Invited Commentary | Diversity, Equity, and Inclusion

Structural Racism and Inequities in Access to Medicaid-Funded Quality Cancer Care in the United States

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Marks et al1 offer important insights into access to high-quality cancer treatment for patients with Medicaid. The authors randomly selected 1 in 3 Commission on Cancer–accredited facilities and trained secret shoppers to pose as people with Medicaid insurance seeking a new patient appointment for treatment of 1 of 4 types of cancer: breast, colorectal, kidney, and skin. Secret shopper or audit methodology avoids bias associated with self-reports of access by facility administrators and has been widely used to study health care access, particularly related to Medicaid. The authors found that only 68% of the facilities accepted new patient appointments for the treatment of all 4 types of cancer. Acceptance was highest for the treatment of breast cancer and lowest for skin cancer. Refusals were highest for comprehensive community cancer programs (higher volume), for-profit hospitals, and those with above and below-average care effectiveness or nonintegrated salary models. These findings are consistent with previous studies on access to care for people with Medicaid and highlight opportunities for improving equity in access to high-quality cancer treatment.2

These findings must be understood in the context of Medicaid, the nation’s largest public health insurance program, which provides care for more than 1 in 5 US residents, who are disproportionately Black, Hispanic, low-income, and disabled. Authorized under the Social Security Act, Medicaid was signed into law in 1965 with shared federal and state funding. Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) offered 90% matching funds to states for expanded coverage to people with incomes up to 138% of the federal poverty limit.3 Subsequent research has documented that Medicaid expansion has improved cancer-related care and has reduced racial health disparities.2 Notably, 14 million US residents face imminent loss of Medicaid coverage when the public health emergency for COVID-19 ends.

Despite documented benefits of Medicaid expansion, the impact of Medicaid coverage is blunted by racialized politics, clinician payment, and stigma. Twelve states have failed to expand Medicaid eligibility: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, North Dakota, South Carolina, South Dakota, Tennesse, Texas, and Wisconsin.3 Members of minoritized racial and ethnic groups account for greater than one-third of the population in 7 of those states (Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, and Texas). The reason for the lack of expansion in these states is largely motivated by politics rather than the desire for equity in health care access. The interaction of politics and race has a strong influence on government policies, including the expansion of the ACA and access to health care for patients of minoritized populations.

Medicaid typically reimburses clinicians less than Medicare, contributing to lower physician participation, especially among specialists. A meta-analysis of secret shopper studies showed that having Medicaid insurance was associated with a 1.6-fold lower likelihood in scheduling a primary care appointment and a 3.3-fold lower likelihood in scheduling a specialty appointment compared with having private insurance.4

Medicaid is stigmatized based on coverage for people who are disproportionately poor and minoritized. In a previous Medicaid secret shopper study, auditors posed as Black and White patients seeking new patient appointments. Researchers posing as Black patients were less likely to be told the practice was accepting new patients and were more likely to experience withholding behaviors and misattributions about Medicaid.5 The strength of associations between perceived race and

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Medicaid acceptance varied according to whether the cue was based on name or accent, with effect sizes varying by region of the country.

Given our history of racialized health care politics, what can be done to improve access to cancer treatment for people insured through Medicaid? The authors offer reasonable suggestions, including improved Medicaid reimbursement, the adoption of integrated salary models, and new payment models. An obvious solution is a single-payer model in which reimbursement is the same for all people, but congressional passage appears unlikely in the near future.

Another approach is recognition that refusing to accept patients with Medicaid contributes to racial health inequities through structural racism fueled by a new racism that promotes equality, rather than equity or racial justice. Structural racism in health care has led to inequitable access to treatment resulting from centuries of health care policies advantaging White populations. Inadequate and inequitable health insurance coverage are some of the greatest structural barriers to access to health care. To address the effects of structural racism on health care, principles of equity (not equality) should be applied to policies, namely those affecting access to quality health care. Equity in cancer care cannot be accomplished as long as factors such as discrimination by race or insurance and inequitable access to health insurance coverage continue to hinder access to quality care. In this case, federal funding for Medicaid, state Medicaid reimbursement policies, and facility policies surrounding the acceptance of Medicaid disproportionately affect Black and other minoritized groups who are overrepresented within Medicaid.

Addressing this manifestation of structural racism presents an opportunity for promoting health equity through actions by the federal and state governments, managed care organizations, accreditation organizations, and cancer centers. The Centers for Medicare & Medicaid should explore requiring facilities to make their policies regarding Medicaid public and take steps to incentivize the acceptance of Medicaid. Managed care organizations can include requirements for Medicaid acceptance in their contracts. Accreditation organizations can support health equity by incorporating access to Medicaid into their standards. Medical centers can improve accountability for racially and economically based discriminatory practices by publicly committing to addressing structural racism and implementing policies that assure all hospital departments are accepting patients with Medicaid. Progress can be monitored by regularly collecting information from patients about their experiences with discrimination (eg, exit survey, patient grievance processes), being transparent about the results, and using the information to implement change that prioritizes patient-centered care and value-based and equity-incentive payments, and requirements to address discrimination. Secret shoppers could be used by institutions if not regulators or accreditors to ensure compliance with Medicaid acceptance policies. To achieve equitable access to quality cancer care, it will be imperative to revise racialized policies that directly affect clinician payment practices and patient access to care and indirectly fuel stigmatization and discriminatory behaviors toward Medicaid and its recipients.

ARTICLE INFORMATION
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REFERENCES


