

# **Racial and Ethnic Disparities in Medicare: What the Department of Health and Human Services and the Centers for Medicare and Medicaid Services Can, and Should, Do**

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Sharpening Medicare's Tools to Reduce Racial and Ethnic Disparities

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**RACIAL AND ETHNIC DISPARITIES IN MEDICARE:  
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I. INTRODUCTION

The fact of the existence of racial disparities in health and in health care in the United States is clear beyond dispute. The Institute of Medicine's (IOM) 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, is only the best known and most comprehensive description of the problem. White males live on average eight years longer than black males, while American Indians in some regions have even shorter life expectancies.<sup>1</sup> African-Americans and American-Indians experience infant mortality rates 2.5 and 1.5 times

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<sup>1</sup> Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds, *Unequal Treatment, Confronting Racial and Ethnic Disparities in Health Care*, 35 (Institute of Medicine 2003) (hereafter IOM).

higher than white Americans.<sup>2</sup> One-third of the U.S. population with end stage renal disease is African-American, even though African-Americans make up only 12% of the population.<sup>3</sup> African-Americans, Hispanics, and American Indians experience a 50% to 100% greater burden of illness and mortality from diabetes than whites.<sup>4</sup>

While the IOM report did not focus specifically on Medicare beneficiaries, there is considerable evidence that they too experience disparities in health status that correlate to race and ethnic status. Forty-six percent of Hispanic and 43% of African-American beneficiaries suffer from fair or poor health status, compared to 26% of white beneficiaries; while 18% of Hispanic and African-American beneficiaries have one or more activity of daily living limitations compared to 11% of white beneficiaries.<sup>5</sup>

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<sup>2</sup> Id.

<sup>3</sup> Id. at 58.

<sup>4</sup> Id. at 64. See also, for more recent data on racial and ethnic disparities, Agency for Healthcare Research and Quality, 2004 National Healthcare Disparities Report (2005) (“Of measures tracked in 2000 and 2001, in both years: Blacks received poorer quality of care than whites for about two-thirds of quality measures and had worse access to care than whites for about 40% of access measures. Asians received poorer quality of care than whites for about 10% of quality measures and had worse access to care than whites for a third of access measures. American Indians and Alaskan Natives (AI/ANs) received poorer quality of care than whites for about a third of quality measures and had worse access to care than whites for about half of access measures. . . . Hispanics received lower quality of care than non-Hispanic whites for half of quality measures and had worse access to care than non-Hispanic whites for about 90% of access measures.” Id. at 2-3).

<sup>5</sup> Kaiser Family Foundation (KFF), Medicare and Minority Americans, [http://www.kff.org/medicare/upload/13219\\_1.pdf](http://www.kff.org/medicare/upload/13219_1.pdf) (visited Nov. 24, 2004)

One can understand why minority Medicare beneficiaries might be in worse health than whites of the same age. An 80 year old African-American from the southern United States is likely to have spent half of her life from a segregated healthcare system, and might well have grown up in abject rural poverty. A 75 year old Laotian beneficiary is likely to have spent years in a refugee camp, and years before that receiving only the most primitive health care. The health care a Hispanic beneficiary from Central America would have received through much of his life might have been little better in quality. But the disparities that racial and ethnic minority Medicare beneficiaries experience are not just disparities in health, but also disparities in health care.

Unequal Treatment documented the fact that racial and ethnic minorities in the United States in general receive significantly less and poorer quality medical care across a wide range of therapeutic interventions than do majority whites.<sup>6</sup> More specific studies find that black Medicare beneficiaries are less likely than white beneficiaries to receive seventeen commonly performed procedures, and more likely to receive four other procedures that are commonly associated with delayed diagnosis or treatment, or with poor medical management.<sup>7</sup>

At first glance, it is not obvious why minority Medicare beneficiaries would receive less

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<sup>6</sup> IOM, *supra* note 1, at 38-74. See also, AHRQ, *supra* note 4.

<sup>7</sup> Marian E. Gornick, et al., *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 335 *New Eng.J. Med.* 791 (1996); A. Marshall McBean and Marian Gornick, *Differences by Race in the Rates of Procedures Performed in Hospitals for Medicare Beneficiaries*, *Health Care Fin. Rev.*, Summer 1994, at 77, 80-86 (1994).

care than whites. Medicare offers basically the same coverage to all beneficiaries. It offers all beneficiaries free choice of physician and provider, as well as, in many parts of the country, a choice of managed care plans. Virtually all hospitals in the country participate in Medicare, as well as the vast majority of health care professionals. Why should minority beneficiaries receive less care?

There are a number of answers to this question, which will be discussed presently. The subject of this paper, however, is not why racial and ethnic disparities exist in Medicare, but rather what those who administer the Medicare program can do to address them.

Note that this is a different question than what Congress can do about disparities in Medicare. Congress could do a great deal to address disparities in Medicare if it chose to do so. It could, for example, require all providers, suppliers and professionals who participate in Medicare to provide interpreter services for beneficiaries who are not fluent in English, or specify that any professional who participates in Medicare must also serve dual-eligible beneficiaries (who receive Medicaid as well as Medicare coverage), or provide bonuses to doctors who serve minority beneficiaries just as it provides bonuses to doctors who work in rural areas. Congress could even spend millions of dollars on increasing services to racial and ethnic minority beneficiaries (just as it has recently committed itself to spend millions of dollars to improve services for rural Medicare beneficiaries<sup>8</sup>).

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<sup>8</sup> See Summary of Rural Provider Provisions of the Medicare Prescription Drug and Modernization Act, available at <http://www.nrharural.org/medicare/SummaryAct.pdf> (visited

Although the Centers for Medicare and Medicaid Services (CMS), which administers the Medicare program, and the Department of Health and Human Services (HHS) within which it is situated, do not have the power to amend statutes or pass appropriations bills, they are far from powerless in combating racial disparities. CMS has the authority, for example, to educate beneficiaries and providers, to assure that providers and contractors comply with conditions of participation and contractual requirements, to oversee the Medicare Advantage (MA) managed care program, to fund research and development projects, to ensure that the quarter of a trillion dollars the Medicare program spends are used to in fact provide covered services, and to oversee the quality of health care received by beneficiaries.

HHS and CMS not only have the power to do far more than they are currently doing to address racial disparities, they also have the responsibility to do so. Title VI of the Civil Rights Act, 42 U.S.C. § 2000d et seq., prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance.<sup>9</sup> Medicare is such a

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Nov. 21, 2004).

<sup>9</sup>As President John F. Kennedy, who fought for this legislation, said in 1963: “Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial discrimination.” Special Message to Congress on Civil Rights and Job Opportunities, in Public Papers of John F. Kennedy, 483, 492 (June 19, 1963). Discrimination against African-Americans in health care is also arguably proscribed independently under the 13<sup>th</sup> Amendment which outlaws the “badges and incidents of slavery.” See Larry J. Pittman, A Thirteenth Amendment Challenge to Both Racial Disparities in Medical Treatments and Improper Physicians’ Informed Consent Disclosures, 48 St. Louis U. L.J. 131 (2003). Moreover, discrimination by hospitals that have received Hill-Burton financing in the past violates the non-discrimination provisions of the Hill-Burton community service obligation. 42 U.S.C. § 291c(3)(2), *Metro. Med. Ctr. v. Harris*, 93 F.2d 775,

program, and Medicare providers and contractors are bound by Title VI.<sup>10</sup> Title VI clearly forbids intentional discrimination against minorities. But HHS regulations implementing Title VI also prohibit “criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect individuals of a particular race, color, or national origin.”<sup>11</sup>

Nor is the power of HHS and CMS merely theoretical. It has been exercised quite effectively in the past. Indeed, in 1965, the former Department of Health, Education and Welfare (HEW), the predecessor of HHS, single-handedly, without specific legislative direction or even specific appropriations, accomplished one of the most remarkable achievements in the history of the American struggle for civil rights—the desegregation of the hospitals of the United States.<sup>12</sup> As of the 1960s, many of the hospitals of the southern United States, and indeed some in the

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787 (8<sup>th</sup> Cir. 1982).

<sup>10</sup> 42 C.F.R. § 80.2. See Sara Rosenbaum, *Racial and Ethnic Disparities in Healthcare: Issues in the Design, Structure, and Administration of Federal Healthcare Financing Programs Supported by Direct Public Financing*, in IOM, *supra* note 1, at 664.

<sup>11</sup> 42 C.F.R. § 80.2(b)(2). In *Alexander v. Sandoval*, 532 U.S. 275 (2001), the Supreme Court held that Title VI, 42 USC § 2000d, only authorizes private causes of action for intentional discrimination. It did not decide, however, whether or not federal regulations issued under 42 USC §2000d-1 authorizes federal regulations and administrative actions addressing actions that have a disparate-impact on racial and ethnic minorities. See Michael S. Shin, *Redressing Wounds: Finding a Legal Framework to Remedy Racial Disparities in Medical Care*, 90 Cal.L.Rev. 2047, 2077-9 (2002). These regulations, therefore, are still valid.

<sup>12</sup> David Barton Smith, *Health Care Divided: Race and Healing a Nation*, 96-142 (1999); Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 Am. J. L. & Med. 203, 210-6 (2001).

North, were segregated by race. President Johnson and HEW decided to use the new Medicare program (created the year after the adoption of Title VI) as a lever to desegregate the hospitals. HEW made it clear that no hospitals would be allowed to participate in the nascent Medicare program unless they integrated. HEW then assembled an army of volunteers from throughout the agency and cobbled together resources they needed to address the problem. HEW faced down recalcitrant hospitals, virtually all of which in the end desegregated rather than forego Medicare funding. A similarly courageous and aggressive program today could undoubtedly do much to address the problem of disparities.

This paper discusses concrete steps that HHS and CMS could take today within the scope of their current legislative authority to address racial and ethnic disparities in Medicare. The first and most important of these steps is for HHS and CMS to make the elimination of racial and ethnic disparities from the Medicare program a top priority. If the disparity problem were to become a priority for Medicare—as important, for example, as the promotion of the Medicare Advantage or the new prescription drug program is currently to CMS—much could be accomplished. Section II of this paper addresses this issue. Once CMS and HHS decide that addressing racial and ethnic disparities is an issue worthy of greater attention, there are many steps that they can potentially take to deal with disparities. One useful way of identifying potential actions is to begin by identifying the causes of racial and ethnic disparities to which these actions would respond. Section III of the paper describes four such causes. The following sections, IV through VII, then discuss what can be done to address each cause. Section VIII concludes. Of necessity, the paper will describe what CMS and HHS are already doing to deal

with disparities. The main focus, however, of this paper is not on what CMS and HHS are doing, but rather on what they can do to reduce, perhaps even some day eliminate, racial and ethnic disparities in the Medicare program.

## II RACIAL AND ETHNIC DISPARITIES MUST BECOME A PRIORITY

As I interviewed people currently or formerly working at CMS while researching this paper, it became clear that the issue of racial and ethnic disparities in Medicare is not currently a high priority at CMS, or, indeed, within HHS.<sup>13</sup> There is considerable evidence of this fact. First, there is no single place within CMS where responsibility is lodged for addressing the problem of racial and ethnic disparities. CMS does have an Office of Equal Opportunity and Civil Rights, which reports to the Administrator's office and has a staff of about twenty. The primary task of this Office, however, is to address equal employment opportunity discrimination complaints within CMS, handle EEO training within CMS, and oversee CMS's affirmative employment programs.<sup>14</sup> Although the staff of OEOCR is conscientious, committed, and knowledgeable regarding racial and ethnic disparity issues, disparities are not its focus. Indeed, civil rights complaints from Medicare beneficiaries are not handled by OEOCR, but are rather referred, under

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<sup>13</sup> This is not to say that HHS does not take seriously the problem of racial and ethnic disparities in health or healthcare in general. A number of divisions within HHS, including perhaps most importantly the Office of Minority Health, are addressing this problem, though much more could be done. Rather, we here address the specific problem of racial and ethnic disparities within Medicare.

<sup>14</sup> See About Office of Equal Opportunity and Civil Rights, at <http://www.cms.hhs.gov/about/oeocr/default.asp> (visited March 2, 2005).

a memorandum of understanding to the Office of Civil Rights of HHS.<sup>15</sup> CMS also does not have its own Office of Minority Health, unlike other major units of HHS, including the Centers for Disease Control or Health Resources and Services Administration.<sup>16</sup>

In the absence of any designated office responsible for disparity issues, everyone, and thus no one, at CMS is responsible. I spoke to a number of people, in the Center for Beneficiary Choices, in the Office of Clinical Standards and Quality, in the Office of Research, Development and Information, and in the Regional Offices, each of which had some responsibility for racial and ethnic disparities issues. But no one person could be identified who was responsible exclusively for minority health issues, and each of these persons with some responsibility for these issues also has other responsibilities. Most of those to whom I spoke also gave the impression that racial and ethnic disparity issues were not the most pressing issue among the many that they were tasked to address, though all were committed—some deeply committed—to addressing these issues.

Second, because there is no office within CMS that explicitly and exclusively addresses racial and ethnic disparities, there is also no dedicated budget for funding initiatives to deal with these issues. A modest amount of research funding is spent on disparity issues, while other activities that address disparities, such as regional office outreach or QIO program initiatives are

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<sup>15</sup> See Office of Equal Opportunity & Civil Rights, FY 2002 Accomplishments, at <http://www.cms.hhs.gov/about/oeocr/Accomplishments2002.asp> (visited Nov. 21, 2004).

<sup>16</sup> See Federal Minority Offices list, available at

funded through the units that carry on those activities, but no single source of money is available to assure that these issues are addressed. One ramification of this is that there is in particular no dedicated source of funding to encourage the involvement of external organizations representing racial and ethnic groups in addressing these issues.<sup>17</sup>

Third, CMS's own statements of its goals suggest that addressing racial and ethnic disparities is not a priority. CMS's FY 2005 GPRA Performance Plan lists 32 goals that CMS currently ranks as its top priorities. Though a number of these goals are directed at other specific populations, such as diabetic beneficiaries or those who reside in nursing homes, none address the specific issue of racial and ethnic disparities.<sup>18</sup> Indeed, none of CMS's GPRA Annual Performance Plan goals have addressed racial and ethnic disparities for the past half decade.<sup>19</sup>

Addressing Racial and Ethnic Disparities is listed as a priority in the HHS FY 2004-2009 Strategic Plan.<sup>20</sup> Objective 3.4 of the HHS Strategic Plan is "Eliminate racial and ethnic health

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<http://www.4woman.gov/minority/offices.htm> (visited March 2, 2005).

