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National Center for Primary Car
Community Voices

July 14, 2006

Hon. Donald Sundquist, Chairman
Hon. Angus S. King, Jr., Vice Chairman
Dr. Gail C. Christopher, Commissioner
Medicaid Commission
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Chairman Sundquist, Vice Chairman King and Commissioner Christopher:

Testifying at the Medicaid Commission on behalf of poor men and men of color was perhaps an exercise in futility. I cannot tell you how dismayed my colleagues and I were to see no men of color either on the Commission itself or among Commission staff. It may be that there were no men of color that were able or willing to serve. It is also possible that none were asked to serve. I fear that the message was futile as the absolute absence of that perspective on the Commission reaffirms a suspicion that African American men are invisible and of no perceived value to mainstream America, as represented on the Commission that you Chair. As reference for the concern, I cite a bit of history that this Commission can eradicate.

The Social Security Act of 1935 and later amendments created Aid to Dependent Children, Old Age Insurance, Aid to the Blind, Unemployment Compensation, and Public Assistance. In order to garner support from the Southern states to ensure passage, certain provisions limited African American participation. "For example, the Act's only exclusively federal program protected workers aged 65 and over from loss of income due to retirement, but contained strict eligibility rules which categorically denied assistance to agricultural workers and domestic servants." (Kaufman, 1997, p. 305). Most of these domestic and agricultural workers were African American men and women. This exclusion guaranteed that the Southern states maintained their underpaid labor force. (Kaufman, 1997). Even though these provisions were race-neutral on their face, their discriminatory intent was evident.

Medicaid is the health system for the poor, the de facto safety net. Poor men deserve coverage. Strangely, if poor men contract a life threatening disease or develop a debilitating chronic condition, Medicaid will cover their illness. HIV/AIDS, strokes, renal disease, amputations are all too common and are a result of largely preventable healthcare system actions. The Commission would be courageous and groundbreaking in its recommendations if it were to recommend coverage for poor men while they still have their health and fund primary care while moving coverage of the poor to Medicare, where this charge belongs. To do less reaffirms the policies that were covered in the document that we distributed titled "The Impact of Medicaid and Other Social Public Policy on the Health of African American Men, their Children and Families" that I have enclosed again with this letter and that can also be viewed on www.communityvoices.org. In addition to reading this document, the Commissioners will find that the Community Voices has models that can sustainably reach and serve the poor with limited assistance, viz. coverage for those currently without insurance. But communities need to at least cover basic costs and this can be done with public payment for the health care for poor men. Medicaid cannot care for poor women and children alone, and needs the assistance of husbands and fathers. **The best thing that Medicaid can do to improve and preserve the health of mothers and children is to preserve and protect the health of fathers and husbands.**

My years of work in community-based programs at the Kellogg Foundation and now at the Morehouse School of Medicine have taught me that communities can do a lot, but they cannot alone solve the problem of escalating health care costs and uninsurance. As a provider in Detroit said to me when I asked them to serve poor men, "Why should we?" Nobody cares, and we are already going bankrupt." And, they did not serve them. Communities are willing to tackle the problems of health care access for all. But they cannot pay for this care. At this point, even the most willing providers must deny comprehensive primary care that includes mental health, substance abuse treatment and restorative health care to men because they have no way of covering the cost.

In addition to working poor men, we also face in this nation rising numbers of individuals that are imprisoned. Forty-four percent of all those in prison are African American men. These men are returning home with conditions and diseases that are untreated and unchecked. As their spouses and children are infected, our healthcare costs rise. As they die too soon or are debilitated by chronic conditions, the burden to society is larger. Many are imprisoned simply because they lack access to mental health care. They lack mental health care because they cannot pay. This is a vicious cycle that the Medicaid Commission can break by providing insurance to treat mental illness before incarceration becomes the only option, by eliminating the practice of cessation of benefits when people are imprisoned and by guaranteeing a Medicaid card and coverage as well as care management when the individuals are released to return to their communities. The Medicaid Commission can break new ground, if it has the will to do so. It will cost our nation's taxpayers much more if the Commission fails to act affirmatively on this issue.

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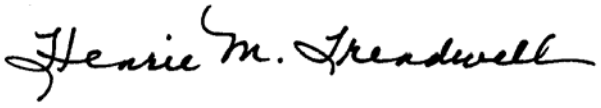
Building a sustainable health care system requires all of us. Medicaid cannot remain in splendid isolation from health departments, systems of social service, departments of corrections and juvenile justice, and other agencies. Additional groundbreaking and even visionary action would be to mandate collaboration with all agencies to pool funds, reduce health disparities, and solve the problem of poor health for communities including mothers and children. Visionary thinking requires nothing less than resourceful proactive policy development.

Specific practice recommendations would include the following. A practice that we have learned from examination of systems in other countries (referenced several times by Dr. Dan Berkowitz) is the use of community outreach workers. Simply stated, using outreach workers to find individuals disconnected from primary health care services and a medical home, or reentering the community from prison is invaluable. In addition to providing health education and guidance, these individuals strengthen the system. In addition, the Medicaid Commission should insist on the provision of culturally competent mental health and substance abuse treatment (on demand), and comprehensive restorative oral health services. Providing coverage for primary health care delivered whenever possible by mid-level practitioners will reduce costs and high costs for physician and dental services (even though far too few of these individuals, educated at public expense choose to serve all poor people, including poor men.). Care management to connect individuals to primary care is essential if we are to mend broken promises (e.g. the infamous Tuskegee Experiment that still lingers in the minds of many). The principle role of Medicaid should be to insure access to primary health care. Secondary and tertiary services should be handled through other systems of payment. Naturally, some staging must occur.

Caring for poor men is not a matter of cost; it is simply a matter of public will and wellbeing. The opportunity that you have is to break the bondage of past injustices that were based on skin color, particularly on gender AND skin color, and to do what is right for the health of **all** Americans. We at the Community Voices Initiative, at the National Center for Primary Care at the Morehouse School of Medicine, and in community service trust that you will have the courage to heal our nation and improve our world. Perhaps no such significant opportunity will be presented before total unraveling of communities of the poor and of color. With the demise of these communities we will witness even greater costs to our health care system.

Thank you.

Sincerely,



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Cc: The Honorable Michael O. Leavitt, Secretary of Health and Human Services
Dr. John Agwunobi, Assistant Secretary for Health
Dr. Mark McClellan, CMS Administrator

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Enclosure: “The Impact of Medicaid and Other Social Public Policy on the Health of African American Men, their Children and Families”

References

Kaufman, R.E. (1997). The cultural meaning of the “Welfare Queen”: Using state constitutions to challenge child exclusion provisions. *New York University Review of Law and Social Change* 23, 301-328.