COMMENTARY

The Centers for Medicare and Medicaid Services (CMS) COVID-19 Brief: Unsettling Racial and Ethnic Health Disparities

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On June 22, 2020, the Centers for Medicare and Medicaid Services (CMS) unveiled an aggregate data set on the impact of the coronavirus disease 2019 (COVID-19) on its beneficiaries. The CMS brief is especially noteworthy for offering COVID-19-related racial and ethnic health disparity data on a national scale, thereby extending reports heretofore limited to states, cities, or health systems. The CMS COVID-19 brief exposes distressing racial and ethnic health disparities. It is the objective of this commentary to trace the origins of the CMS COVID-19 brief, discuss its salient findings, and consider its implications. (J Am Board Fam Med 2021;34:S13–S15.)

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On June 22, 2020, the Centers for Medicare and Medicaid Services (CMS) first unveiled an aggregate data set on the impact of the coronavirus disease 2019 (COVID-19) on its beneficiaries.[1] The CMS COVID-19 brief ("Preliminary Medicare COVID-19 Data Snapshot") comprises the first comprehensive nationwide COVID-19 account to draw on Medicare encounter, claim, and enrollment data.[1] The CMS brief is especially noteworthy for offering COVID-19-related racial and ethnic health disparity data on a national scale, thereby extending reports heretofore limited to states, cities, or health systems. Enumerating COVID-19 cases as well as attendant hospitalizations from January 1 to July 18, 2020, the most recent CMS COVID-19 brief exposes distressing racial and ethnic health disparities.[1] African American beneficiaries proved 2.3 times as likely to contract COVID-19 than white counterparts.[1] The attendant hospitalization risk proved 3.8 times as high.[1] Substantial if lower risk estimates held for Hispanic or Latino beneficiaries, who proved 2.0 times as likely to be affected and 2.6 as likely to be hospitalized.[1] It is the objective of this commentary to trace the origins of the CMS COVID-19 brief, discuss its salient findings, and consider its implications.

Congressional calls for the collection and reporting of quality national data on the racial and ethnic characteristics of subjects who are tested or treated for COVID-19 have been on the rise for some time. On March 27, 2020, several U.S. senators and representatives called on the secretary of the Department of Health and Human Services (DHHS) "to monitor and address racial health disparities in our nation's response to the coronavirus disease 2019 (COVID-19) public health emergency."[2] It was not long thereafter, on April 7, 2020, that CMS Administrator Seema Verma pledged to release demographic claims data "concerning the outcomes of COVID-19 based on race, ethnicity, and gender that are currently available to the agency."[3] Absent apparent progress, however, Rep. Frank J. Pallone (D-NJ), chair of the Committee on Energy and Commerce, called on Administrator Verma to release the data in question on April 15, 2020, and again on June 16, 2020.[3] In these written communications, Rep. Pallone highlighted the import of a CMS analysis that is critically focused on the "clear demographic disparities in care that have become apparent as a result of the COVID-19

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pandemic but have long persisted in our health care system."[3]

The data of the CMS COVID-19 brief were sourced from Medicare fee-for-service claims, Medicare Advantage encounter data, and Medicare enrollment information.[1] COVID-19 cases and hospitalizations were broken down by state, race/ethnicity, age, gender, dual eligibility for Medicare and Medicaid ("dual-eligible" beneficiaries), and urban/rural locations.[1] The overall case and hospitalization rates proved to be 1208 and 338 per 105 beneficiaries, respectively.[1] Urban beneficiaries were 2.1 times as likely to be diagnosed with COVID-19 and 2.4 times as likely to be hospitalized than rural counterparts.[1] The highest case and hospitalization rates (5119 and 2476 per 105 beneficiaries, respectively) were noted for those afflicted with end-stage renal disease (ESRD).[1] It would thus seem that an urban location and affliction with ESRD contributed to a higher case rate and to greater disease severity in Black and Hispanic populations that are disproportionately urban and subject to ESRD. The racial and ethnic disparities in COVID-19 outcomes were most readily reflected in the ratio of hospitalizations to cases, which proved substantially higher for African American (0.39) and Hispanic or Latino (0.30) beneficiaries than white counterparts (0.23).[1] The aforementioned observations seem to be in harmony with those of the Johns Hopkins University and American Community Survey according to which the COVID-19 infection rate in predominantly African American counties (137.5 per 105) was 3.5-fold higher than that in predominantly white counterparts.[4] The death rate in predominantly African American counties (6.3 per 105), for its part, proved 5.7-fold higher than that of predominantly white counterparts.[4] The CMS COVID-19 brief was also in harmony with recently released data by the Centers for Disease Control and Prevention, according to which the national age-adjusted hospitalization rate for African American subjects (178.1 per 105) was 5 times that of white counterparts (40.1 per 105).[5] The corresponding hospitalization rate for Hispanic or Latino subjects proved to be 4 times that of white counterparts.[5]

