COVID-19 Exposes Urgent Inequities: A Call to Action for Healthcare Reform

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Keywords: health equity; health policy; health advocacy; COVID-19; healthcare reform; HHS;

Executive Summary: The COVID-19 pandemic has exposed undeniable health inequities among marginalized communities (MC), including black, indigenous, and other people of color (BIPOC) in the United States (Forno and Celedón 2012, Kaiser Family Foundation 2017, US National Center for Health Statistics 2019, Glasgow 2020). The lack of centralized support for local health responses has jeopardized many MC/BIPOC (Baah, Teitelman, and Riegel 2019). We propose the **Department of Health and Human Services (HHS)** implement the following policy steps:

1. Centrally collect patient data on social determinants of health and equity and post-COVID-19 health outcomes (Paradies et al. 2015, Jones et al. 2009, Magnan 2017). Real-time data collection allows for real-time quality improvement and implementation of policies to mitigate inequities in the short-term.
2. Expand and implement Centers for Medicare and Medicaid (CMS) value-based care models (VBCM) to address inequities in the long-term. VBCMs institutionalize data collection initiated in **Step 1** while concurrently implementing interventions.
3. Temporarily expand Medicaid coverage for individuals needing subsidized insurance. This provides a safety net for those suffering employment instability during the crisis, alleviating some root causes of health inequities.

These steps will centralize resources, empowering local health systems to control and contain outbreaks disproportionately occurring among MC/BIPOC. HHS is positioned to implement these policies and mitigate further damage from COVID-19. HHS agencies such as the Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) have successfully implemented centralization responses, such as the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in response to the HIV/AIDS epidemic, effectively targeting disparities (Valdiserri and Holtgrave 2020). These previous successful responses by the HHS should compel intervention in the present crisis.

I. Background

Preliminary data on COVID-19 reveals significant disparities in health outcomes by race (Forno and Celedón 2012; Kaiser Family Foundation 2017; US National Center for Health Statistics 2019). In 37 states, black Americans are dying from COVID-19 at rates up to 50% greater than expected (Godoy and Wood 2020). In Michigan, black Americans represent 14% of the population, but 41% of COVID-19-related deaths as of May 26th (APM Research Lab 2020). While many reports focus on black Americans, similar effects are being reported in Indigenous (Eschner 2020, CDC 2020), low-income, undocumented immigrant, incarcerated, and disabled populations (Dunn et al. 2020; Page et al. 2020; United Nations 2020).

Health inequities were similarly revealed during the HIV/AIDS epidemic and have since been aggressively targeted by the HHS. Despite these efforts, lack of structural change prevented inequities from being adequately addressed in the wake of other public health emergencies; HHS programs failed to gain comparable ground in a largely black and poor population in the wake of Hurricane Katrina (Rudowitz, Rowland, and Shartzer 2006). The HHS has not fully engaged its capacity to address the same disparities in today's crisis (Valdiserri and Holtgrave 2020; El-Sadr et al. 2012).

These three disasters demonstrate how crises can disproportionately damage MC/BIPOC. This is partly due to disparities in underlying risk factors (Forno and Celedón 2012; Kaiser Family Foundation 2017; US National Center for Health Statistics 2019). For example, Mississippi reports similar rates of diabetes in white and black Mississippians, but diabetes causes more than twice as many deaths in the latter group (Lamees El-sadek, Zhang, and Funchess 2018). Similarly, countless reports document statistically significant disparities in rates of disease and death in MC/BIPOC (Noonan, Velasco-Mondragon, and Wagner 2016; Myers et al. 2015; Krahn, Walker, and Correa-De-Araujo 2015).

Long-standing social determinants of equity (SDOE) operating through social determinants of health (SDOH) creates additional predisposing disparities, including employment as an essential worker and crowded housing conditions (Oppel Jr et al. 2020). To address these disparities, HHS released a statement on June 8 outlining initiatives the agency is currently undertaking to address health disparities; however, these measures do not provide infrastructure for crisis aversion and lasting healthcare reform (HHS 2020).

This memo contextualizes our recommendations with the respective successes and failures of the HHS response to the HIV/AIDS epidemic and Hurricane Katrina. Ignoring the lessons HHS has learned from past health crises will doom us to repeat the same mistakes. Many experts have characterized the cyclical national response to pandemics as "panic-neglect-panic-neglect" (Valdiserri and Holtgrave 2020). Neglect will deepen existing inequities in suffering due to COVID-19, and further expand the health gap between marginalized and non-marginalized communities.