<sup>17</sup> See Summit Health Institute for Research and Education, Inc., Final Report, CMS Multicultural Workshop (2002).

<sup>18</sup> Centers for Medicare and Medicaid Services, FY 2005 GPRA Annual Performance Plan, <http://www.cms.hhs.gov/about/performanceplan/APP2005.pdf> (visited March 2, 2005).

<sup>19</sup> Id. at V-198 - V-200

<sup>20</sup> HHS, HHS Strategic Plan, FY 2004-2009, <http://aspe.hhs.gov/hhsplan/2004/goals.shtml#goals> (visited March 2, 2005).

disparities.’<sup>21</sup> There is no information, however, as to how this objective will be achieved with respect to Medicare in the Medicare section of the more programmatic FY 2005 HHS Annual Performance Plan.<sup>22</sup> Neither is the goal reflected in CMS’s own Performance Plan.

CMS should also establish an Office of Minority Health directly under the Administrator, as have other divisions of HHS. This office would take responsibility for the educational, outreach, and research issues raised by racial and ethnic disparities. This Office needs to have a budget commensurate to its responsibilities, and be given responsibility—and authority—to oversee all of the other educational, outreach, and research efforts within CMS dealing with racial and ethnic disparities. In particular, this Office should also be charged with developing close relationships with leaders and leadership organizations within minority communities, to assure close communication and partnering with these communities. To this end, the Office should have an advisory group composed of both people within CMS and external to CMS who are experts in disparities issues. CMS should further establish as a key goal of its GPRA Performance Plan the diminution or elimination of racial and ethnic disparities in its health care programs.

HHS should also consider whether it should create a new Office of Civil Rights within CMS or expand the current CMS OEOCR dramatically to take over the civil rights enforcement responsibilities of the HHS OCR. As will be discussed later in this paper, OCR has neither been

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<sup>21</sup> Id., at 12.

<sup>22</sup>HHS, HHS Annual Performance Plan, Fiscal Year 2005, <http://www.hhs.gov/budget/05budget/FY05AnnualPerformancePlan.pdf>, at pp. 52-56 (visited

very aggressive nor successful in addressing racial disparities in Medicare, and it might be necessary to locate authority elsewhere to secure enforcement of the civil rights laws.

While it is important that CMS create an Office of Minority Health specifically tasked to address racial and ethnic disparities, it is also essential that this Office not become the sole locus of responsibility within CMS for dealing with disparities. All senior executive service (SES) staff within CMS, and in particular the directors of the Center for Beneficiary Choices, the Center for Medicare Management, the Office of Clinical Standards and Quality, and the Office of Research Development and Administration and the Regional Administrators should be directed to address racial and ethnic disparity issues relevant to their areas of authority. Their merit increases in compensation from year to year should be determined in part based on how well they address these issues. Development of budgets within centers, offices, and regional offices, should also take into account elimination of racial and ethnic disparities as a top priority.

Finally, CMS should include a Racial and Ethnic Disparities Impact Statement with each of the regulations it publishes for the Medicare program to assure that it considers how its regulatory actions might affect (and might be used to meliorate) racial and ethnic disparities. Once CMS and HHS has made elimination of racial and ethnic disparities a priority, they can proceed to take more specific actions. Until they do so, however, it is unlikely that they will take adequate or sufficient steps to address the disparities problem.

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March 2, 2005).

The remainder of this paper explores the specific actions CMS and HHS could take. It begins, however, by considering the causes of racial and ethnic disparities, as only once we understand these causes can we decide how to address them.

### III. THE CAUSES OF RACIAL AND ETHNIC DISPARITIES IN MEDICARE

Commentators commonly identify four primary categories of causal factors that contribute to racial and ethnic disparities in the use of health care services: financial barriers; other logistical, organizational, or systemic barriers; provider attitudes and behavior; and patient attitudes and behavior.<sup>23</sup>

Financial barriers are an important factor for explaining racial and ethnic disparities in the United States health care system generally. Racial and ethnic minorities in the United States are disproportionately poor and uninsured. African-Americans are almost twice as likely to be uninsured as white Americans, while Hispanics are almost three times as likely.<sup>24</sup> Minorities covered by Medicare, of course, nominally receive the same benefits received by majority non-Hispanic whites. Medicare coverage, however, leaves significant gaps, however, for all beneficiaries. During 2005, for example, a Medicare beneficiary must pay a \$912 deductible before Medicare begins to cover hospital care, and after 60 days of hospitalization must pay a \$228 per day copayment.<sup>25</sup> Part B recipients have to meet a \$110 deductible before coverage accrues, and thereafter must pay a 20% copayment for most services. Most Medicare recipients have private supplemental insurance to fill these gaps, which they either purchase individually or receive as a retirement benefit. Racial and ethnic minorities, however, tend disproportionately to

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<sup>23</sup> See, e.g., IOM, *supra* note 1, at 126-154; American College of Physicians, Racial and Ethnic Disparities in Health Care Position Paper (2003), available at [http://www.acponline.org/hpp/healthcare\\_disp.pdf](http://www.acponline.org/hpp/healthcare_disp.pdf) (visited Nov. 21, 2004).

<sup>24</sup> IOM, *supra* note 1, at 83-85.

<sup>25</sup> [http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std\\_adp.php?p\\_faqid=1560&p\\_created=1095443945](http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_adp.php?p_faqid=1560&p_created=1095443945) (visited March 2, 2005)

lack supplemental coverage. Approximately 45% of African-American and Hispanic beneficiaries have no form of insurance supplemental to Medicare, while only 27% of white beneficiaries lack supplemental coverage.<sup>26</sup> Many minority beneficiaries worked at low-paying jobs that did not offer retirement benefits, and cannot now afford the high cost of individual supplement policies.

Minority Medicare beneficiaries are disproportionately (compared to majority beneficiaries) covered by Medicaid, which does fill the gaps in Medicare coverage. Over one third of African-American and one quarter of Hispanic beneficiaries receive Medicaid, compared to only a little over 10% of white beneficiaries.<sup>27</sup> Only the poorest Medicare beneficiaries, however, are eligible for full Medicaid coverage.<sup>28</sup> Other beneficiaries with incomes up to 100% of the federal poverty level receive mandatory assistance from Medicaid under the Medicare Savings Programs with Medicare premiums, coinsurance, or deductibles; while those who have incomes up to 120% of the poverty level have their Part B premiums covered. Some beneficiaries also receive extended Medicaid coverage under state medically needy programs or other optional state Medicaid programs. Many minority beneficiaries, however, are not quite poor enough to be covered by Medicaid, and thus must spend their meager income on deductibles and coinsurance payments or do without health care.

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<sup>26</sup>EBRI News Release, Fewer Medicare Beneficiaries Covered by Supplemental Insurance, 2000, <http://www.ebri.org/prrel/pr515.htm> (visited Nov. 22, 2004)

<sup>27</sup> KFF, *supra* note 5.

<sup>28</sup> In most states their income must meet Supplemental Security Income levels of \$579 for an individual and \$869 for a couple in 2005.

Institutional barriers to minority access to health care are the second major cause of racial and ethnic disparities. Even when minority beneficiaries have the financial resources to obtain Medicare covered services (or when financial barriers are not a serious problem, as with home health or other services that require no coinsurance payments, or hospital care once the deductible is met and before covered days expire), they still often face other logistical, organizational, or systemic barriers. Providers may simply not be available in the parts of cities or towns where minorities disproportionately live. Minorities may also lack transportation to get to providers. Medicare Advantage (MA) plans, which are heavily subsidized by Medicare, and thus are often able to offer benefits not available to traditional Medicare beneficiaries or lower cost-sharing rates, may not have adequate provider coverage in areas where minorities disproportionately live.

Minorities who are Medicaid recipients may also have a difficult time finding providers who accept Medicaid. Many physicians set quotas as to the number of Medicaid patients they will treat, or refuse to treat Medicaid patients altogether.<sup>29</sup> Medicaid status in many parts of the country correlates highly with minority status, thus these physicians are in effect, if not in intent, discriminating against racial minorities. Medicaid programs that offer very low physician payment rates or that refuse to cover Part B coinsurance amounts when Medicare payments exceed Medicaid rates, moreover, encourage this discrimination by discouraging physicians from accepting Medicaid recipients.

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<sup>29</sup> Sidney D. Watson, *Medicaid Patient Participation: Patients, Poverty and Physician*  
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Research shows that minorities rely disproportionately on practitioners of the same racial or ethnic group.<sup>30</sup> But these practitioners may not have as good access to specialist referral networks as white practitioners, thus minority beneficiaries may not be able to get access to specialists as readily as majority white beneficiaries.<sup>31</sup> Minorities are also disproportionately dependent on hospital outpatient departments and emergency rooms (in particular those of large urban hospitals) for receiving care, and often face difficulties in negotiating these clinical bureaucracies.<sup>32</sup>

Finally, limited English proficiency (LEP) poses a major access barrier for many minority beneficiaries.<sup>33</sup> Providers often lack adequate translation services, and beneficiaries who lack English proficiency may have to depend on provider employees with no training in interpretation, family members, or even other patients for interpretation. Basic forms and explanatory materials, moreover, may not be available in any language other than English, imposing a further barrier to access. In particular, LEP beneficiaries may experience greater deficits in knowledge about Medicare, and have a harder time using the Medicare program.

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Self-Interest, 21 *Am.J.L.& Med.* 191, 193 (1995).

<sup>30</sup> See, e.g., Peter B. Bach, et al., *Primary Care Physicians Who Treat Blacks and Whites*, 351 *N.Eng.J.Med.* 575, 578-9 (2004).

<sup>31</sup> IOM, *supra* note 1, at 145-7.

<sup>32</sup> *Id.* at 108-112, 144-5.

<sup>33</sup> See, e.g., Lieghton Ku and Glenn Flores, *Loss in Translation: Paying for Interpreter Services in Healthcare for the Millions of Americans with Limited English Proficiency*, 3-6 (forthcoming); Mara Youdelman and Jane Perkins, *Providing Language Interpretation Services*

A third cause of racial disparities in the receipt of Medicare services is professional attitudes and behavior. There is ample, though not always uncontroverted, evidence that many health care professionals treat members of racial and ethnic minority groups differently than they do white majority patients. For some professionals, this may be the result of conscious discrimination. For more it is probably the result of unarticulated beliefs or stereotypical thinking about the likelihood that minorities will benefit from certain procedures, be able to understand or comply with certain treatment regimens, or, perhaps, be able to afford certain forms of treatment.<sup>34</sup> The fact that patient race is one of the key descriptors used in clinical rounds and medical presentations, despite the fact that race is largely a social construct with limited genetic basis,<sup>35</sup> suggests that it is largely used as a decision-making heuristic based on stereotypical thinking.<sup>36</sup> Physicians' expectations or suspicions concerning the ability of minority patients to comply with treatment and about complicating factors such as substance abuse, poor living conditions, or family support, may shape clinical judgments regarding diagnosis and treatment, as may unarticulated assumptions about a minority patient's lack of truthfulness, self-discipline, initiative or intelligence or assumptions about the patient's tolerance

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in Health Care Settings: Examples from the Field, 1-2 (Commonwealth Fund, 2002).

<sup>34</sup> See Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 *Vill. L. Rev.* 195, 205-23 (2003).

<sup>35</sup> See Erik Lillquist & Charles A. Sullivan, *The Law and Genetics of Racial Profiling in Medicine*, 39 *Harvard Civ. Rts., Civ. Lib. L. Rev.* 391, 402-26 (2004).

<sup>36</sup> See Rene Bowser, *Racial Bias in Medical Treatment*, 105 *Dick.L.Rev.* 365, 375-81 (2001); Rene Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 *Mich. J. Race & L.* 79, 119-20 (2001).

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for pain.<sup>37</sup>

To the extent such beliefs exist, they simply reflect beliefs generally held in the majority American culture. Studies find, for example that 44% of American whites believe that blacks are lazy and 51% believe that they are prone to violence, while only 5% of whites view whites as lazy and 15% as prone to violence,<sup>38</sup> and similar attitudes have been identified in doctors.<sup>39</sup> The conditions under which clinical encounters commonly take place—brief encounters under time pressure where complex decisions must be made in the presence of cognitive overload—encourage the use of stereotypes as heuristics for decision-making.<sup>40</sup> Cultural and language barriers may impede the physician’s ability to learn of and understand the patient’s symptoms and treatment preferences, while the difficulty of empathy across race, and often class, boundaries, may make it more difficult for the physician to understand the patient’s hopes and fears.<sup>41</sup> The result of all of these factors is that racial and ethnic minorities tend to receive less, and less aggressive, treatment than majority whites.

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<sup>37</sup> M. Gregg Bloche, *Race and Discretion in American Medicine*, *Yale J. of Health Pol’y, L. & Ethics* 95, 104 (2001). See also Shin, *supra* note 11, at 2060-76 (exploring the psychological bases of professional bias).

<sup>38</sup> David R. Williams, *Race, Health, and Health Care*, 48 *St. Louis U. L. J.* 13, 32 (2003).

<sup>39</sup> Michelle van Ryn & Jane Burke, *The Effect of Patient Race and Socio-Economic Status on Physicians’ Perceptions of Patients*, 50 *Soc.Sci. Med.* 813 (2000).

<sup>40</sup> Williams, *supra* note 38, at 33. See, describing in detail the problems that attend a clinical encounter in the context of racial stereotyping, Lu-in Wang, *Race as Proxy: Situational Racism and Self-Fulfilling Stereotypes*, 53 *DePaul L. Rev.* 1013, 1091-1101 (2004).