Increasingly cognizant of the impact of racial and ethnic health disparities on COVID-19 outcomes, the DHHS has recently seen to the implementation of 5 relevant initiatives. First, the DHHS extended its partnership with private pharmacies and grocery chains with an eye toward enhancing access to COVID-19 testing. Now more than 600-strong nationwide, the supplementary COVID-19 testing sites improve access in multiple areas noted for their COVID-19 vulnerability. Second, the DHHS awarded more than $21 million to support the COVID-19 response efforts of community health centers, the lion's share of which is to expand testing capacity. Third, the DHHS now requires that laboratories report the age, race, ethnicity, sex, zip code, and type of test performed on patients. Pursuant to the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the results are to be reported daily by state and local health departments to the Centers for Disease Control and Prevention. Fourth, the DHHS awarded $59.5 million to expand primary care training in underserved communities via the Teaching Health Center Graduate Medical Education program. Fifth, the DHHS Office of Minority Health announced the selection of the Morehouse School of Medicine as the awardee of a new $40 million grant "to fight COVID-19 in rural and socially vulnerable racial and ethnic minority communities."[6] To this end, Morehouse School of Medicine will "coordinate a strategic network of national, state, territorial, tribal and local organizations to deliver COVID-19-related information to communities hardest hit by the pandemic."[6] Known as the National Infrastructure for Mitigating the Impact of COVID-19 within Racial and Ethnic Minority Communities (NIMIC), the 3-year effort is to educate and assist community-based organizations across the nation in the fight against the pandemic.[6]

The unsettling racial and ethnic health disparities affirmed by the CMS COVID-19 brief are neither new nor surprising. Rooted in long-standing social injustice, racial and ethnic health disparities are a reflection of national inattention to health equity and thereby to the welfare of the less fortunate among us. The panoply of risk enhancers, that is, the social and structural determinants of health, is all too familiar. Leading this inventory are economic and educational disadvantages, intermittent employment as "essential workers," recurrent unemployment, absent paid sick leave, crowded living quarters, subpar sanitation, poor nutrition, compromised health literacy, absent health insurance, historic distrust of the health care system, and limited access to quality health care. Short-term fixes will not do. Nothing less than an unshakable national commitment will be required to render racial and ethnic health disparities a thing of the past. One can only hope that the recent inception of equity-seeking social movements will see to the dismantling of the prevailing

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structural racism and the health care consequences thereof. In the interim, primary care providers would do well to recognize and address the excess vulnerability of racial and ethnic minorities to COVID-19 and the complications thereof.

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References

1. Centers for Medicare and Medicaid Services. Preliminary Medicare COVID-19 data snapshot. 2020. Available from: https://www.cms.gov/research-statistics-data-systems/preliminary-medicare-covid-19-data-snapshot. Accessed September 25, 2020.
2. Letter from members of Congress to Alex M. Azar II, Secretary U.S. Department of Health and Human Services. 2020. Available from: https://pressley.house.gov/sites/pressley.house.gov/files/2020.03.27%20Letter%20to%20HHS%20re%20racial%20disparities%20in%20COVID%20response.pdf. Accessed September 25, 2020.
3. Letter from Rep. Frank J. Pallone (D-NJ) to Seema Verma, Administrator, Centers for Medicare & Medicaid Services. 2020. Available from: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/CMS.2020.6.16.%20Letter%20re%20COVID-19%20Disparity%20Data.pdf. Accessed September 25, 2020.
4. Johns Hopkins Libraries. Databases. American Community Survey. 2020. Available from: https://www.census.gov/programs-surveys/acs/. Accessed Sept 25, 2020.
5. Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-19). Health equity considerations and racial and ethnic minority groups. 2020. Available from: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html. Accessed September 25, 2020.
6. Office of Minority Health. U.S. Department of Health & Human Services. HHS announces partnership with Morehouse School of Medicine to fight COVID-19 in racial and ethnic minority and vulnerable communities. 2020. Available from: https://www.hhs.gov/about/news/2020/06/23/hhs-announces-partnership-morehouse-school-medicine-fight-covid-19-racial-ethnic-minority.html#:~:text=The%20U.S.%20Department%20of%20Health,rural%20and%20socially%20vulnerable%20communities. Accessed September 25, 2020.

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