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Report of the Study Panel on
Medicare and Disparities

Strengthening Medicare's Role in Reducing Racial and Ethnic Health Disparities

October 2006

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The Robert Wood Johnson Foundation provided the primary financial support for this project. Additional funding was provided by The California Endowment and the Joint Center for Political and Economic Studies.

Suggested Citation:
Vladeck, Bruce C., Paul N. Van de Water, and June Eichner (eds.) 2006. *Strengthening Medicare's Role in Reducing Racial and Ethnic Health Disparities.* Washington: National Academy of Social Insurance.

ISBN: 1-884902-47-2

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National Academy of Social Insurance
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Acknowledgments

The National Academy of Social Insurance and the Study Panel on Medicare and Disparities gratefully acknowledge the assistance of a number of individuals for their help on this report. Rose Crum-Johnson served as liaison with the Centers for Medicare & Medicaid Services through July 2005, and Susan McNally thereafter. Anne Weiss of the Robert Wood Johnson Foundation and Ignatius Bau of The California Endowment provided support and encouragement. Responsibility for the report and its recommendations, however, remains with the study panel.

Contents

Summary

Disparities in health care for racial and ethnic minorities and low-income persons pose a pressing national problem. This report of a study panel convened by the National Academy of Social Insurance examines Medicare's role in moving towards a solution. The panel concludes that Medicare is obligated to take the lead in reducing disparities—both for its beneficiaries and throughout the health system—and makes 17 recommendations to those who set policy for and administer the Medicare program.

Disparities are evident in the sources of health care, in the amount and type of care received, and in health outcomes. Hurricane Katrina in 2005 revealed that Louisiana essentially had a two-tier health system—one system for the insured population (including those with Medicare and Medicaid), and another serving a largely poor, minority population. At Charity Hospital, the hub of the health care safety net in New Orleans, nearly three-quarters of the patients were African American, and 85 percent had annual incomes of less than $20,000 (Rudowitz, Rowland, and Shartzer 2006). But not only Louisiana has two health care systems. Nationwide, black patients and white patients are to a large extent treated by different physicians, and the physicians treating black patients report facing greater difficulties in obtaining access to important clinical resources (Bach *et al.* 2004).

Disparities in access to health care and medical treatment have been documented again and again, notably in the Institute of Medicine's 2002 report *Unequal Treatment*. The *2005 National Healthcare Disparities Report* finds that "disparities related to race, ethnicity, and socioeconomic status still pervade the American health care system." Even among Medicare beneficiaries, marked disparities persist in health care, although disparities in the use of health care services by race and income have diminished since Medicare's implementation.

Summary Table
Recommendations of the National Academy of Social Insurance Study Panel on Medicare and Disparities

Quality of Clinical Care

Improve the ability of individual providers and the health care system to provide high-quality care to beneficiaries who are members of underserved racial and ethnic minorities.

1.1 Increase the focus of quality improvement programs on reducing disparities
1.2 Strengthen the capability of providers, medical groups, health care organizations, and the health system to improve quality and reduce disparities.
1.3 Structure incentives for quality in ways that will reduce—not exacerbate—disparities.
1.4 Ensure that beneficiaries have a primary provider of care.

Access to Care

Increase the access of underserved minority beneficiaries to health care by promoting programs that provide supplementary coverage, improving access to providers, and expanding educational and outreach activities.

2.1 Ensure that minority beneficiaries are enrolled in existing programs that supplement Medicare coverage.
2.2 Set deductibles and copayments to encourage the use of services that have the potential of reducing disparities in care.
2.3 Improve access to providers for minority beneficiaries.
2.4 Educate beneficiaries and their families about promoting good health and accessing health care services.

Education of Health Professionals

Educate health professionals to improve the health system's diversity and cultural competence.

3.1 Increase the number of minority providers, medical staff, and medical school faculty.
3.2 Encourage and enhance training in cultural competence for providers.
3.3 Ensure that all types of training promote reductions in disparities.

Capability and Practice of Institutions

Hold individual and institutional providers responsible for reducing racial and ethnic health disparities.

4.1 Collect the data necessary for assessing, monitoring, and targeting disparities.
4.2 Strengthen the role of accreditation organizations in reducing disparities.
4.3 Ensure that all providers comply with the guidelines for services to patients with limited English proficiency and the standards for providing culturally and linguistically appropriate services issued by the Department of Health and Human Services.

