuous eligibility for all adults, while Kansas provides 12-month continuous eligibility for parents and caretakers who are covered under Section 1931, a provision requiring states to cover parents whose incomes fall under the state income eligibility level.[183, 184] California, New Mexico, and Washington are also working to follow Oregon in offering multi-year continuous coverage for children under Medicaid and CHIP.[185]

FULLY IMPLEMENT ACA REDUCTIONS TO ADMINISTRATIVE BURDENS

States should implement existing ACA policies that reduce administrative burdens in the application and enrollment processes.

Policy changes in the ACA have great potential to reduce administrative burdens. For example, the ACA prohibited mandatory in-person interviews, required that states use already available data to confirm eligibility and, where possible, automatically renew individuals' coverage, and eliminated asset tests for adults under 65 who do not qualify for Medicaid based on disability.[186] However, many states have not fully implemented the changes.[187, 188]

v A recent proposed rule from CMS focused on streamlining Medicaid and CHIP would require states to conduct renewals no more than once every 12 months (with limited exception). For more information, see "Streamlining Eligibility & Enrollment Notice of Proposed Rulemaking (NPRM)." Centers for Medicare & Medicaid Services, 31 August 2022. Available at https://www.cms.gov/newsroom/fact-sheets/streamlining-eligibility-enrollment-notice-propose-rulemaking-nprm.

Enrollment simplification measures in the ACA should be extended to people who qualify for Medicaid on the basis of disability, who are currently excluded from many of them.[189] The exclusions leave these participants at higher risk of losing coverage due to procedural reasons despite still meeting eligibility requirements.[190] In August 2022, CMS proposed a rule that, if implemented and enforced, would extend these burden-reducing measures to participants with disabilities.[191]

REDUCE DATA CHECKS & VERIFICATION REQUESTS

States should rely on already available data to reduce the number and frequency of data checks and verification requests.

People who qualify for Medicaid also often participate in other public programs, such as the Supplemental Nutrition Assistance Program (SNAP), and data sharing can allow for administrators to cross-check for Medicaid and CHIP eligibility.[192] By increasing the number of reference databases and reliance on already available data, states can reduce the burden on Medicaid and CHIP applicants and participants to provide documents verifying their eligibility.[193]

To promote stable coverage, it is critical that the increased reliance on available data is instituted in tandem with a reduction in data checks on households. Although states are not federally required to conduct these checks, 30 states periodically check electronic data sources for changes in participant income or other circumstances throughout the 12-month enrollment period, and a number of states provide participants only 10 days to respond to related information requests to confirm continued eligibility.[194] Many of these checks are performed by algorithms and other automated decision-making systems, which can be influenced by institutional biases and prevent individuals from fully understanding the reasons for benefits termination.[195] Consequently, state and federal agencies must institute practices that promote transparency, reduce bias, and provide pathways for exceptions that can reject automatic decisions.[196]

Frequent data checks can take away vital Medicaid or CHIP coverage from participants due to onerous, time-sensitive verification and paperwork requirements.[197] Periodic data checks disproportionately harm workers with more than one job or workers who switch between jobs throughout the year.[198] In addition to harming participants, these checks are not cost-effective for states. When a participant loses coverage due to a data check, goes a period of time without coverage, and then re-enrolls, the costs of their health care are often higher than if their coverage had been uninterrupted.[199] Further, the cyclic churn of participants losing coverage and re-enrolling incurs additional administrative costs to state agencies.[200]

In August 2022, CMS proposed a rule focused on streamlining eligibility and enrollment for the Medicaid and CHIP programs that would–among other burden-reducing measures–establish guidelines for states to consult available data before disenrolling a participant who cannot be reached via mail; create pathways for states to refer to available data to update addresses when participants move within the same state; require that participants have enough time to provide documentation to maintain eligibility; and implement a process whereby participants can be transitioned between Medicaid and CHIP when their income fluctuates or they become eligible for the other program, even if the participant does not respond to an information request.[201]

IMPROVE ACCESS TO ONLINE SERVICES

States should design online applications and account management portals for the application and renewal processes to maximize access.