II. Policy recommendation

The HHS is uniquely positioned to centralize resources to manage healthcare related to the COVID-19 crisis in the following areas:

- Implement large-scale healthcare support systems through a multitude of agencies. In this proposal, we focus on the capacity of the CDC, CMS, and FDA.
- Implement data collection with metrics pertinent to pandemic tracking like PEPFAR and Ending the HIV Epidemic (EHE). These HHS programs already track COVID-19 and health demographic data to redirect resources to pre-identified MC/BIPOC populations (amfAR 2020b; Birx and Achrekar 2020).
- Mobilize and quickly respond during the immediate crisis. In the aftermath of Katrina, HHS was eventually able to develop resources for effective acute use and longer-term healthcare access for MC/BIPOC (Rudowitz, Rowland, and Shartzer 2006; Andrulis, Siddiqui, and Gantner 2007).

i. Disadvantages

Many of these recommendations carry a fiscal note and the success of these measures relies on compliance from local governments. However, the cost is mitigated by adaptation of pre-existing HHS programs used to address the HIV/AIDS and Katrina crises. Additionally, healthcare providers may perceive an initial increase in regulation as health

systems are restructured to VBCMs. Currently, CMS also risks disproportionately penalizing VBCMs unless CMS proactively incorporates equity-framed performance measures (American Academy of Family Physicians et al. 2020).

ii. Advantages

These recommendations provide straightforward guidance to enhance and implement pre-existing models, such as PEPFAR and EHE, VBCM/PCF, Medicaid expansion (Kaiser Family Foundation 2020), targeting both short- and long-term impacts at the intersection of COVID-19 and health disparities. Benefits of similar programs have been observed in the HIV/AIDS crisis and Medicaid expansion after Katrina, in terms of morbidity, mortality, and foreign relations (El-Sadr et al. 2012).

Amalgamated SDOE/SDOH data can be used to direct limited resources to areas with identified inequities and vulnerabilities. Centralized data collection and intervention will help contain and mitigate the spread of COVID-19.

A VBCM paradigm with a broad health equity lens resolves concerns regarding provider autonomy and narrow single-issue responses. Furthermore, a focus on community partnerships will improve population health outcomes and health system relationships.

III. Steps for implementation

i. Step 1: Short-term infrastructure - allocation of COVID-19 relief funding

MC/BIPOC suffer due to inequities in SDOH (Taylor 2019). Evidence-based decision-making is crucial to prevent further damage to disadvantaged communities. These inequities are exacerbated by diminishing public health funding, hindering the HHS's ability to gather demographic data and advise the U.S. pandemic response.

We recommend **HHS** immediately adopt the following, in line with recent recommendations (Warren et al. 2020):

- Increase allocation of funding to the CDC and FDA to support COVID-19 containment, testing, monitoring, and mitigation as recommended by Forman (Forman 2020). This can be practically and inexpensively implemented through existing frameworks such as PEPFAR, which has proven able to maintain treatment resilience during crises (El-Sadr et al. 2012).
- Require all labs to collect and report SDOH/SDOE, including race, work, socioeconomic status, housing status, and food security, and testing data to the CDC (Feeding America 2020; Desilver 2020; Dunn et al. 2020; Patel and McGinnis 2020). Data collected by the COVID Tracking Project shows all but one state reports some type of demographic information for their COVID-19 cases. While race or ethnicity has been identified for 90% of deaths and roughly half of all cases (Godoy and Wood 2020; Bharel 2020), this data is not being collected consistently and transparent reporting is not required locally or nationally (Prevention 2020). Collecting and reporting this data is vital, as was learned in the aftermath of Katrina; local agencies failed to come to consensus on appropriate data collection parameters, leading to a failure to meet MC disaster preparedness needs (Andrulis, Siddiqui, and Gantner 2007).
- Expand healthcare reporting structures to require collection of all SDOH data on race, work, socioeconomic status, housing status, and food security (Feeding America 2020; Desilver 2020; Dunn et al. 2020). The EHE and PEPFAR Initiatives provide excellent frameworks for this effort and already collect COVID-19 data that is publicly available.
- Incentivize incorporation of the above data into future Electronic Health Record Certification requirements by CMS. These data will be useful in tracking, treating, and mitigating disparate effects of post-COVID-19 outcomes as they emerge. Early research indicates possible impacts to fertility, brain, heart, and mental health (Zhou et al. 2020; Servick 2020; Ma et al. 2020).

Funding for these ventures can be derived from the supplemental awards allocated to health centers in Section 3211 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act or with passage of the next COVID-19 relief bill. These monitoring mechanisms should guide HHS prioritization of available test kits and federal stockpile supplies to areas of greatest need with the goal of reducing

disparities in outcomes (Prakash 2020; Forman 2020; Patel and McGinnis 2020; Godoy and Wood 2020; Millett et al. 2020).

ii. Step 2: Long-term infrastructure - value-based care with equitable data collection and intervention

Since 2012, CMS has employed VBCM programs to incentivize quality of care for Medicare patients (Centers for Medicare and Medicaid 2020). The general aims are to decrease healthcare costs, prioritize population health, and improve individual health outcomes (Centers for Medicare and Medicaid 2020). International programs, like PEPFAR, which incentivize remediation of health disparities through evidence-based, outcome-oriented strategies have been able to address systemic health inequities MC/BIPOC face (Valdiserri and Holtgrave 2020). We propose adjusting current VBCMs, including the Primary Care First (PCF) model (Centers for Medicare and Medicaid 2019).