Administrative Priorities and Structure

Make the reduction of disparities a top priority and administrative focus at the Centers for Medicare & Medicaid Services (CMS).

5.1 Establish CMS performance goals for the reduction of racial and ethnic disparities among Medicare beneficiaries.
5.2 Enhance the organizational structure of CMS to support the reduction of disparities.
5.3 Address racial and ethnic disparities as a civil rights compliance issue.

Minorities also fall short of whites on many measures of health status. Blacks, for example, have a shorter life expectancy than whites, and blacks are more likely to have many chronic medical conditions. The life expectancy of a black male is 6.3 years less at birth than that of a white male and 2.0 years less at age 65. Former Surgeon General David Satcher has estimated that some 83,000 excess deaths could be prevented each year if the black-white mortality gap could be eliminated (Satcher *et al.* 2005). Thirty percent of black Medicare beneficiaries live with diabetes, compared with 18 percent of white beneficiaries (Westat 2006a). Medicare cannot immediately close a gap in health status caused by a lifetime of disparate care.

Because of its dominant influence over the entire health care sector, Medicare has unique opportunities to, and responsibility for, reducing racial and ethnic health disparities. Along with its ability to improve the care provided to its 9 million minority beneficiaries, Medicare's leverage as the largest purchaser and regulator of health care provides an ability to achieve reductions in disparities. As a social insurance program, Medicare has the responsibility to ensure that all those who have contributed to the program receive appropriate care on a fair and nondiscriminatory basis.

The panel's recommendations fall into five categories:

1. Improving the quality of clinical care,
2. Increasing access to care,
3. Educating health professionals to improve diversity and cultural competence,
4. Holding health care providers responsible for reducing disparities, and
5. Making the reduction of disparities a top administrative priority and focus.

In each of these areas, Medicare has tools that it can use to help reduce disparities. The summary table lists the recommendations, and the panel's report details both the recommendations and their rationale. Some of the recommendations would require legislation, but most could be implemented by the Centers for Medicare & Medicaid Services and the Department of Health and Human Services within their current statutory authority. Most of the recommendations would require additional Medicare spending—especially for program administration—and the panel urges the Congress to appropriate the necessary funds.

Introduction

Medicare makes a vital contribution to reducing disparities in access to medical care among its beneficiaries. Upon reaching age 65, virtually all Americans—rich and poor, minority and white—become eligible for Medicare, and minorities under age 65 constitute a disproportionate share of those who qualify for Medicare on the basis of a long-term disability. All beneficiaries are eligible for the same package of benefits. And the vast majority of health care providers participate in Medicare, which helps ensure that all beneficiaries have access to services. Yet Medicare must do more.

Marked disparities persist in health care among Medicare beneficiaries, although disparities in the use of health care services by race and income have diminished since the program's implementation (Williams 2004; Long and Settle 1984). The 2002 Institute of Medicine (IOM) report *Unequal Treatment* found sizable racial and ethnic disparities in health care usage and outcomes among Medicare beneficiaries, even after adjusting for socioeconomic differences and other health care access-related factors (IOM 2002). Minority beneficiaries also fall short of whites on many measures of health status. Blacks, for example, have a shorter life expectancy at age 65 than whites, and black beneficiaries are more likely than whites to have chronic conditions, such as hypertension or diabetes (Westat 2006a). Although many outcomes (such as life expectancy at age 65) have improved for minority beneficiaries in recent years, the same outcomes have also improved for whites, so that the relative disparity has actually increased.

Medicare can and should be a leader in reducing racial and ethnic health disparities. Along with its ability to improve the care provided to its 9 million minority beneficiaries, Medicare influences the rest of the health care system. Its leverage as the largest U.S. purchaser and regulator of health care offers a unique opportunity to reduce disparities. As a purchaser, Medicare provides health coverage to 43 million aged and disabled people, of whom one in five is non-white or Hispanic. Its reimbursement and coverage policies are widely imitated. Many private insurers follow Medicare approval for coverage of new medical technologies. Medicare has also been instrumental in moving the health care system toward prospective payment systems and electronic payments.