A fourth and final set of factors that contribute to racial and ethnic disparities are the attitudes, knowledge, and behavior of beneficiaries. In general, Medicare beneficiaries vary widely in their trust in scientific medicine, their confidence in medical professionals and institutions and in their advice, their tolerance for pain and discomfort, and their attitudes towards the short and long-term trade-offs presented by treatment decisions. To some extent these differences may be linked to racial and ethnic minority status.<sup>42</sup> More specifically, the experience of a half a life-time of segregated medical care, compounded by the collective memory of the Tuskegee experiments, undoubtedly contributes to the lack of trust that African-American beneficiaries may feel toward health care providers.<sup>43</sup> Distrust for a system that is perceived as biased may lead to a disinclination to accept aggressive treatment or treatment that has not been adequately explained.<sup>44</sup> At least as important, however, may be lack of knowledge and understanding of the health care system and of Medicare benefits. Disproportionately, minority beneficiaries were uninsured before securing Medicare coverage, and therefore lack established connections with providers and experience as to how to find and use health care services.<sup>45</sup> Particularly important may be lack of knowledge about the preventive benefits available from Medicare, and of how to gain access to them. Patients may also simply not

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<sup>41</sup> Bloche, *supra* note 37, at 104-5.

<sup>42</sup> *Id.* at 105.

<sup>43</sup> *Id.* at 105; See also, Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 *St. Louis U Pub. L. Rev.* 191 (1996).

<sup>44</sup> Wang, *supra* note 40, at 1083-5.

<sup>45</sup> Kathryn M. Langwell & James W. Moser, *Strategies for Medicare Health Plans*

understand the professionals who are treating them because of their limited English proficiency or because of cultural differences that cause them to hear something other than what the professional intended to communicate.

Because there are multiple causes of racial and ethnic disparities in Medicare, no single approach to solving the problem of disparities will be effective. Rather multiple approaches, addressing each of the varied problems, will be necessary. The discussion that follows identifies potential solutions for addressing each of the identified problems.

#### IV. FINANCIAL BARRIERS TO ACCESS

Four primary opportunities exist to remove financial barriers that minorities face in gaining access to Medicare services. First, every effort needs to be made to assure that minority Medicare beneficiaries receive all Medicaid benefits to which they are entitled. Second, CMS must do what it can to assure that state Medicaid programs have adequate providers available to meet the needs of Medicaid-dependent minorities. Third, CMS needs to make sure that racial and ethnic minorities have access to MA plans. Finally, CMS should make sure that racial and ethnic minority beneficiaries, and in particular poor minority beneficiaries, have access to Medicare Part D prescription drug plans. These will be discussed in turn.

##### A. Maximize Medicaid Coverage for Dual Eligibles

States must offer all Medicaid benefits to elderly and disabled people who qualify for the federal Supplemental Security Income program (unless the state instead applies more restrictive standards that are at least as generous as those applied by the state in 1972 when the SSI program began).<sup>46</sup> States must also offer “Medicare Savings Programs” to assist Medicare beneficiaries with premiums and cost-sharing obligations. States must, for example, cover all Medicare premiums and cost-sharing obligations for “qualified Medicare beneficiaries” (QMBs), Medicare-eligible persons whose family income does not exceed 100% of the federal poverty limit and whose resources do not exceed twice the Supplemental Security Income eligibility limit.<sup>47</sup> States must also pay Part A premiums for “qualified disabled and working individuals,” (who are eligible for Medicare and whose income does not exceed 200% of poverty),<sup>48</sup> and Part B premiums for persons who would be QMBs, except that their income exceeds 100% of the poverty level, but whose income is less than 120% of the poverty level (Specified Low-Income Medicare Beneficiaries, or SLMBs).<sup>49</sup>

While states must extend Medicaid coverage to Medicare beneficiaries who fall into these categories, states have the option of covering many other Medicare beneficiaries, and often do. States may, for example, cover aged and disabled persons who receive state supplemental public

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<sup>46</sup> 42 U.S.C. § 1396a(a)(10)(A)(i)(II), (f).

<sup>47</sup> 42 U.S.C. §§ 1396a(a)(10)(E), 1396d(p).

<sup>48</sup> 42 U.S.C. §§ 1396a(a)(10)(E)(ii); 1396d(s).

<sup>49</sup> 42 U.S.C. § 1396a(a)(10)(E)(iii).

assistance payments,<sup>50</sup> persons in medical institutions whose income does not exceed 300% of SSI levels,<sup>51</sup> and persons receiving home and community-based care and hospice care who would be eligible for Medicaid if they were institutionalized.<sup>52</sup> Most importantly, states may cover aged and blind “medically needy” persons whose nominal incomes exceed eligibility levels for cash assistance but whose medical expenses are so large that by covering these expenses these persons can “spend down” to cash assistance eligibility levels. For example, a person with who receives \$1200 a month in Social Security, but who incurs \$500 a month in medical expenses, would become eligible for a state medically needy program because her remaining income available to cover her living expenses would be less than the SSI eligibility level.

While many Medicare beneficiaries receive Medicaid coverage, many others are eligible but not covered. It is estimated that 40% to 50% of beneficiaries eligible for the Medicare savings programs are not enrolled.<sup>53</sup> As minority beneficiaries tend disproportionately to be poor, they are in all likelihood disproportionately represented among Medicare beneficiaries who are eligible for Medicaid but not covered.

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<sup>50</sup> 42 U.S.C. § 1396a(a)(10)(A)(ii)(XI).

<sup>51</sup> 42 U.S.C. §§1396a(a)(10)(A)(ii)(V)., 1396b(f)(4)(c).

<sup>52</sup> 42 U.S.C. §1396a(a)(10)(A)(ii)(VI) & (VII).

<sup>53</sup> See Kim Gaun, Medicaid Programs to Assist Low-Income Medicare Beneficiaries: Medicare Savings Programs Case Study Findings. 11 (Kaiser Family Foundation, 2002), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14334> (visited Nov. 21, 2004).

Ideally, every Medicare beneficiary also eligible for Medicaid or for a Medicare Savings program would be automatically enrolled in it, just as Medicare Part B beneficiaries are automatically enrolled in Part B. A beneficiary should have to opt out if he or she chooses not to participate, as is the case with Part B enrollment. Given the difficulty of establishing the eligibility requirements for Medicaid, it is probably not possible to arrange this. CMS (and, more specifically, its Center for Beneficiary Choices and regional offices) should, however, make increasing Medicaid coverage of Medicare dual-eligibles, including minorities, a major focus of its educational efforts. This was a goal of CMS's Performance Plan from FY 2002 to FY 2004, but has been discontinued as of FY 2005.<sup>54</sup> CMS undertook a number of initiatives in the late 1990s and early 2000s towards increasing outreach, but most of these seem to have ended. This is unfortunate, as much remains to be done.

Although the Medicare.gov website includes a link to "Medicaid Enrollment", it does not specifically mention either the possibility of Medicaid eligibility or the existence of Medicare Savings Programs. The "Medicare and You, 2005" publication does cover both topics, and does introduce the topic on the inside of its front cover, but coverage of Medicaid eligibility is buried deep inside the book and is quite cursory. These resources should be reformatted to make reference to the Medicaid program more prominent. CMS should also assure that those who staff its direct contact informational programs, such as 1-800-MEDICARE, the State Health Insurance Programs (SHIPs) are well informed about Medicaid issues and proactive in informing

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<sup>54</sup> CMS, Annual Performance Plan, *supra* note 18, at V-179 - V-181.  
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those who seek assistance about Medicaid possibilities.<sup>55</sup> The SHIPs, indeed, have a statutory obligation to educate beneficiaries with respect to Medicare and the linkages between Medicare and Medicaid.<sup>56</sup> Medicare outreach efforts to minority communities, such as those initiated by or coordinated through the regional offices, should make getting information out about Medicaid and Medicare Savings Program a priority. CMS should also coordinate with the Social Security Administration, which has a statutory obligation to identify and enroll beneficiaries in the Medicare savings programs.<sup>57</sup>

The primary responsibility for educational outreach with respect to Medicaid eligibility, however, lies with the states, which are primarily responsible for administering the Medicaid program. A number of strategies have been identified that states can pursue to increase dual eligible participation, including liberalizing asset test requirements, eliminating the threat of estate recoveries, enhancing Medicare savings benefits, streamlining enrollment and redetermination processes, and engaging in outreach activities and partnerships.<sup>58</sup> CMS has been actively engaged in supporting the states in their outreach efforts in the past, including a grant to six states of \$950,000 in 2000 to fund outreach projects, four of which focused on racial

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<sup>55</sup> See CMS, Building Partnerships for Innovative Outreach and Enrollment of Dual Eligibles (2000), <http://www.cms.hhs.gov/researchers/projects/consumers/2nmepfullrpt.pdf>, (visited Nov. 21, 2004).

<sup>56</sup> 42 U.S.C. § 1395b-3(c)(2).

<sup>57</sup> 42 U.S.C. § 1320b-14.

<sup>58</sup> Gaun, *supra* note 53. See also, Heidi Shaner, Dual Eligible Outreach and Enrollment: A View from the States (1999), <http://www.cms.hhs.gov/dualeligibles/oereport.pdf> (visited Nov. 21, 2004).

and ethnic minorities.<sup>59</sup> CMS needs to continue and expand its encouragement of the states in this area, and should restore extending Medicare Savings program enrollment as a performance goal.

## B. Maximize Medicaid Provider Participation

Even when Medicare beneficiaries receive Medicaid benefits, they may face barriers to care if professionals and providers do not participate in the Medicaid program. This presents a second financial access issue that CMS and HHS must address—adequate access to providers who accept Medicaid. Many physicians do not serve (or do not accept new) Medicaid beneficiaries.<sup>60</sup> Though there are many reasons for this, one factor seems to be that many state Medicaid programs pay very little for services, particularly physician services. One major problem is that many states do not fully cover Medicare Part B coinsurance obligations because their Medicaid payment rates are less than Medicare payment rates.<sup>61</sup> The federal Medicaid statute requires that Medicaid payment rates be “consistent with efficiency, economy, and quality of care and . . . sufficient to enlist enough providers so that care and services are available under the [state Medicaid] plan at least to the extent that such care and services are available to the general

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<sup>59</sup> CMS, Building Partnerships, *supra* note 55.

<sup>60</sup> Stephen Zuckerman, Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation, Health Affairs web exclusive, available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.374v1> (visited Nov. 21, 2004).

<sup>61</sup> See Rosenbaum, *supra* note 10, at 664, 683-4.  
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population in the geographic area.”<sup>62</sup> CMS is responsible for assuring that state Medicaid plans comply with federal requirements, including this one. If state Medicaid physician payment rates are not sufficient to enlist enough providers to care for minority dual-eligibles, therefore, CMS has an obligation to disapprove state payment rates. Moreover, if the failure of state Medicaid programs to recruit a sufficient number of physicians and providers in all geographic areas disproportionately affects minorities, a serious question arises as to whether the state is compliance with Title VI, and HHS may need to take action to secure compliance. Finally, as the Medicaid program is increasingly operated through waivers granted to the states under 42 U.S.C. § 1315 (“§ 1115 waivers”), CMS must evaluate all waiver requests carefully to make sure that they do not increase racial and ethnic disparities in general, and disparities affecting Medicare beneficiaries in particular.

### C. Assure Access to Medicare Advantage Plans

A third strategy that CMS should pursue to remove financial barriers is to make sure that racial and ethnic minorities have access to a range of MA plans. A primary focus of the Medicare Modernization Act, and indeed one of the primary policy emphases of CMS at this moment, is strengthening the MA managed care program. The MMA provides for lavish Medicare spending on MA plans, indeed it is estimated that CMS spends 8.4% more per beneficiary on MA plans as it spends per beneficiary on traditional Medicare.<sup>63</sup> Under 42 U.S.C.

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<sup>62</sup> See 42 U.S.C. § 1396a(a)(30), 42 C.F.R. § 447.200, 447.201, 447.204

<sup>63</sup> Brian Biles, Lauren Hirsch Nicholas, and Barbara S. Cooper, *The Costs of*

§ 1395w-24(f), payments that an MA plan receives above the actuarial value of its benefits must be passed on to beneficiaries in additional benefits or lowered premiums (or be paid into a stabilization fund). MA plans may even charge their members lower premiums than the general Medicare Part B premium paid by beneficiaries in traditional Medicare. In fact, most plans are passing on excess funds to beneficiaries, since this helps them attract members.<sup>64</sup>

Managed care membership rates for blacks (the only minority group for which statistics are available) are lower than white membership rates (16% versus 17.4% in 2000).<sup>65</sup> Access by racial and ethnic minorities to an MA plan, or, even better to several MA plans competing with each other to offer better benefits or lower premiums, can, however, play a very important role in assuring poor Medicare beneficiaries access to care. Though access to MA plans can help alleviate financial barriers to care, the manner in which MA plans are operated can in turn aggravate disparities. CMS strategies to improve minority access to MA plans will be discussed, therefore, in the next section addressing institutional barriers to access.

#### D. Assure Access to Part D Prescription Drug Plans

A final action that CMS can take to lower financial barriers facing minorities is to

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Privatization: Extra Payments to Medicare Advantage Plans (Commonwealth Fund, 2004), available at [http://www.cmwf.org/usr\\_doc/biles\\_extrapayments\\_ib\\_750.pdf](http://www.cmwf.org/usr_doc/biles_extrapayments_ib_750.pdf) (visited Nov. 21, 2004).

<sup>64</sup> Biles, supra note 63, at 47.

<sup>65</sup> Centers for Medicare and Medicaid Services, Health Care Financing Review, 2002 Statistical Supplement, Table 6, available at <http://www.cms.hhs.gov/review/supp/2002> (visited March 3, 2005).

maximize opportunities for minorities to gain access to pharmaceutical benefits that will be afforded by the Medicare Part D program established by the Medicare Modernization Act (MMA). A great deal of evidence has accumulated in recent years documenting the difficulties that poor Medicare recipients have experienced in gaining access to pharmaceuticals.<sup>66</sup> There is also evidence that racial and ethnic minorities in general have also had difficulty gaining access to drugs.<sup>67</sup>

The MMA offers four different routes through which low income Medicare beneficiaries can be assisted in accessing drugs. First, for the interim period between the effective date of the MMA and the implementation of the Part D benefit (January 1, 2006), the MMA offers a Transitional Assistance cash benefit of up to \$600 per year for Medicare recipients with incomes up to 135% of the poverty level who obtain discount cards.<sup>68</sup> About 12 million Medicare beneficiaries, many of them minorities, have incomes below this level, though many of these are already covered by Medicaid. CMS estimated initially that about 4.7 million low-income beneficiaries would participate in the program.<sup>69</sup> As of December of 2004, only 1.5 million

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<sup>66</sup> See Dana Safran, et al., Prescription Drugs and Seniors, How Well are the States Closing the Gaps, Health Affairs Web Exclusive, July 31, 2002.