We recommend **CMS** implement the following to address disparities in healthcare outcomes for all institutions benefitting from Medicare and Medicaid dollars:

- Integrate and refine equitable metrics for data collection and monitoring population health outcomes*.* VBCMs should institutionalize data collection mechanisms proposed in **Step 1.** Additionally, VBCMs should require partnerships with local organizations to form community advisory boards for health systems to ensure MC/BIPOC needs are met (Levi and DeSalvo 2020).
- Integrate formalized Community Needs Assessments and Community Action Plans with community initiatives to assess and address SDOE/SDOH to improve community health (Moody-Williams 2018) as well as direction for health systems to collaborate with community organizations and spend "community benefit dollars" to address relevant issues outside hospitals' direct control, including laws and policies impacting housing, food, and job accessibility (Anderson et al. 2018). Inability to appropriately implement these partnerships has been disastrous in previous public health emergencies. During Katrina, cultural/language barriers, distrust of messengers, and reliance on informal sources of information made it more difficult for public health officials to ensure the safety of disproportionately impacted communities (Andrulis, Siddiqui, and Gantner 2007); on the contrary, PEPFAR was able to handle the same issues in HIV/AIDS work via collaboration with community organizations (Fenton and Valdiserri 2006; Valdiserri and Holtgrave 2020).
- Utilize payment models to incentivize decreases in health disparities. VBCMs should be modified to reward healthcare providers for reducing disparities resulting from SDOE/SDOH. Profitable VBCMs should be incentivized to reinvest in community programs that promote health equity, as previously outlined by health organizations (Mutha et al. 2012; Anderson et al. 2018). States have modeled this by reporting performance measures and quality improvement stratified by SDOE/SDOH; requiring partnering organizations to address racial disparities, with financial accountability contingent on outcome evaluations; incentivizing VBCMs with bonus funds for projects that effectively address SDOE/SDOH; and using SDOE/SDOH-adjusted methods for assessing provider performance (Patel and McGinnis 2020; Crumley and McGinnis 2019; Health 2019).

Implementation of these policies should be instituted centrally given their great success during temporary PEPFAR-funded programs in the past (U.S. President's Emergency Plan for AIDS Relief 2020).

iii. Step 3: Disaster Mitigation and Preventative Care – Medicaid Coverage Expansion

MC/BIPOC are disproportionately under- and uninsured (Artiga, Orgera, and Damico 2019; Taylor 2019; Kaiser Family Foundation 2017), which has complicated care in a multitude of previous health programs, including EHE (amfAR 2020a). Many SDOE/SDOH impact access to affordable healthcare and preventive care, putting MC/BIPOC at greater risk of infection and severe complications during this pandemic (Promotion 2020).

Employment instability has led to loss of insurance for nearly 27 million during this pandemic, with

about 5.7 million falling into a coverage gap where they cannot replace their insurance, due to barriers like immigration status (Pifer 2020). Studies estimate up to 16 million more could lose insurance as unemployment rises (Garfield et al. 2020, Garrett and Gangopadhyaya 2020).

We recommend **HHS** immediately provide temporary federally incentivized Medicaid expansion with broadened Medicaid presumptive eligibility to include vulnerable populations, including essential workers, renters, undocumented immigrants, unemployed, and those in the Medicaid gap. Reform is needed, particularly in Southern states with prohibitive eligibility requirements or without Medicaid expansion. These are diverse populations with poor overall health and significant racial health disparities (Taylor 2019; Foundation 2018). Federal medical assistance percentage (FMAP) can be reinstated to encourage hold-out states to expand (Forman 2020). To prevent ineffective expansion of coverage, states should exclude prohibitive eligibility requirements and the public rule should be overturned (Forman 2020; Taylor 2019).

These measures have already proven possible: in the aftermath of Katrina, an HHS-approved Medicaid waiver program was implemented to provide temporary coverage to survivors who evacuated Louisiana (Rudowitz, Rowland, and Shartzer 2006; Kaiser Family Foundation 2020). Such measures decrease barriers to healthcare for MC/BIPOC. Furthermore, they decrease the influence of the SDOE on access to quality healthcare, improving long term pandemic-related health outcomes. Additionally, most states expanded Medicaid with negligible costs and in some cases significant savings (Hayes et al. 2020). This short-term measure could lay the foundation for future lasting Medicaid expansion or other healthcare reform.

IV. Conclusion

If appropriately enacted, these measures will produce resilience in the face of future health emergencies and make a significant investment toward addressing health outcome disparities.
Pandemics unmask existing inequities and amplify intersectional disadvantages (Crenshaw 1990). Our short-term responses to crises set precedent for long-term policies; the COVID-19 response is no different. Therefore, informed decision-making is crucial to prevent further harm to disadvantaged communities.

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Acknowledgements
The authors of this memo were brought together by their work through the Civic Engagement Council (CEC), an initiative sponsored by the Associated Students of WSU Health Sciences (ASWSUHS). Their work has been supported by two CEC member organizations: the Health Sciences Student Advocacy Association (HSSAA) and the Health Equity Circle (HEC). We would also like to acknowledge the support and guidance of Jack Downs and Ilene Friedman, J.D. in completing this work.