In its regulatory role, Medicare influences the safety and quality of care, directly through its conditions of participation for most institutional providers and indirectly through influencing the standards of private accrediting organizations. To implement the quality improvement requirements of the Balanced Budget Act of 1997, Medicare strengthened its standards for managed care plans (MedPac 2002). In the fee-for-service sector, Medicare relies less heavily on regulatory requirements, focusing instead on voluntary educational and feedback efforts and claims review, but the results there have been notable as well (Jencks, Huff, and Cuerdon 2003).

Study Panel's Charge

The National Academy of Social Insurance's Study Panel on Medicare and Markets found significant racial, ethnic, and income-related disparities in preventive care, primary care, and essential medical and surgical treatments for Medicare beneficiaries and called for immediate remedial actions (King and Schlesinger 2003). In response to that charge, the academy convened this Study Panel on Medicare and Disparities to determine how Medicare might help to reduce disparities—both for its beneficiaries and throughout the health care system. The panel is a diverse group that includes academics, consultants, health plan administrators, and executives of health care companies and provider associations or alliances. As part of its work, the panel reviewed the existing literature on disparities and commissioned five new research papers.

The members of the study panel have concluded that Medicare is obligated to take the lead in reducing disparities. As a social insurance program, Medicare has a duty to ensure that all beneficiaries who have contributed payroll taxes and paid premiums—regardless of their race or ethnicity—receive appropriate care. As a federal program, Medicare is required to give effect to civil rights laws by ensuring that all beneficiaries have equal access to health care of equally high quality. These issues will become even more important in the future, as the proportion of minorities among the elderly population and among Medicare beneficiaries continues to increase. Today, minorities (non-whites and Hispanics) account for 17 percent of the U.S. population age 65 and over. By 2050, that proportion will grow to 39 percent (Federal Interagency Forum 2004).

Overview of Health Disparities

Health disparities among racial and ethnic groups are long-standing. Exactly a century ago, W.E.B. Du Bois published *The Health and Physique of the Negro American*, in which he and his colleagues documented the above average rates of disease and mortality among African Americans. Du Bois correctly attributed these disparities to blacks' low socioeconomic status and lack of access to quality health care, or what he called the "conditions of life" (Du Bois 1906).

Since then, disparities in treatment and access to care have been documented again and again (Gornick 2000; IOM 2002; AHRQ 2005). Recent studies find that health care for racial and ethnic minorities continues to lag behind, even for Medicare beneficiaries. One study examining the gap between black and white Medicare fee-for-service beneficiaries in the use of nine high-cost surgical procedures found that the differences increased significantly between 1992 and 2001 for five of the nine procedures, remained unchanged for three procedures, while narrowing significantly for one procedure (Jha 2005). Another, analyzing

Health Plan Employer Data and Information Set (HEDIS) measures for Medicare managed care enrollees, concluded that from 1997 to 2003 the gap between whites and blacks was narrowed for seven of nine measures but did not disappear entirely in any category and widened for two: glucose control among diabetics and cholesterol control among heart patients (Trivedi *et al*. 2005).

Health disparities have many causes. In addition to disparate medical treatment, access to care is a contributory factor. Medicare's lack of comprehensive coverage is a major source of health disparities, as minority beneficiaries are less likely to be able to afford uncovered medical costs or to have private supplementary insurance (Census 2006). They are more likely, however, to qualify for public means-tested programs (such as Medicaid and the Medicare Savings Programs), though numerous barriers impede their enrollment (Ebeler, Van de Water, and Demchak 2006). Minority beneficiaries may have difficulty accessing health providers because of provider shortages in areas in which they live. Also, minorities and whites receive care at different health care sites, and in some cases the quality of care may not be comparable.

Other significant factors outside of Medicare's realm have been shown to contribute to health disparities (Kawachi, Kennedy, and Wilkinson 1999; Adler *et al.* 2000). Lower levels of income and education are highly correlated with health status. Substandard housing, poor nutrition, physical inactivity, and smoking all have long-term impacts on health. So does inadequate access to health care prior to Medicare eligibility. Nonetheless, racial and economic disparities remain even after taking account of differences in socioeconomic factors and access to health care (IOM 2002).