<sup>67</sup> Jennifer Schorer, Randall Brown, and Bridget Lavin, Racial Disparities in Prescription Drug Use Among Dually Eligible Beneficiaries, 25 Health Care Fin. Rev., Winter 2003-2004, at 77.

<sup>68</sup> 42 U.S.C. § 1395w-141(g).

<sup>69</sup> See Kaiser Family Foundation, The Medicare Prescription Drug Discount Card Program: Implications for Low-Income Beneficiaries (April 2004), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=34808> (visited Nov. 21, 2004).

beneficiaries had signed up for the benefit, even though CMS had mailed 2 million cards to low-income beneficiaries in October and required only a phone call to activate the card.<sup>70</sup>

Second, under the MMA, Medicare beneficiaries covered by Medicaid will receive drug benefits through Medicare Part D instead of through Medicaid. This transfer will benefit some beneficiaries who live in states with particularly parsimonious Medicaid program, but may be less beneficial to those who live in states with generous formularies or minimal cost-sharing.<sup>71</sup>

Third, the MMA extends Part D benefit assistance to some beneficiaries currently not covered by Medicaid. Prescription drug plans will be available with reduced cost-sharing and premiums for beneficiaries with incomes as high as 150% of the poverty level.<sup>72</sup> Applications for this program will be processed by Social Security as well as state Medicaid offices,<sup>73</sup> and there is the possibility that many beneficiaries who are not currently receiving Medicaid, including minority beneficiaries, will receive significant assistance with their pharmaceutical cost. A recent study estimates that these people will spend 83% less on pharmaceuticals than

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<sup>70</sup> See Kaiser Daily Health Policy Report, One Year after Creation, Medicare Drug Discount Card Program Falls Short of Expected Enrollment (Dec. 8, 2004), available at [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?hint=3&DR\\_ID=27131](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=27131) (visited March 1, 2005) (only 100,000 beneficiaries called in to activate their cards).

<sup>71</sup> Kaiser Commission on Medicaid and the Uninsured, Implications of the New Medicare Law for Dual Eligibles: 10 Key Questions and Answers, Jan. 9, 2004, <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=28805> (last visited Nov. 21, 2004).

<sup>72</sup> 42 U.S.C. § 1395w-114.

<sup>73</sup> 42 U.S.C. § 1395w-114(a)(3)(B)(I).

they would have spent without the new program.<sup>74</sup> Much will depend, however, on how well the availability of this assistance is publicized and on how great an effort is made to enroll eligible beneficiaries in the assistance program. The same study estimates that 5.7 million beneficiaries with incomes below 150% of the poverty level will not receive subsidies, many because they will not sign up for the program, and that these persons will spend as much as 10 times more than those who do receive the subsidy.<sup>75</sup>

Finally, the MMA leaves the door open to supplemental state pharmacy assistance programs. Currently about three dozen states operate pharmacy assistance programs, most of them aimed at low income elderly and disabled persons.<sup>76</sup> Some of these programs only offer discounts and are likely to be largely superseded by the Part D benefit for Medicare beneficiaries. Others, however, offer subsidies, and could supplement Part D benefits. Part D, for example, allows beneficiaries whose income is too high to qualify for Part D assistance, but low enough to participate in state pharmaceutical benefits, to use those benefits to fill the “doughnut hole” which otherwise requires Part D beneficiaries to spend out of pocket \$3600 (during 2006) before they become eligible for catastrophic assistance under the program.<sup>77</sup> The

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<sup>74</sup> Jim Mays, et al., *Estimates of Medicare Beneficiaries’ Out-of-Pocket Drug Spending in 2006*, iii (Kaiser Family Foundation 2004), available at <http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=48947> (last visited Nov. 21, 2004).

<sup>75</sup> *Id.* at iv.

<sup>76</sup> National Conference of State Legislatures, *State Pharmaceutical Assistance Programs*, <http://www.ncsl.org/programs/health/drugaid.htm>.

<sup>77</sup> 42 U.S.C. §§ 1395w-102(b)(4)(B), 1395w-133(c)(4).

MMA requires HHS to coordinate the implementation of the Part D benefit with state pharmaceutical assistance programs.<sup>78</sup> Outreach to low income minority beneficiaries to assure that they have maximum access to state as well as federal benefits should be a high priority in this process.

## V. INSTITUTIONAL BARRIERS TO ACCESS

Racial and ethnic disparities in access to and use of Medicare services result not only from financial barriers to access, but also from logistical, organizational, and systemic obstacles. Many minority Medicare beneficiaries have adequate financial resources to cover Medicare cost-sharing obligations, or have Medigap insurance or retiree benefits that fill the gaps. Many others have full Medicaid coverage to fill Medicare's gaps. Finally, some Medicare services—for example, home health services or flu and pneumonia vaccines—are available without copayments or deductibles, so financial concerns are not the primary burden to care. Nevertheless, nonfinancial institutional access barriers—logistical, organizational, and systemic—continue to result in racial and ethnic minorities lacking the same level of access to care enjoyed by white majority beneficiaries. This section discusses these barriers, and what CMS or HHS might be able to do to address them.

### A. Increase Availability of Minority Health Professionals

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<sup>78</sup> 42 U.S.C. § 1395w-133(a).

An initial problem faced by minorities is lack of equal access to physicians. One key factor here is the relative paucity of minority physicians.<sup>79</sup> A number of studies show that racial and ethnic minorities feel more trusting of and are better able to communicate with physicians from their own racial and ethnic groups, and tend disproportionately to use such physicians. Twenty-five percent of African-Americans and 23% of Hispanics responding to one recent survey reported that they were cared for by African-American or Hispanic physicians.<sup>80</sup> Minorities, however, are under-represented in the medical profession and in medical schools. Only 4% of physicians are African-Americans and only 5% are Hispanic, while only 11% of all medical school graduates are from minority groups.<sup>81</sup> This problem is to some extent addressed by programs operated by the Health Resources and Services Administration's, Bureau of Health Professions, including its Student Assistance Program's loans and scholarships for disadvantaged students under Titles VII and VIII of the Public Health Services Act and the National Health Services Corp's Educational Assistance Program.<sup>82</sup> It is also addressed partially by a number of programs that CMS's Office of Research, Development and Information has for some time

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<sup>79</sup> Joseph R. Betancourt, et al, *Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care*, 118 *Pub. Health Rep.* 293 (July/Aug 2003).

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> see <http://bhpr.hrsa.gov>. See also, recommending increases in these programs to address the lack of funding for minority health professional education, Sullivan Commission on Diversity in the Healthcare Workforce, *Missing Persons: Minorities in the Healthcare Workforce*, 96-98 (2004), available at <http://admissions.duhs.duke.edu/sullivancommission/documents/MissingPersonsChapter5.pdf> (visited Nov. 22, 2004). The Supreme Court's latest rulings on affirmative action permit admission decisions designed to promote a diverse student body in professional schools. See

funded in conjunction with historically black colleges and universities and Hispanic serving institutions.<sup>83</sup> These research programs study issues of importance to minorities, but they also help to support the infrastructure necessary for teaching future minority physicians. HHS needs to put more resources, however, into educating minority practitioners, and needs to encourage health professions schools to be more proactive in recruiting and retaining minority students.

#### B. Increase Access of Minorities to Health Care Professionals and Providers

HHS must not just do what is possible to expand the pool of minority professionals, but must also try to expand the total pool of professionals and institutions available to racial and ethnic minorities. A number of studies have shown that minorities and minority communities do not have the same access to hospitals, nursing homes, physicians, and other providers, professionals and suppliers that white majority beneficiaries enjoy.<sup>84</sup> In some instances this results from physicians or health care providers avoiding neighborhoods with large minority populations, MA plans “redlining” their coverage areas to avoid minority members, or hospitals relocating from inner-city to suburban locations.<sup>85</sup> It may also result from the fact that many minority beneficiaries are dependent on physicians who accept Medicaid, and experience

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Grutter v Bolinger, 539 U.S. 306 (2003).

<sup>83</sup> See <http://www.cms.hhs.gov/researchers/priorities/grants.asp> (visited Nov. 22, 2004).

<sup>84</sup> See, e.g., IOM, *supra* note 1, at 108-112, 143-8.

<sup>85</sup> See, Thomas E. Perez, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, in IOM, *supra* note 1, at 626, 642-5.

difficulties in accessing equal care because of this dependence.<sup>86</sup>

Some of these are issues that HHS and CMS can address, others are not. HHS and CMS cannot dictate where doctors locate or which patients they see. Title VI, however, at least prohibits intentional discrimination, and HHS is able to sanction physicians who refuse to see patients explicitly on the basis of race. HHS has long taken the position, most recently reiterated in its 2003 Guidelines regarding the implications of the Title VI prohibition against national origin discrimination for persons with limited English language proficiency, that doctors who accept Part B payments are not covered by Title VI because they are receiving insurance payments rather than federal financial assistance.<sup>87</sup> This position may have been defensible when Medicare indemnified patients for bills that they paid their doctors on a reasonable charge basis. Today, however, doctors are paid on a fee schedule basis just like all other providers, and most are “participating physicians” who are paid directly by Medicare. There is no real difference, therefore, between physicians and other providers.<sup>88</sup>

This is not to say that physicians who do not have minority patients on their patient lists are necessarily violating Title VI. In many cases, a plausible explanation based on other economic or practice factors will be available. But physicians who intentionally refuse to treat minority patients (or who discriminate against minorities in scheduling or in other respects)

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<sup>86</sup> Bloche, *supra* note 37, at 110

<sup>87</sup> See HHS, Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47311, 47313, n.4 (Aug. 8, 2003). For a history of this interpretation, see Crossley, *supra* note 34, at 265; Smith, *supra* note 12, at 163

should be held responsible for violation of Title VI. And physicians should be held to the same standards as other providers with respect to providing language-appropriate services to beneficiaries with limited English language proficiency. Finally, other Medicare providers, such as home health agencies or nursing homes, are clearly subject to Title VI and should be subject to OCR enforcement actions when they redline or otherwise exclude minorities.<sup>89</sup>

CMS could also do more to encourage physicians to serve minority communities. Section 413(a) of the MMA<sup>90</sup> provides for a new 5% incentive payment for physician's furnishing services in physician scarcity areas (PSAs). This is in addition to an existing 10% incentive payment for health care professionals practicing in Health Professional Shortage Areas.<sup>91</sup> Health Professional Service Areas can be defined to include urban areas and special populations, and automatically include federally qualified health centers,<sup>92</sup> and the 10% incentive is being used in some areas to attract health care professionals to serve underserved minorities. The new MMA provision is directed at "counties or equivalent areas" where Medicare beneficiaries are underserved by primary care or specialist physicians. The new provision, however, is being interpreted by CMS to apply at the county level, and thus will exclude many urban areas where counties as a whole are adequately served, but the particular areas where

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<sup>88</sup> See Rosenbaum, *supra* note 10, at 694-5..

<sup>89</sup> Perez, *supra* note 85, at 642-7.

<sup>90</sup> To be codified at 42 U.S.C. § 1395l(u).

<sup>91</sup> 42 U.S.C. § 1395l(m).

<sup>92</sup> 42 U.S.C. § 254e(a).

minorities tend to live within the county are not. CMS should reconsider these provisions to assure maximum incentives for physicians to serve underserved minorities.

### C. Increase Access Through Medicare Advantage

Though physicians and other healthcare professionals should be held accountable when they violate Title VI, there is probably more to be gained in terms for removing institutional barriers to equal access to care by focusing on Medicare Advantage (MA) plans. Managed care is a key piece in the racial and ethnic disparities puzzle. To the extent that managed care imposes additional bureaucratic barriers to the receipt of care through utilization review, network, or formulary requirements, it is likely to magnify the effects of racial and ethnic disparities if, as is often asserted, minorities are less skilled in manipulating bureaucracy or are served by professionals who are less well-connected within managed care systems.<sup>93</sup> If MA plans disproportionately terminate the contracts of minority physicians, who often serve disadvantaged populations with high-cost health needs, these MA plans will end up denying their benefits to minority beneficiaries.<sup>94</sup> If managed care plans, on the other hand, truly deliver on the promise of coordinated care and disease management, if they can develop utilization review approaches that are sensitive to the special needs and disadvantages of minorities, if they can offer incentives for providing preventive care that minorities might otherwise lack, they can be

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<sup>93</sup> Bloche, *supra* note 37, at 106

<sup>94</sup> David R. Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21 *Health Care Fin. Rev.* Summer 2000 at 75.

part of the solution rather than of the problem.<sup>95</sup>

Managed care plans present an ideal target for CMS efforts to address the problem of racial and ethnic disparities. While there are thousands of doctor's offices nationwide, there are only about 300 MA plans.<sup>96</sup> If CMS can hold these plans to their responsibilities to address racial and ethnic disparities, they in turn can assure that their provider and professional networks provide access to care for minorities. They can also use their own internal utilization review and quality improvement programs to assure that minorities in fact receive appropriate, high quality, care.

The evidence of their achievement so far in this area is ambiguous. One recent study of over 300,000 Medicare beneficiaries in managed care concluded that blacks received poorer quality care than whites.<sup>97</sup> Another survey of black physicians found that 92% believed that managed care organizations terminate the contracts of black doctors more often than white doctors, and that 88% of respondents had been refused a contact by a managed care organization.<sup>98</sup> Yet another study found that minority enrollees in Medicare managed care plans

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<sup>95</sup> Bloche, *supra* note 37, at 113-20.

<sup>96</sup> Lindsay Harris, Lori Achman and Marsha Gold, Medicare Advantage and Medicare Beneficiaries, Monthly Tracking Report for October 2004, available at <http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=48616> (visited March 2, 2005).

<sup>97</sup> Eric C. Schneider, Alan M. Zaslavsky, and Arnold M. Epstein, Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care, 287 JAMA (10), 1288 (2002).