Medicaid and CHIP's reliance on paper documentation and mail to prove and maintain eligibility has often resulted in eligible individuals experiencing interruptions in coverage or not being able to receive coverage in the first place.[202] For many, online applications and account management portals can present a useful alternative and, if operated effectively, can reduce disparities in access to Medicaid and CHIP coverage.[203] However, poorly designed, non-mobile-friendly websites make it more difficult to use these services to apply for and renew benefits. People with low incomes are more likely to use smartphones to access the internet than broadband home service.[204] Research has shown that website design choices can make a real difference; mobile-friendly sites that have undergone comprehensive user-based testing and allow users to upload photos of documents to verify eligibility can significantly increase access.[205]

Principles to Center & Empower Program Participants & Their Communities

This section offers three principles, informed by our discussions with stakeholders, that policymakers and administrators should utilize when implementing policy changes to Medicaid and CHIP. The principles are participant-centered accountability, power-sharing with community-based organizations, and resources for community-based organizations.

Participant-Centered Accountability

Establish built-in mechanisms for participants to share their experiences with providers and decision-makers for the Medicaid and CHIP programs.

As long as the voices of people of color remain de-centered and disempowered, an equitable federal support system cannot be actualized.[206, 207] To be truly transformative, Medicaid and CHIP policies must engage participants as active co-creators, empowering them to exercise control over their own lives and well-being. In 2022, CMS announced a plan to take a participant-centered approach to improving quality and advancing health equity.[208] One of the goals of the CMS National Quality Strategy is to ensure that the voice of the individual is included in decisions involving their care and that there are direct pathways for participant feedback regarding provider, facility, or payer performance to inform CMS's quality improvement approach.[209]

In order to further participant-centered accountability, CMS should continue to test provider reimbursement models that prioritize patient well-being.[210]

Power-Sharing With Community-Based Organizations

Ensure continuous, compensated, and institutionalized community-based organizations' involvement at all levels of the policy process through formal pathways, such as advisory groups.

In order to center the voices of the people most affected by Medicaid and CHIP policies and advance health equity, decision-making power must be appropriately distributed among stakeholders including members of marginalized communities, such as Black and Brown people.[211] Power-sharing can take many forms, including agencies inviting community-based organizations to participate in task forces and convenings that guide program and budget changes, inviting community-based organizations to participate in planning and assessment meetings, or subcontracting with community-based organizations to promote program participation.[212, 213] Authentic, long-term relationships between federal and state institutions and community partners would help ensure continuous, sustained pathways for formal participation at all levels of the policy process.[214] The Integrated Care for High Risk Pregnancies (ICHRP) program, a grant-supported initiative administered by the Minnesota Department of Human Services (DHS) in partnership with local African American community leaders and medical professionals, is an example of a power-sharing arrangement aiming to reduce racial health disparities.[215]

Power-sharing with communities marginalized by the health care system must include equitable compensation for members' participation. Otherwise, program participants could be exploited.[216, 217] As one strategy, the Minnesota DHS recommends contracting with respected community partners to host conversations with participants, ensuring the participants are compensated for their time and reimbursed for expenses, including travel and child care.[218]

Resources for Community-Based Organizations

Direct state and federal funding toward community-based groups led by communities of color who have been marginalized by the health care system.

CMS has found that some community-led programs—such as those focusing on physical activity, chronic disease management, and fall prevention—have likely driven down health care costs and the rate of unplanned hospital visits for participants.[219, 220] Community-based initiatives and social services address unmet needs and promote health among community members, and state and federal funds should be allocated towards investing in these efforts.

An example of this principle in action is Medicaid coverage of community health workers (CHWs). CHWs are trusted community members, often employed by community-based organizations, who provide culturally competent services to people who are often underrepresented in health care systems.[221] They perform many services, including health promotion, advocacy on behalf of patients and their families, and connecting community members with resources.[222] Evidence indicates that CHW-led interventions can reduce racial health disparities.[223] According to KFF's 2022 Medicaid budget survey, only 29 out of 48 responding states reported allowing Medicaid funding to cover services provided by CHWs.[224] With sustainable funding, community-based organizations would be able to grow and improve services and contribute to better health outcomes for Medicaid and CHIP participants.

Conclusion

Medicaid and CHIP are vital pillars of our health care system, and can be transformed into programs that redress past and present inequities and deliver high-quality care for everyone. Thoughtful, purposefully anti-racist improvements to Medicaid and CHIP's policies and service delivery would advance racial health equity and improve the health and well-being of millions more families. Implementing anti-racist program transformations while prioritizing the voices, needs, and agency of participants and their communities would aid in the creation of a health care system that truly works for all.

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