HLB's Health Equity Essentials Update

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On behalf of the Hooper, Lundy & Bookman, P.C. Health Equity Task Force, here is our most recent HLB Health Equity Essentials Update.

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NUMBER OF RURAL HOSPITALS DELIVERING BABIES CONTINUES TO SHRINK DRASTICALLY

A newly issued report from the Center for Healthcare Quality & Payment Reform (CHQPR) claims that, just since 2020, over 100 rural hospitals have stopped delivering babies or will by the end of this year. Moreover, a mere 42% of all rural hospitals still offer labor and delivery services. These figures are daunting for pregnant women because the implications include longer commutes to find a hospital that provides these vital services, which can be life-threatening for medically complicated pregnancies. The CHQPR report does, however, outline possible actions that can be taken to curb this alarming trend.

HHS TERMINATING HIV-RELATED AND NUMEROUS OTHER RESEARCH GRANTS

In accordance with the Trump Administration's February 2025 memorandum – Radical Transparency About Wasteful Spending – the Department of Health and Human Services (HHS) has been terminating numerous grants. HHS maintains the Tracking Accountability in Government Grants System (TAGGS), a database of grants awarded by HHS's twelve operating divisions, including the NIH, and the running list of terminated grants can be found here.

THRESHOLDS FOR LONG-RECOGNIZED OVARIAN CANCER BIOMARKER LEADS TO TREATMENT DISPARITIES

The original study conducted on cancer antigen 125 (CA-125) in 1981 involved mostly White women as subjects, which established the thresholds applied universally to all women for early detection of ovarian cancer. A March 2025 study published in *JAMA Network Open*, however, concluded that the healthy levels of CA-125 in Black women were 10 to 37% lower, and for Native American women up to 20% lower, compared to White women. Consequently, these diverse populations have experienced delays in treatment and poorer health outcomes due to underdiagnosis based upon CA-125 test results.

CONSOLIDATION AND RESTRUCTURING OF HHS AGENCIES UNDERWAY

As part of his "Make America Healthy Again" (MAHA) platform, HHS Secretary Robert F Kennedy, Jr announced his initial plans to reduce perceived waste and inefficiencies within the Department, which includes an additional reduction in personnel by 10,000 FTEs, purportedly saving taxpayers $1.8 billion annually. In addition, the previous 28 divisions within HHS will be reduced to 15 newly restructured and repurposed divisions. The plans establish the Administration for a Healthy America (AHA), which will combine multiple agencies including the Office of the Assistant Secretary for Health (OASH), Health Resources and Services Administration (HRSA), Substance Abuse

and Mental Health Services Administration (SAMHSA), Agency for Toxic Substances and Disease Registry (ATSDR), and National Institute for Occupational Safety and Health (NIOSH) as one entity. Meanwhile, a MAHA caucus has been established in both the House and Senate to align legislative efforts with the Secretary's societal health goals, including improving access to primary care and nutritious food sources.

CMS ANNOUNCES END OF APPROVING SECTION 1115 MEDICAID DEMONSTRATION WAIVERS' INCLUSION OF NON-MEDICAL PROGRAMS

On April 10, the Centers for Medicare and Medicaid Services (CMS) sent a letter to all state Medicaid directors, informing them that CMS would no longer be approving proposed 1115 Medicaid waivers' inclusion of programs with a non-medical purpose, such as housing, nutrition, and transportation assistance. CMS's rationale is that such programs have historically not otherwise been covered under Medicaid and should not be subject to federal matching funds as part of new Section 1115 applications (nor will existing ones be allowed as part of any renewals).

INDIVIDUAL SOCIAL RISK SCREENING PROVIDES BETTER ASSESSMENT OF OUTPATIENT HEALTHCARE NEEDS

Another *JAMA Network Open* study published earlier this month determined that individual social risk screenings are more accurate in assessing and adequately determining patients' needs for outpatient services compared to the traditional local community level screenings that rely upon the federal Neighborhood Deprivation Index (NDI). Individual self-reported social risk screening requires patients to indicate their specific social needs, such as financial assistance, food, housing, or transportation. Although these individualized screenings may be more productive, they are nonetheless hampered by dependency upon a greater concentration of resources, as well as patients' reluctance to participate due to the perceived stigma, among other challenges.