<sup>98</sup> R. Lavizzo-Mourey et al, The Perceptions of African-American Physicians Concerning  
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report less positive experiences and greater difficulty accessing specialists than do white members.<sup>99</sup> There is also a concern that some Medicare managed care plans might be “redlining” their marketing efforts to avoid areas with high concentrations of minority beneficiaries, or unfairly terminating the contracts of minority physicians with high minority caseloads.<sup>100</sup> Redlining practices might involve, for example, having shorter hours or fewer locations in minority neighborhoods than in white neighborhoods, using enrollment counseling or benefit packages (formularies for example) to discourage minority members, having fewer physicians or imposing discriminatory standards on physicians in minority neighborhoods.<sup>101</sup>

But there are also positive signs. One of the studies noted above also found that minority members of Medicare managed care plans are more likely to report improvements in health status and lower rates of worsened health than white members.<sup>102</sup> And NASI’s own recent study of the role of private health care plans in Medicare concluded that “enrollment of Medicare beneficiaries in coordinated care plans reduces some disparities in care, but not all.”<sup>103</sup>

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their Treatment by Managed Care Organizations, 88 *Journal of the National Medical Assn*, 210-14 (1996)..

<sup>99</sup> Langwell & Moser, *supra* note 43, at 136.

<sup>100</sup> Perez, *supra* note 85, at 643-5.

<sup>101</sup> Sara Rosenbaum, et al., *Civil Rights in a Changing Health Care System*, 16 *Health Aff.* 90, 92, 97-100 (1997).

<sup>102</sup> Langwell & Moser, *supra* note 43, at 135-6.

<sup>103</sup> National Academy of Social Insurance, *The Role of Private Health Plans in Medicare: Lessons from the Past, Looking to the Future*, 126 (2003).

Under 42 C.F.R. § 422.504(h),<sup>104</sup> MA plans must agree contractually with CMS to comply with the civil rights laws. The prior Medicare+Choice regulations also included a provision in the discrimination prohibition section,<sup>105</sup> requiring compliance with the civil rights acts, but CMS has eliminated this provision in the recently promulgated MA regulations, arguing that it was redundant with section 422.504(h). While it is technically correct that the discrimination prohibition section is redundant, the elimination of the section is unfortunate in that it suggests a de-emphasis on the importance of civil rights compliance.

Many of the existing MA regulations address issues important to minority beneficiaries. A first key issue is the service area served by MA plans. In general local MA plans must serve a full county or group of counties, and mirror the service area served by the MA organizations commercial plans.<sup>106</sup> CMS may approve “partial county” service areas, but only if it determines that such an area “is necessary, nondiscriminatory, and in the best interest of beneficiaries.” Needless to say, CMS should be very reticent in approving partial- county areas, as MA plan use of such areas could provide an easy out for MA plans that prefer not to serve minority communities. In particular, it should not allow managed care organizations whose commercial plans serve only white areas to use this as an excuse for not serving minority communities in their Medicare business. It should also scrutinize closely MA plans that serve areas with high minority populations but have few minority members to determine whether the plan’s

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<sup>104</sup> 422.502(h) under the previous Medicare+Choice regulations.

<sup>105</sup> Former 42 CFR § 422.110(c).

<sup>106</sup> 42 C.F.R. § 422.2

configuration of providers or marketing practices are discouraging minority enrollment.

MA plans “must be available to all MA-eligible individuals within the plan’s service area”<sup>107</sup> All services offered under the plan must be accessible from the service area.<sup>108</sup> Plans may not in their marketing practices “engage in any discriminatory activity, including targeted marketing to Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas.”<sup>109</sup> MA plans must “maintain and monitor a network of appropriate providers that is . . . sufficient to provide adequate access to covered services to meet the needs of the population served.”<sup>110</sup> Plans are also responsible for assuring the providers offer office hours that are “convenient to the population served and do not discriminate against Medicare enrollees.”<sup>111</sup> Finally, the MA access regulations must be interpreted in light of the HHS Title VI regulations, which provide, “in determining the site or location of facilities, an applicant or recipient may not make selections with the effect of excluding individuals from, denying the benefits of, or subjecting them to discrimination under any programs to which this regulation applies, on the ground of race, color, or national origin, or with the purpose or effect of defeating or substantially impairing the accomplishment of the

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<sup>107</sup> Id.

<sup>108</sup> Id.

<sup>109</sup> 42 C.F.R. § 422.80(e)(1)(ii).

<sup>110</sup> 42 C.F.R. § 422.112(a)(1).

<sup>111</sup> 42 C.F.R. § 422.112(a)(8)(I)

objectives of the Act or this regulation.”<sup>112</sup>

Several MA regulations address issues of cultural competency in managed care.<sup>113</sup>

The MA access to services regulation requires that plans, “ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds,”<sup>114</sup> and “ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.”<sup>115</sup> The MA regulations further provide that health care professionals affiliated with MA plans “must provide information regarding treatment options in a culturally-competent manner, including an option of no treatment.”<sup>116</sup>

CMS has also addressed racial disparities in Medicare managed care as a quality issue, but seems to be retreating from this position. Amendments to the Medicare+Choice provisions imposed by the 2000 Medicare Benefits Improvement and Protection Act (BIPA) required M+C plans (including private fee-for-service and preferred provider organization plans) to have an

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<sup>112</sup> 42 C.F.R. § 80.3(b)(3).

<sup>113</sup> See, discussing the concept of cultural competency and its application to managed care, Lisa C. Ikemoto, *Racial Disparities in Health Care and Cultural Competency*, 48 St. Louis U. L.J. 75 (2003)

<sup>114</sup> 42 C.F.R. § 422.122(a)(9).

<sup>115</sup> 42 C.F.R. § 422.122(a)(9)(I).

<sup>116</sup> 42 C.F.R. § 422.206(a)(2).

ongoing quality assessment and performance improvement (QAPI) program that was to “include a separate focus with respect to all of the elements [required for QAPI programs] on racial and ethnic minorities.”<sup>117</sup> The MMA, however, removed this requirement, and CMS’s recently promulgated MA regulations also drop it as a regulatory requirement.<sup>118</sup> BIPA also required HHS to report to Congress biennially as to how QAPI programs were focusing on racial and ethnic minorities, the means they used to address this focus, and the impact such programs were having on “eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction,” and to include “recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.”<sup>119</sup> This provision was repealed by the MMA, and although it had been in place for four years, no reports were ever filed.

CMS has taken some limited steps to address racial disparities in and through Medicare managed care plans. It has published, together with AHRQ, two impressive guides for managed care plans, one on Providing Oral Linguistic Services, the other on Planning Culturally and Linguistically Appropriate Services. It has insisted that accreditation organizations approved to accredit MA plans include standards addressing cultural and linguistic issues to the extent

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<sup>117</sup> Codified at 42 USC 1395w-22(e)(2)(A)(xii), 1395w-22(e)(B).

<sup>118</sup> See CMS, Medicare Advantage Program Proposed Rule, 69 Fed. Reg. 46866, 46886-87 (2004).

<sup>119</sup> Codified at 42 U.S.C. § 1395w-22(e)(5).

required by CMS regulations.<sup>120</sup> In its most ambitious initiative, CMS required M+C organizations to conduct a QAPI project in 2003 addressing either clinical health disparities or culturally and linguistically appropriate services (CLAS).<sup>121</sup> Organizations that focused on clinical disparity projects were to focus on one of four clinical areas--diabetes, pneumonia, congestive heart failure or mammography--while projects that focused on CLAS were to conduct a project addressing language access or organizational support. Projects were to include an intervention and outcome analysis to determine if the intervention brought about improvement. A description of the required QAPI studies is included in Appendix A to Chapter 5 of the Medicare Managed Care Manual.

The reports from the QAPI projects are currently being reviewed by Quality Improvement Organizations (QIOs), and will then be reviewed by CMS. Apparently, however, the projects varied greatly in scope, with some plans carrying out comprehensive assessments of their ability to provide CLAS, others merely updating their provider directories to indicate linguistic competency. As noted above, CMS did not file the report on this effort as required by BIPA.

CMS could and should do more to enlist and ensure the assistance of MA plans in

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<sup>120</sup> See, e.g., CMS, Medicare+Choice Organizations--Approval of the Joint Commission on Accreditation of Healthcare Organizations for Medicare+Choice (M+C) Deeming Authority for Managed Care Organizations, 67 Fed. Reg. 13337, 13338-9 (2002).

<sup>121</sup> See Sidney Watson, Equity Measures and Systems Reform: Using Quality Assessment and Performance Improvement (QAPI) Mandates to Reduce Racial and Ethnic Disparities in Care (forthcoming).

addressing racial and ethnic disparities. First, it must make sure that MA plans in fact define their service areas so as to include racial and ethnic minorities. Further, CMS must carefully review the marketing practices of MA plans to assure that the MA plans market their services to minorities to the same extent that they do to majority white populations. MA plans should be required to make plan materials available in all languages spoken by significant numbers of enrollees. CMS should require MA plans to track new enrollees to make sure that they have initial appointments with their primary care physicians and receive all appropriate Medicare covered preventive care and services. CMS should carefully review MA disenrollment practices to make sure that racial and ethnic minorities are not unfairly treated. CMS must enforce its requirements that MA plans assure that professionals and providers are fully available to racial and ethnic minority members. MA plans should be required to contract only with hospitals that accept Medicaid, or even only with those that agree to provide a designated level of free and reduced cost care.<sup>122</sup>

Given the importance of minority physicians for treating minority beneficiaries, plans should make special efforts to recruit minority physicians. CMS should carefully review MA plan terminations of minority physicians to make sure that plans are not terminating physicians on a discriminatory basis (or that plans are not terminating minority physicians to rid themselves of high-cost minority enrollees with serious health problems). Finally, MA plans should be required to provide cultural competency training for all plan providers.<sup>123</sup>

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<sup>122</sup> Bloche, *supra* note 37, at 120.

<sup>123</sup> See Langwell & Moser, *supra* note 43, at 142-3 (discussing such programs).

CMS could also do more to emphasize racial and ethnic disparities in its MA quality improvement and review programs. It is unfortunate the CMS has moved so quickly to remove from its quality improvement regulations any mention of racial and ethnic disparities. Though Congress has removed from the MA legislation a specific requirement for QAPI initiatives to address disparities, the statute at the same time removed virtually all specific requirements as to the essential elements of QAPI plans. Nevertheless, the A regulations continue to impose a number of detailed requirements to assure that MA quality improvement projects address other quality issues through appropriate and valid intervention and evaluation methodologies. Racial and ethnic disparities are an important quality issue, and CMS should continue to require that plans address them.

CMS should also use its Consumer Assessment of Health Plans (CAHPS) data to assess plan performance with respect to addressing racial and ethnic disparities. CAHPS data are based on a national survey of MA plan members (conducted in English and in Spanish) to evaluate consumer assessment of plan performance. CMS has generated a number of concept papers considering the use of CAHPS data for evaluating the performance of plans with respect to minority enrollees.<sup>124</sup> One paper for example, looked at difference in race/ethnicity in managed care smoking cessation programs,<sup>125</sup> while another looked at health profiles of racial

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<sup>124</sup> See also *Id.*, reviewing CAHPS findings with respect to the experience of racial and ethnic minorities with Medicare managed care.

<sup>125</sup> <http://www.cms.hhs.gov/researchers/projects/consumers/mc1overview.pdf> (visited March 2, 2005).

and ethnic minorities enrolled in managed care.<sup>126</sup> Yet another analysis of CAHPS data concluded that minority beneficiaries were more satisfied overall with their health plans than other enrollees, but were less satisfied with the process of care and their ability to access needed services.<sup>127</sup> Finally, CMS has issued a report on the potential use of CAHPS to assess plan performance with respect to minorities.<sup>128</sup> This report concluded that given the small numbers of minority members of any given plan identified by the CAHPS survey and the problems with ethnic identity data in Medicare databases, the data were of limited value for assessing plan performance with respect to minorities. The report suggested, however, that better data could be obtained by improving Medicare ethnic identity information, aggregating ethnic groups for data collection, and focusing on plans with high minority memberships. Clearly more can be done with CAHPS data to assess the experience of minorities with Medicare managed care, and to feed back to MA plans suggestions with respect to concerns to which they need to attend.

CMS could also encourage the National Committee for Quality Assurance to add topics related to racial and ethnic disparities to its accreditation standards and Health Plans Employer Data and Information Set (HEDIS) measures.<sup>129</sup> CMS has long worked closely with the NCQA in developing measures for evaluating managed care. The NCQA has expressed interest in the

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<sup>126</sup> <http://www.cms.hhs.gov/researchers/projects/consumers/mc3overview.pdf> (visited March 2, 2005).

<sup>127</sup> [http://www.cms.hhs.gov/researchers/projects/consumers/mc\\_overview6.pdf](http://www.cms.hhs.gov/researchers/projects/consumers/mc_overview6.pdf) (visited March 2, 2005).

<sup>128</sup> [http://www.cms.hhs.gov/researchers/projects/consumers/5mc\\_ovw.pdf](http://www.cms.hhs.gov/researchers/projects/consumers/5mc_ovw.pdf) (visited March 2, 2005).

racial and ethnic disparity issue in the past, and should be encouraged to address it further.<sup>130</sup>

Finally, CMS has to be extraordinarily careful in the implementation of the provisions of the MMA providing for specialized MA plans for special needs individuals.<sup>131</sup> Traditionally, MA plans were not able to exclude any Medicare beneficiaries except for ESRD recipients. The MMA, however, allows for the provision of plans available only to “special needs individuals,” defined to include institutionalized beneficiaries, dual-eligibles, and individuals with severe or disabling chronic conditions.<sup>132</sup> Specialized plans might well offer real benefits to persons with complex medical conditions requiring specialized medical care. If specialized plans are used, however, to place Medicaid recipients in managed care ghettos, they could seriously aggravate the disparities already affecting Medicare beneficiaries. A recent CMS Interim Guidance on specialized plans is somewhat hopeful, in that it prohibits MA plans from passively enrolling their dual-eligibles in specialized plans and makes it clear that regulatory requirements will not be waived for such plans.<sup>133</sup> One cannot help but be concerned, however, that these plans will result in further segregation of care received by minority beneficiaries.

In interviewing current and former CMS employees while gathering information for this

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<sup>129</sup> Williams and Rucker, *supra* note 94, at 84-5.

<sup>130</sup> See NCQA Releases Draft 2003 MCO, MBHO and PPO Standards (2002), <http://www.ncqa.org/communications/news/mcopubcomment2003.htm> (visited Nov. 23, 2004).

<sup>131</sup> To be codified at 42 U.S.C. §§ 1395w-21(a)(2)(a), 1395w-29(b)(6) & (f).

<sup>132</sup> 42 U.S.C. § 1395w-29(b)(6)(B).

paper, I was told over and over again that the top priority of CMS at the moment is implementing the MMA, and that addressing racial and ethnic disparities has dropped far behind as a priority. The two need not, however, be incompatible. Medicare managed care is one of the best tools available there for addressing racial and ethnic disparities, because, at its best, its emphasis on preventive care, care for the chronically ill, and coordination of care can be of tremendous benefit to minorities. It would be a great tragedy, however, if the great wealth of resources that Congress has made available for addressing managed care under the MMA were to be consumed without addressing the problem of racial and ethnic disparities.

#### D. Improve Provider Cultural and Linguistic Competence

##### 1. Linguistic Competence

For many minority beneficiaries, the most significant barrier to access to care is lack of ability to communicate with professionals and providers because of limited English proficiency. A number of studies have demonstrated the seriousness of this problem. Spanish-speaking patients discharged from emergency rooms, for example, are less likely than English-speaking patients to understand their diagnosis, medications, or follow-up care plans; are less likely to return if they have a problem; and are less satisfied with care.<sup>134</sup> Similarly, Spanish-speaking patients with non-Spanish speaking physicians are more likely to omit medications, miss office appointments, and go to the emergency room for care than those with Spanish-speaking

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<sup>133</sup> <http://www.cms.hhs.gov/healthplans/specialneedsplans/qaspecneeds06-23.pdf>.

<sup>134</sup> Betancourt, et al, supra note 79, at 18

physicians.<sup>135</sup>

The prohibition of Title VI against discrimination on the basis of national origin forbids providers who receive federal funding from discriminating on the basis of language proficiency.<sup>136</sup> Executive Order 13166, issued in 2000, required federal agencies that provided financial assistance to non-federal entities to publish guidances on what their recipients needed to do to comply with Title VI requirements.<sup>137</sup> On August 30, 2000, HHS published a Policy Guidance addressing the Title VI prohibition. A revision of this Guidance was issued by HHS on August 8, 2003.<sup>138</sup> The revised Guidance endorses a “flexible and fact-dependent” standard for making an “individualized assessment that balances . . . four factors: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people’s lives; and (4) the resources available to the grantee/recipients and costs.<sup>139</sup> The specified intent of the guidance is to “suggest a balance that ensures meaningful access by LEP persons to critical services while not imposing undue burdens on small businesses, small local governments, or

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<sup>135</sup> *id.*

<sup>136</sup> *Lau v. Nichols*, 414 US 563 (1974)

<sup>137</sup> See, *Ikemoto*, *supra* note 113, at 104-6.

<sup>138</sup> HHS, *Guidance*, *supra* note 87.

<sup>139</sup> *Id.* at 47314.

small nonprofits.”<sup>140</sup>

The 2003 Guidance does, indeed, afford providers a great deal of flexibility in serving LEP beneficiaries. The document also places a heavy emphasis on voluntary compliance and educational interventions. The flexibility provided by this Guidance, however, makes it imperative that HHS be proactive in securing compliance. HHS needs to make absolutely certain that providers do not mistake the Guidance’s emphasis on flexibility and voluntary compliance for a lack of resolve on the part of HHS to assure that accessibility for LEP beneficiaries is improved. The Office of Civil Rights of HHS, which is responsible for assuring Title VI compliance in HHS programs including Medicare, must keep reminding providers on a regular basis that language accessibility is an important issue that it will not ignore, and that providers cannot ignore. In particular, OCR needs to make it clear to large institutional providers that the flexibility found in the Guidance is primarily intended to assist small providers with limited resources, and not to excuse large providers that have resources from providing competent interpreters and translated documents.

There is also much HHS can do to assist providers with compliance. To begin, HHS could help with paying for interpreter services. States may pay for interpretation services under Medicaid and SCHIP and receive federal matching funds.<sup>141</sup> At least ten state Medicaid

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<sup>140</sup> Id.

<sup>141</sup> Ku and Flores, *supra* note 33.

programs currently cover interpreter services.<sup>142</sup> CMS normally considers the cost of regulatory compliance in constructing Medicare payment formulas, and nothing in the Medicare statute prohibits CMS from considering the cost of interpreters. The OMB has recently estimated that the cost of interpreter services for ER, inpatient hospital, outpatient physician, and dental visits for LEP patients would be \$4.04 per visit, or about .5% of the cost of an average visit.<sup>143</sup> The Medicare program should be able to incorporate this cost.

HHS could also develop standards for certifying interpreters as competent. It could assist providers in translating commonly-used documents, such as privacy disclosures or brochures explaining common procedures. HHS could collect language accessibility information through its CAHPS surveys. It can also require facilities to engage in QAPI projects to improve language accessibility.

Finally, HHS OCR should consider undertaking several well-aimed enforcement actions. As was amply demonstrated in the late 1990s by the Department of Justice and Office of Inspector General fraud and abuse enforcement projects and again in the early 2000s by the Office of Human Subjects Research Protection research compliance programs, nothing concentrates the attention of recalcitrant providers like federal enforcement actions. CMS needs to do more to inform beneficiaries as to how and when to complain to OCR, and OCR needs to

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<sup>142</sup> Id.

<sup>143</sup> Office of Management and Budget, Report to Congress: Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency, 56, March 2002, X:\Communications Projects\Web\Publications for the Web\Disparities Papers\jostfinal.doc

pursue aggressively complaints that it receives. Civil rights enforcement is beyond the scope of this paper, and will not be dealt with at length here. It must be noted, however, that HHS OCR has been subjected to persistent and repeated criticism regarding the timidity of its approach to enforcement.<sup>144</sup>

People whom I spoke with at HHS repeatedly referred to the LEP issue as the “low-hanging fruit” of civil rights enforcement action. If a health care provider that receives Medicare payments services a large population of non-English speaking beneficiaries, yet has not translated its basic informational documents and depends on family members for interpretation, the provider is in violation of Title VI—no complex analysis of intent is necessary. If HHS is powerless to take enforcement action in this context, no one can possibly take its commitment to civil rights seriously.

## 2. Culturally and Linguistically Appropriate Services (CLAS)

A closely-related focus of HHS has been the articulation and implementation of the fourteen standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) developed by the HHS Office of Minority Health “to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate

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[www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf](http://www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf)

<sup>144</sup> U.S. Commission on Civil Rights, *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality*, vol. II., *The Role of Federal Civil Rights Enforcement Efforts* (1999); Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care*

manner.”<sup>145</sup> Four of these standards—those requiring facilities to provide language assistance services without cost, provide patients information in their own language about the right to receive assistance, assure the competence of language assistance, and make available easily understood patient-related material and signage—are otherwise imposed by federal regulations implementing the discrimination on the basis of national origin prohibitions of Title VI, and are thus mandatory.<sup>146</sup> But compliance with most of the CLAS standards—those requiring the provision of culturally sensitive care by a diverse organizational staff with appropriate organizational support (including education, data collection, needs assessments, strategic planning, and consumer involvement)—is not specifically required. Rather, these standards are recommended by the OMH for inclusion in federal or state certification standards or private accreditation standards, or simply for voluntary compliance.

CMS does not independently require providers, professionals, or contractors to comply with the CLAS standards. Cultural competency requirements are imposed, as noted above, on MA plans and their providers. Recipients of services from the Program of All-Inclusive Care for the Elderly (PACE) are also entitled to “have all treatment options explained in a culturally competent manner.”<sup>147</sup> CMS should, however, work together with accreditation agencies to encourage all Medicare providers to comply with the CLAS guidelines.

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Delivery, 6 Tex. F. on C.L. & C.R. 1, 28-33 (2001).

<sup>145</sup> HHS, OHS, Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report, 3 (2001). See also, Ikemoto, supra note 113 at 08-111

<sup>146</sup> HHS, National Standards, supra note 145.

Since the inception of the Medicare program, Medicare has depended on private accreditation agencies to determine whether institutional providers are competent to provide services to Medicare beneficiaries.<sup>147</sup> With respect to hospitals, for example, Medicare has its own certification requirements, but hospitals may alternatively be certified on the basis of their compliance with accreditation requirements promulgated by the Joint Commission on the Accreditation of Healthcare Organizations, and most are. Joint Commission accreditation standards currently address racial and ethnic disparities obliquely. They require, for example, that hospitals comply with federal and state laws (LD.1.30), respect the patient's need for effective communication (PR.2.100), and provide education and training specific to the patient's needs and as appropriate to the care and services involved (PR.6.10).<sup>149</sup> The Joint Commission has developed surveyor training modules addressing CLAS issues and used them for training surveyors. JCAHO is also currently conducting a major study, entitled "Hospitals, Language and Culture," looking at how hospitals are implementing cultural and linguistic sensitivity standards, with an eye toward identifying emerging or promising practices in this area on which realistic

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<sup>147</sup> 42 C.F.R. § 460.112(e)(1).

<sup>148</sup> Timothy Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 *B.C.L.Rev.* 835 (1983).

<sup>149</sup> See JCAHO, 2004 Joint Commission Standards Related to Culturally and Linguistically Appropriate Service Provision, Working Document (May 27, 2004); Office of Minority Health National Culturally and Linguistically Appropriate Service (CLAS) Standards Crosswalked to Joint Commission 2004 Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care and Home Care (2004). Only one specific current JCAHO accreditation requirement specifically addresses language issues. EP.2 requires that: "Written information provided is appropriate to the age, understanding, and as appropriate to the population serviced, the language of the [patient/resident/client]."

and achievable standards could be built.<sup>150</sup> CMS should encourage JCAHO and other accreditation agencies to move forward to develop such standards. If they fail to do so, CMS should use its own authority to supplement accreditation standards, and adopt the CLAS standards as Medicare provider certification standards.<sup>151</sup>

#### E. Address Racial and Ethnic Disparities as a Quality Issue

However else one may conceptualize racial and ethnic disparities in Medicare, they certainly raise quality of care issues. When minorities fail to receive appropriate care because of organizational barriers (or, for that matter, because of professional attitudes), the providers or professionals who are caring for them are providing poor quality care. When LEP beneficiaries do not understand the information they are receiving from professionals or providers or are not understood by them, they also are receiving poor quality care (under conditions that threaten patient safety). When millions of Medicare beneficiaries receive care below the standard enjoyed by other beneficiaries because of their race, there is a serious quality of care problem that needs to be addressed.

This is why cultural and linguistic competency, indeed, equal treatment of minorities, should be addressed through accreditation and certification standards. CMS should also require

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<sup>150</sup> See Hospitals, Language and Culture: A Snapshot of the Nation Fact Sheet, available at <http://www.jcaho.org/about+us/hlc/facts.htm> (visited March 2, 2005).

<sup>151</sup> 42 U.S.C. § 1395x(e)(9).  
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all categories of providers who have obligations under the law to perform QAPI activities, and not just MA plans, to incorporate equity and access concerns into their QAPI programs.<sup>152</sup> The main effort of CMS to address racial and ethnic disparities as a quality issue, however, has been through the QIO program.

The QIOs (formerly Peer Review Organizations) are private organizations that contract with Medicare to review and improve the quality of health care received by Medicare beneficiaries.<sup>153</sup> Their obligations to CMS are spelled out in three-year contracts based on scopes of work (SOWs). One of the requirements of the sixth SOW, running from 1999 to 2002, was that QIOs develop and implement projects to identify underserved populations, recognized barriers to healthcare unique to those populations, and develop interventions to address those barriers.<sup>154</sup> The 7<sup>th</sup> SOW (2002-5) continued this focus on underserved populations, as will the proposed 8<sup>th</sup> SOW. The QIOs are supported in these efforts by the Underserved Quality Improvement Organizations Support Center (UQIOSC), located in Memphis, Tennessee.

Underserved populations include not only racial and ethnic minorities, but also dual-eligibles, and under the 7<sup>th</sup> SOW, rural beneficiaries. Twenty-seven of the 53 6<sup>th</sup> SOW projects focused on African-Americans, 3 on Hispanics, 2 on Native Americans, and 1 on American

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<sup>152</sup> See Watson, *supra* note 121.

<sup>153</sup> See 42 U.S.C. §§ 1320c-1 - 1320c-5.

<sup>154</sup> See QSource, *QIO Efforts to Reduce Healthcare Disparities, 1999-2002*, 4..

Samoans (19 focused on dual-eligibles).<sup>155</sup> Under the 7<sup>th</sup> SOW, 30 of the 53 projects focused on minorities, including 22 that focused on African-Americans, 4 on Hispanics, 3 on Native Americans and 1 on American Samoans. Each project also focused on one clinical condition—heart failure, breast cancer, diabetes mellitus, influenza, and pneumonia. Each QIO had to identify a clinical condition within its state as to which there was a disparity of at least 7% between disadvantaged and non-disadvantaged populations.

QIO interventions are evidence-based, and address both healthcare systems and sociocultural barriers. Systems barriers include issues such as shortages of local professionals, limited access to facilities or supplies, lack of coordinated care or physician recommendations, and lack of effective communication between patients and professionals.<sup>156</sup> Sociocultural issues include language proficiency problems, lack of transportation, lack of knowledge about clinical conditions or the healthcare system, lack of trust in the healthcare system, fatalism, and lack of social support.<sup>157</sup> In the 6<sup>th</sup> SOW QIO projects, 6 of the interventions addressed healthcare systems, 19 sociocultural, and 26 combined interventions.<sup>158</sup> Each of the projects involved partnerships with providers or community organizations. Overall under the 6<sup>th</sup> SOW, 41 (79%) of the projects improved quality of care for the target population, while 31 (61%) of the projects

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<sup>155</sup> Id. at 4.

<sup>156</sup> Id at 11-13.

<sup>157</sup> Id. at 13-15.

<sup>158</sup> Id. at 17.

reduced target population disparity.<sup>159</sup> Five states reduced disparities by greater than 10%, but the average reduction in disparity was 1.4%.<sup>160</sup>

The QIO projects have been, and continue to be, modestly successful in addressing racial and ethnic disparities. They are intensely focused, however, on specific populations, communities, and medical conditions. Their greatest value is as pilot studies, demonstrating interventions that might work for particular problems and groups. As pilot studies, however, they would be most valuable if they could form the basis for more ambitious projects replicating successes. CMS needs to expand the QIO disparities project, therefore, providing more resources to support it, using it to develop conceptual frameworks and measurement methodologies for understanding disparities and strategies for addressing them better, and creating and strengthening national and community partnerships to replicate successful interventions.<sup>161</sup> Unfortunately, CMS seems to be diluting the program rather than strengthening it. Nineteen of the projects under the 7<sup>th</sup> SOW concern rural beneficiaries rather than racial and ethnic minorities, and another 3 the dually-enrolled. This is a valuable program, and CMS should keep it focused on racial and ethnic disparities if it hopes to address this problem successfully.

#### F. Address Racial and Ethnic Disparities as a Compliance Issue

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<sup>159</sup> Id. at 23.

<sup>160</sup> Id.

<sup>161</sup> Id. at 27-29.

As has been already noted, policies and practices that result in disparate treatment of minorities in federal programs, including Medicare, are in violation of federal law.<sup>162</sup> The frontline responsibility for enforcing this law resides with HHS OCR. As one scans the OCR's website and reviews its recent publications, one sees a great deal about the Privacy Rule, about LEP discrimination, and about disability discrimination. It is difficult to avoid the impression that OCR has very little, if any, enforcement activity currently underway involving race discrimination, an impression that is reinforced in talking to OCR staff and former staff. OCR has very limited resources—\$35 million is requested for 2005, compared to a budget of \$20 million in 1970 when the office was established (in 1970 dollars).<sup>163</sup> Though resources have grown considerably in the last four years, much of this budget is now consumed with interpreting and enforcing the Privacy Rule.

If providers are to believe that HHS is serious about enforcing Title VI, more resources for enforcement are necessary, and they must be directed toward race discrimination. If Congress does not make such resources available, HHS OCR must make hard decisions about allocating resources. It should not focus all of its efforts on the “low-hanging fruit” of LEP discrimination, but also to climb up the tree to reach some of the race discrimination fruit hidden

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<sup>162</sup> More specifically, they violate Title VI and its implementing regulations, 42 C.F.R. § 80.2(b)(2).

<sup>163</sup> See, U.S. Commission on Civil Rights, Funding Federal Civil Rights Enforcement, 2000-2003, <http://www.usccr.gov/pubs/crfund02/report.htm> (visited Nov. 24, 2004), HHS budget, FY 2005, <http://www.hhs.gov/budget/05budget/ocr.html> (visited Nov. 24, 2004).

in the upper branches.

Even in the absence of resources, indeed in the absence of a commitment from HHS OCR to address this issue, it is possible for HHS to make progress. A very simple, yet very dramatic, step that HHS could take to signal to providers that racial and ethnic disparities are a priority would be to issue an amendment to all of the compliance guidances issued by the Office of Inspector General to identify compliance with Title VI as an issue to be addressed by all Medicare providers in their compliance plans and programs. Though OIG compliance guidances are focused on fraud and abuse issues, they also address other programmatic concerns such as EMTALA or HIPAA privacy.<sup>164</sup> The OIG should encourage each provider or contractor that participates in Medicare to address compliance with the nondiscrimination prohibition of Title VI, and line out for each type of entity what compliance might involve in terms of addressing racial and ethnic disparities. Including this factor in the standards addressed by the compliance plan mandate would bring into play all of the elements of compliance plans, including implementation of written policies, procedures, and standards of conduct; education and training of staff in compliance; internal monitoring and audits to assure compliance; providing open lines of communication regarding noncompliance (including anonymous reporting of violations); investigation and correction of violations; and enforcement through well publicized disciplinary guidelines.<sup>165</sup> Most importantly, however, an explicit amendment to all compliance guidances,

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<sup>164</sup> See, e.g., HHS OIG, OIG Draft Supplemental Compliance Guidance for Hospitals, 69 Fed. Reg., 32012, 32024-26 (2004).

<sup>165</sup> See HHS OIG Compliance Guidances, <http://oig.hhs.gov/fraud/complianceguidance.html> (visited March 2, 2005).

would signal that race discrimination is a priority for the Medicare program.

#### G. Other Steps and Programs for Addressing Institutional Problems that Result in Disparities

One chronic and pervasive problem in addressing disparities is the lack of data necessary for understanding disparities and evaluating steps that could be taken to address them. This topic is beyond the scope of this paper, other than to note that CMS and Medicare providers and contractors need to improve data collection activities.

Further research on disparities issues in Medicare is also necessary. CMS's Office of Research, Development, and Information has a number of such projects underway.<sup>166</sup> Perhaps the most ambitious ongoing research project is the Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities, authorized by the 2000 BIPA legislation. This project has identified one institutional intervention—the use of healthcare facilitators such as community health workers—as the most effective intervention to pursue as it moves into its demonstration project phase.<sup>167</sup>

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<sup>166</sup> See, CMS, Active Projects Report, 2003, 99-106. One particular issue that requires further research is the relationship between racial disparities and geographic disparities. Katherine Baicker, et al, Who You Are and Where You Live: How Race and Geography Affect the Treatment of Medicare Beneficiaries, Health Affairs Web Exclusive (2004), <http://content.healthaffairs.org/cgi/reprint/hlthaff.var.33v1> (visited Nov. 24, 2004)

<sup>167</sup> See Schneider Institute for Health Policy, Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities, Evidence Report and Evidence-Based Recommendations.  
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Yet another possible approach to institutional barriers to racism would be greater use of minority contractors. The MMA gives CMS much greater flexibility in the contractors it can use for Medicare administration. It is quite possible that minority contractors would be more sensitive to disparity issues, and CMS should try to identify and contract with such contractors.

Finally, it is possible that pay for performance could be used creatively to address disparity issues. Physicians or managed care companies, for example, could be paid extra for providing preventive services to minority beneficiaries<sup>168</sup> or for superior clinical outcomes for beneficiaries, including minorities.<sup>169</sup> Hospitals could receive incentives for diminishing unexplained disparities in angioplasty rates.<sup>170</sup>

## VI. PROFESSIONAL ATTITUDES AND BEHAVIOR

The third cause of racial and ethnic disparities identified above is professional attitudes and behavior. As has already been noted, the possibility of enforcement of Title VI against professionals who participate in Medicare yet consciously discriminate against racial and ethnic minorities should not be ruled out. Indeed, a few highly publicized Title VI actions brought

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<sup>168</sup> David A. Hyman and Charles Silver, *You Get What You Pay for: Result-Based Compensation for Health Care*, 58 Wash. & Lee L. Rev 1427, 1481-2 (2001). Medicare already has underway several pay for performance demonstration projects. See Medicare Pay for Performance (P4P) Initiatives, at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1343> (visited March 2, 2005).

<sup>169</sup> Bloche, *supra* note 37, at 118.

<sup>170</sup> Watson, *supra* note 12, at 224.

against physicians who engage in blatantly discriminatory activity might have a significant effect in raising the consciousness of physicians regarding the seriousness of the disparities problem.

Doctors who consciously realize that disparate treatment of minority patients is wrong and illegal might be less likely to rely unconsciously on racial stereotypes in treatment.<sup>171</sup> To this end, as mentioned above, OCR's interpretation that Title VI does not apply to doctors who participate in Medicare should be changed.

On the other hand, most professional behaviors that result in racial and ethnic disparities, such as unconscious stereotypical thinking, are probably not amenable to civil rights enforcement. If progress is to be made in this area, it is probably going to depend on educational interventions.<sup>172</sup> Fortunately, CMS has many opportunities for educating providers, some of which are currently being utilized, and others that could be developed further.

The primary vehicle through which provider education is currently being pursued is the QIO program, the main focus of CMS's racial and ethnic disparities work. While QIO disparities interventions have often aimed at beneficiary education, some have focused on provider education as well. Sixth SOW QIO interventions, for example, included provider assistance for file and case history management for monitoring diabetics, physician and medical staff education with respect to pneumococcal immunizations, generation of physician profiles to inform physicians about disparity issues, promotion of standing orders for early administration of

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<sup>171</sup> Bowser, Racial Bias, *supra* note 36, at 382;

<sup>172</sup> See, discussing cultural competency education, Carol R. Horowitz, et al., Approaches  
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antibiotics, and hospital detailing visits to promote the use of aspirin for beneficiaries with AMI.<sup>173</sup>

MA plans should also be required to encourage their professionals to reach out aggressively to minorities. As already noted, MA plans have an obligation to “Ensure that services are provided in a culturally competent manner,”<sup>174</sup> and to make sure that professionals affiliated with the plan “provide information regarding treatment options in a culturally-competent manner.”<sup>175</sup> MA plans have much greater and more direct control over their participating professionals than does Medicare, and should bear the main burden of responsibility for make sure that those professionals are educated as to the issue of disparities and take steps to address it.

A third possibility is the use of local coverage determinations (LCDs) or other claim screens to attempt to change professional behavior. Medicare contractors develop LCDs to determine when an item or service will be covered by Medicare, and how it should be coded. Although LCDs are commonly thought of as decisions whether or not to cover a particular technology, they are in fact often utilization screens that identify whether or not particular

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to Eliminating Sociocultural Disparities in Health, 21 Health Care Fin. Rev. 57 (Summer 2000).

<sup>173</sup> QSource, supra note 154, at 17-18.

<sup>174</sup> 42 C.F.R. § 422.122(a)(9).

<sup>175</sup> 42 C.F.R. § 422.206(a)(2).

services or products are “reasonable and necessary” in a particular situation.<sup>176</sup> LCDs, or perhaps other forms of claim screens, could be developed by contractors to address situations where minorities receive disparate care.

It would take creative thinking to design LCDs or claim screens that would serve this end. LCD screens normally flag services that are provided unnecessarily or that have not yet been approved for Medicare coverage for nonpayment. But the nonprovision of services, or the provision of services that are inadequate under the circumstances, could also be characterized as “unreasonable.” Contractors could through literature reviews identify situations where minorities are commonly underserved. They could then design screens to encourage appropriate provision of care in those circumstances. Thus, for example, a contractor that receives a claim from a primary care physician for an initial office visit from a minority patient where no claim is submitted within 60 days thereafter for covered preventive screening tests could send the physician a reminder to recommend indicated screening tests.

Claim screening programs could also perhaps be designed that would review the claims of physicians who serve both majority and minority populations, and to alert the physician to disparate patterns of care that were identified. If a physician tended to provide certain services disproportionately to minorities, or, alternatively, disproportionately tended not to provide certain services to minority beneficiaries, these patterns could be flagged and the physician be notified.

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<sup>176</sup> See Medicare Program Integrity Manual, 13.1.3.  
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CMS should also require contractors to educate providers as to racial and ethnic disparity issues under the requirements of section 1889 of the Social Security Act, and to use the funds appropriated under that section for this end. Funds appropriated under this provision are to be used: “to increase the conduct by Medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items,”<sup>177</sup> which could be interpreted to cover improper underservice of minority beneficiaries.

The regional offices should, and do, provide education to professionals on these racial and ethnic disparity issues. The regional offices have been at the front lines in CMS’s current efforts to educate providers and beneficiaries on disparity issues. Whenever possible, regional office staff ought to partner with contractors and professional groups and associations to promote greater awareness among professionals about the facts of racial and ethnic disparities and about appropriate responses to disparities. The CLAS standards, discussed above, should be a focus of regional office and contractor educational efforts.

A final possibility would be for CMS to use its financial influence to try to increase attention to issues of racial and ethnic disparities in medical education. The payments CMS makes to hospitals through direct and indirect medical education cost payments finance a considerable share of the cost of post-graduate medical education in the United States. In 2004, Medicare spent \$2.7 billion on direct medical education subsidies and \$5.8 billion on indirect

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<sup>177</sup> 42 U.S.C. § 1395zz(b)(2).

medical education costs.<sup>178</sup>

In theory, Medicare could use this financial clout to influence what and how residents are taught. Presently it only does this directly with respect to one issue—abortion. In general Medicare medical education payments can go to finance any accredited residency program.<sup>179</sup> This rule is subject to an exception, however, allowing payment for residence in programs “that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.”<sup>180</sup> CMS thus determines the shape of post-graduate medical education to the extent that it dictates that such education need not cover abortion. Medicare medical education funding is also used to influence medical education in other respects, moreover, for example, to encourage residencies in rural hospitals or in certain specialties.<sup>181</sup> The MMA directs medical education funds towards residencies in rural hospitals. CMS should consider also using its medical education funding clout to assure that medical residents, as well as others funded through Medicare education subsidies such as nurses, are educated with respect to cultural competency issues. This could be done through the regulations governing direct or indirect medical education subsidies, or perhaps through conditions of

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<sup>178</sup> See Rebecca E. Brucoleri, Graduate Medical Education Funding, [http://www.amsa.org/pdf/Medicare\\_GME.pdf](http://www.amsa.org/pdf/Medicare_GME.pdf) (visited Nov. 24, 2004).

<sup>179</sup> 42 C.F.R. § 412.105.

<sup>180</sup> 42 C.F.R. § 412.105(f)(i)(D).

participation governing teaching hospitals.

## VII. BENEFICIARY ATTITUDES AND BEHAVIOR

The fourth cause of racial and ethnic disparities in Medicare is beneficiary attitudes and behavior. A key component of any CMS or HHS program to address racial and ethnic disparities, therefore, must be beneficiary outreach and education. CMS has ample statutory authority to engage in outreach efforts to beneficiaries, indeed it has a statutory mandate to do so. 42 U.S.C. § 1395b-2(a) requires HHS to prepare and distribute to beneficiaries a description of what Medicare covers and does not cover and of the limitations on payment and cost-sharing imposed under the program, while § 1395b-2(b) requires HHS to maintain and publicize the 1-800-MEDICARE toll-free telephone information program. 42 U.S.C. § 1395b-3 requires HHS to establish a beneficiary assistance program to provide outreach to beneficiaries, including information about Medicare, Medicaid and Medicare supplemental policies.

HHS is also obligated under other parts of the Medicare statute to provide specific kinds of information to beneficiaries. 42 U.S.C. § 1395w-21(d), for example, requires HHS to inform beneficiaries regarding options available under the Medicare managed care program, including information with respect to particular plans regarding enrollee satisfaction with plans, disenrollment from plans, health outcomes, and compliance with program requirements.<sup>182</sup> HHS

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<sup>181</sup> See Bruccoleri, *supra* note 178.

<sup>182</sup> 42 U.S.C. § 1395w-21(d)(4)(D).

will also be required to provide beneficiaries with information regarding plans and benefits available under the Part D prescription drug program.<sup>183</sup> Finally, Medicare administrative contractors have an independent statutory obligation to educate and assist Medicare beneficiaries.<sup>184</sup>

Though it is difficult to avoid the impression that HHS and CMS have been quite reticent in recent years in attacking most aspects of the problem of racial and ethnic disparities in Medicare, they have quite enthusiastically embraced beneficiary education and outreach efforts. Indeed, beneficiary outreach and education efforts seem to be the almost exclusive focus of recent HHS and CMS efforts to address racial and ethnic disparities. This is illustrated by the HHS Strategic plan, which under Objective 3.4, “Eliminate racial and ethnic health disparities” lists five proposals as to “How We Will Accomplish Our Goals,” three of which are aimed at beneficiary education.<sup>185</sup> It is also wholly consistent with the focus of the current administration on consumer empowerment.

It would be a serious mistake to believe that beneficiary outreach and education is a completely adequate and sufficient response to the problem of racial and ethnic disparities. The problem has too many causes, discussed above, for this to be true. More specifically, it would

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<sup>183</sup> 42 U.S.C. § 1395w-101(c)

<sup>184</sup> 42 U.S.C. § 1395kk-1(a)(4)(c).

<sup>185</sup> HHS, *supra* note 20, at 12. One of the other two is aimed at provider education and technical assistance, the other at research.

also be a mistake to assume that the only problem that minority beneficiaries face in being able to fully utilize otherwise available Medicare services is ignorance of their availability. Interventions must also address the problem of mistrust of health care professionals and institutions, and indeed of health care itself. Nevertheless, the absence of knowledge about the availability of Medicare services is certainly one barrier that impedes the full use by minority beneficiaries of beneficiary services. Efforts, therefore, to educate racial and ethnic minority beneficiaries to be more intelligent and knowledgeable consumers of Medicare services should certainly be encouraged. To the extent that education and outreach programs also increase the trust that minority Medicare beneficiaries place in Medicare, Medicare professionals and providers, and Medicare services, or the assertiveness with which minority beneficiaries seek out Medicare services, these programs will be even more valuable.

CMS has a number of beneficiary outreach and education projects underway to address racial and ethnic disparities. Some of these programs are directed out of CMS's own Office of Beneficiary Choices, other projects are run out of the CMS regional offices, still others are operated by Medicare contractors or by states or community groups with assistance from CMS. CMS's most ambitious education and outreach program is operated through the QIOs, and is overseen by the CMS's Office of Clinical Standards and Quality. CMS also cooperates in minority education and outreach efforts directed by other parts of HHS, such as the CDC's Racial and Ethnic Approaches to Community Health (REACH 2010) program,<sup>186</sup> CDC's Racial and

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<sup>186</sup> See <http://www.cdc.gov/reach2010>. It is interesting that the REACH 2010 website

Ethnic Adult Disparities in Immunization Initiative (READII),<sup>187</sup> the HHS Closing the Gap Campaign, the HHS Celebra La Vida Con Salud initiative, the various programs and initiatives of the HHS Office of Minority Health, and the general HHS Healthy People 2010 initiative.<sup>188</sup>

CMS has also undertaken several beneficiary education programs on its own. First, CMS has attempted to address language barriers by making its primary informational vehicles available in languages other than just English. The *Medicare & You* handbook is now available in Spanish as well as English, Spanish language service advisors are available at 1-800-MEDICARE (which also has available advisors who speak other languages), and [www.Medicare.gov](http://www.Medicare.gov) has information available in Spanish and Chinese as well as English.

Second, CMS sponsors or funds outreach projects specifically aimed at minority beneficiaries. Through CMS's own REACH project (Regional Education About Choices in Health), CMS regional offices partner with local groups to reach specific minority groups. CMS also funds the SHIP (State Health Insurance Assistance Program), which provides local in person or phone counseling to individuals about Medicare issues and group outreach and education projects, largely through local volunteers.<sup>189</sup> CMS has developed Spanish and cultural competency training materials for SHIP's, and funded special outreach programs to minorities.

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does not list CMS as a collaborator in the project, though it does list most of the other HHS divisions.

<sup>187</sup> See <http://www.cdc.gov/nip/specint/readii/#solution>.

<sup>188</sup> See <http://www.healthypeople.gov> (visited March 2, 2005).

<sup>189</sup> 42 U.S.C. § 1395b-4.

It has advertised Medicare services in ethnic and non-English newspapers, and worked with faith-based organizations.

Third, CMS engages in beneficiary outreach and education through the QIO program. CMS's QIO disparity initiatives were described briefly earlier in this paper. Though some QIO projects focus on provider education or monitoring, most are primarily focused on beneficiary outreach. Most of these projects are directed toward reducing disparities in the use of preventive care, including diabetes screening and prevention, mammography screening, and flu and pneumococcal vaccines. Most QIO projects aimed at racial and ethnic minorities are also aimed at African-American beneficiaries.

Finally, several CMS projects have a special emphasis on educating and assisting minority beneficiaries. The Cancer Prevention and Treatment Demonstration Project for Ethnic and Racial Minorities, funded by BIPA 2000 and described above, is the most generously funded single CMS project focused on racial and ethnic disparities and will probably also include a significant outreach and education component as its demonstration projects get underway. CMS's recently implemented Chronic Care Improvement Program, which works directly with beneficiaries with chronic illnesses to help them manage their own illnesses and adhere to their care plans, has also focused heavily on minority communities.<sup>190</sup>

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<sup>190</sup> See HHS Announces Awards to Improve Quality of Care for Medicare Beneficiaries with Chronic Illnesses (Dec. 8, 2004) available at <http://www.cms.hhs.gov/medicarereform/ccip/ccippr.pdf>.

While CMS is to be commended for all of the initiatives that it has underway for reaching out to minority beneficiaries, it could do more. Given the broad statutory authority that CMS has for conducting beneficiary education and outreach, its activities are constrained only by the limits of its imagination and resources. CMS should receive continued encouragement, therefore, to expand its outreach and education efforts.

- First, CMS should take full advantage of its HORIZON (Health Outreach Initiative Zeroing in on Needs) project.<sup>191</sup> The HORIZON project has generated four racial and ethnic group specific CDs with a wealth of information as to how to communicate effectively with these groups. This material needs to be used extensively by CMS and its contractors for beneficiary educational outreach efforts.
- Second, CMS should expand its minority beneficiary information projects beyond coverage of screening and immunization services. CMS educational interventions to date (for example through the QIOs) have focused heavily on screening and immunization, yet disparities in diagnostic and treatment services should also be addressed.
- Third, CMS should review the adequacy of the State Health Insurance Programs (SHIPs) for outreach, and not depend solely on this largely volunteer project. CMS has depended heavily on the SHIPs for outreach to minority beneficiaries. These programs vary in quality and focus, but have not consistently focused on the informational needs of

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<sup>191</sup> See HORIZONS Communication Toolkit,  
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minorities, or fully met these needs.<sup>192</sup>

- Fourth, CMS needs to do still more to expand language accessibility. Most of the materials explaining the Medicare program are still only available in English, or, in some cases, English and Spanish.

## VIII CONCLUSION: LOCAL SOLUTIONS TO NATIONAL PROBLEMS

### NATIONAL SOLUTIONS TO LOCAL PROBLEMS

CMS and HHS can do a great deal to address the problem of racial and ethnic disparities, even in the absence of further legislative authority. The problem is complex, however, and a wide range of solutions are necessary to address it. On the one hand, the problem is highly localized—disparities result from the attitudes and behavior of particular professionals or beneficiaries. On the other hand, it is clearly a national problem, as are particular causes of it, such as the inadequacy of Medicaid payment rates. Solutions must be appropriate, therefore, to both the localized and national character of the problem.

There is no necessary correlation between the level at which the problem exists and the level at which it can be addressed, however. National solutions, such as more aggressive

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<http://www.cms.hhs.gov/partnerships/tools/materials/horizons/default.asp?>

<sup>192</sup> See Gary Gaumer and Holly Korda, *Special Populations and Their Use of Medicare Information: Program Monitoring of Customer Service and Information Projects*, Final Project Report, 69 (2003), [www.cms.hhs.gov/researchers/projects/consumers/5SP\\_fullrpt.pdf](http://www.cms.hhs.gov/researchers/projects/consumers/5SP_fullrpt.pdf).

enforcement of the Title VI or provision of language-appropriate Medicare information resources, may address local problems of provider discrimination or beneficiary lack of information. Local solutions, such as QIO interventions, can demonstrate models for addressing, the larger national problem of disparities.

In the end, what is needed is first and foremost a commitment by CMS and HHS to make reducing or eliminating racial and ethnic disparities a high priority. Once they embrace this goal, CMS and HHS must establish a broad, evolving, and unfolding set of solutions to address the problem at all levels and throughout the Medicare program. Then, and only then, can we hope that the problem of racial and ethnic disparities in Medicare will be overcome.

**RACIAL AND ETHNIC DISPARITIES IN MEDICARE:  
WHAT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND THE  
CENTERS FOR MEDICARE AND MEDICAID SERVICES CAN, AND SHOULD, DO**

**Major Recommendations**

I CMS should make addressing racial and ethnic disparities a top priority.

- CMS should identify the elimination of racial and ethnic disparities as a priority in its GPRA annual performance plan.
- CMS should establish an Office of Minority Health directly under the Administrator to address disparity issues with a budget commensurate to its responsibilities.
- All senior executive service (SES) staff within CMS, and in particular the directors of the Center for Beneficiary Choices, the Center for Medicare Management, the Office of Clinical Standards and Quality, and the Office of Research Development and Administration and the Regional Administrators should be directed to address racial and ethnic disparity issues relevant to their areas of authority.
- CMS should include a Racial and Ethnic Disparities Impact Statement with each of the regulations it publishes for the Medicare program to assure that it considers how its regulatory actions might affect (and might be used to meliorate) racial and ethnic disparities.

II. CMS should take steps to limit the financial barriers that minorities face in gaining access to Medicare services.

- CMS should work aggressively to assure that minority Medicare beneficiaries receive all

Medicaid benefits to which they are entitled.

- CMS must assure that state Medicaid programs have adequate providers available to meet the needs of Medicaid-dependent minority beneficiaries.
- CMS should ensure that all racial and ethnic minority beneficiaries have access to Medicare Advantage plans.
- CMS should make sure that racial and ethnic minority beneficiaries, and in particular poor minority beneficiaries, have access to Medicare Part D prescription drug plans and to the subsidies available under Part D.

III. Medicare must take steps to decrease or eliminate logistical, organizational, systemic, and institutional barriers that minorities face in gaining access to care.

- HHS and CMS should do more to help to increase the availability of minority health professionals.
- The HHS Office of Civil Rights should make it clear that Title VI of the Civil Rights act applies to health care practitioners.
- CMS should use incentive programs creatively to increase the number of professionals serving in minority communities.
- HHS should enforce the civil rights laws against professionals and providers who discriminate against minorities
- CMS and HHS should require and assist providers to improve their cultural and linguistic competency. While OCR needs to expand its focus to address other discrimination issues, it also needs to be even more aggressive in assuring that providers in fact comply with linguistic access requirements.

- CMS should ensure that Medicare Advantage (MA) plans fully serve minorities by not limiting their service areas to exclude minorities. It should also scrutinize closely MA marketing, enrollment and disenrollment practices, and provider networks to make sure that MA plans are not discouraging minority enrollment. CMS should use the quality assessment and performance improvement (QAPI) program to encourage MA plans to serve underserved minorities, and use its Consumer Assessment of Health Plans (CAHPS) data to assess plan performance with respect to addressing racial and ethnic disparities. CMS must take care in implementing MA special needs plans to ensure that they do not become ghettos for dual-eligibles.
- CMS should encourage accreditation agencies to require compliance with its culturally and linguistically appropriate services (CLAS) standards
- CMS must also continue to approach minority access to health care as a quality issue, though its Quality Improvement Organization (QIO) program.
- The HHS Office of Inspector General should require civil rights compliance in all of its compliance guidance.
- CMS should take additional steps to decrease institutional barriers to care, including keeping better data on minority access to care, funding research on minority access issues, using minority contractors where possible, and using pay for performance to increase minority access.

IV. CMS should address professional attitudes and behaviors that result in underservice to minorities.

- CMS should continue to use the QIO program to improve professional care for

minorities.

- Medicare Advantage plans should encourage professionals to be more sensitive to the needs of minorities.
- Local coverage determinations (LCDs) or other claim screens should be used to attempt to change professional behavior;.
- CMS should require Medicare contractors to educate providers as to racial and ethnic disparity issues.
- The regional offices should continue to educate and inform professionals as to racial and ethnic disparity issues.
- CMS should use Medicare medical education subsidies to try to increase attention to issues of racial and ethnic disparities in medical education

V. CMS should continue to improve beneficiary education and outreach to make sure that minority beneficiaries understand and use the services available to them.

- CMS should continue to participate in HHS outreach programs, as well as to provide its own outreach programs through the Center for Beneficiary Choices and regional offices.
- CMS should take full advantage of the materials developed through its HORIZON (Health Outreach Initiative Zeroing in on Needs) project.
- CMS should expand its minority beneficiary information projects beyond coverage of screening and immunization services.
- CMS should review the adequacy of the State Health Insurance Programs (SHIPs) for outreach, and not depend solely on this largely volunteer program for outreach to minority beneficiaries.

- CMS needs to do still more to expand language accessibility to Medicare information.

Most of the materials explaining the Medicare program are still only available in English, or, in some cases, English and Spanish.