Medicare's Efforts to Reduce Disparities

Medicare reduced disparities from its very beginning, when it required hospitals to desegregate even before it began paying benefits. In 1965, most hospitals across the country were segregated—*de jure* in much of the South, *de facto* in the rest of the country. Black physicians were not granted privileges in "white" hospitals, and black patients were not admitted to many hospitals or were segregated by floor or room. The Hill-Burton Act provided federal funds for the construction of racially separate hospitals. In 1966, as a condition of participation for Medicare—to become eligible for Medicare reimbursement—hospitals were required to desegregate. Though they met with some resistance, federal officials were steadfast in requiring hospitals to comply with the Civil Rights Act. More than 1,000 hospitals integrated their medical staffs, waiting rooms, and hospital floors in a period of less than four months (Smith 1999).

Some of Medicare's more recent efforts are also worthy of note. Today, Medicare is administered by the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). CMS has made great strides in improving the availability and accuracy of racial and ethnic data, and these data have been instrumental in documenting disparities. Since 1999, Medicare's Quality Improvement Organizations have undertaken a number of initiatives specifically aimed at reducing racial and ethnic disparities. Under its new Quality Improvement Roadmap, CMS has established a disparities workgroup that reports to the agency's Quality Council for the purpose of coordinating agency plans to address disparities. Though these and other efforts by CMS are steps in the right direction, a strengthened, multi-pronged strategy will be necessary for Medicare to realize its full potential in reducing racial and ethnic health disparities.

Choice of Terminology

The word "*minority*," though commonly used, is not an ideal term because it oversimplifies America's complex demographic picture. In some areas, no single racial or ethnic group constitutes a majority of the population. Some groups that are a numerical minority are neither underserved by the health care system nor underrepresented among health care providers.

Furthermore, there is substantial heterogeneity within racial and ethnic groups. For example, "Asian" includes persons from countries such as Japan, China, Vietnam, Philippines, and Indonesia; "Hispanic" includes persons from Puerto Rico, Mexico, Cuba, and Central America; and "black" includes persons whose ancestors came from Africa to the United States prior to the Civil War, as well as persons who arrived recently from Africa, the Caribbean, or other countries. Strategies to reduce disparities must be cognizant of the cultural, educational, and other differences among persons within each of these larger groups.

The advantage of using the term "minority," however, is that it is commonly interpreted as encompassing racial or ethnic groups other than non-Hispanic whites—blacks, Asian Americans, Native Hawaiians and Other Pacific Islanders, American Indians and Alaska Natives, and Hispanics. The annual *National Healthcare Disparities Report*, published by the Agency for Healthcare Research and Quality, reports data for these groups and describes them collectively as "racial and ethnic minorities" (AHRQ 2005).

Instead of "minority," the study panel considered using the term "historically underserved groups" or, in the context of medical students and providers, "historically underrepresented groups." Although these alternatives might be more accurate, they are unwieldy and unfamiliar. The report therefore uses the traditional term “minority,” although the panel’s focus is on minority groups or subgroups that experience the poorest health care or health outcomes.

Consistent with *Healthy People 2010* and the *National Healthcare Disparities Report*, the study panel defines “*disparities*” as any differences among populations in health and health care. At issue, however, is whether Medicare should attempt to assure equal health outcomes as well as equal health care. Medicare’s charge is primarily as a payer of clinical care, although increasingly Medicare is being assessed on the quality of care that it provides, and many of the factors that influence health outcomes are outside of Medicare’s scope. This report therefore focuses primarily on what Medicare can affect directly—the provision of health care—though health status should not be ignored, as it allows for targeting particular health conditions, assessing the effectiveness of treatment, and modifying programs accordingly.

The Panel’s Vision

The study panel’s vision is that all Medicare beneficiaries, including racial and ethnic minorities, will have:

- Equitable access to high quality health care,
- Providers with whom they can communicate effectively and who can communicate effectively with them,
- Providers who understand how beneficiaries’ culture affects their health and health care and who incorporate this understanding into their treatment of patients, and
- Health care that is responsive and tailored to their individual needs.

Our analyses and recommendations are grouped under five headings:

- Quality of clinical care,
- Access to care,
- Education of health professionals,
- Capability and practice of institutions, and
- Administrative priorities and structure.

In each of these areas, Medicare has tools that it can use to help reduce disparities. The report's recommendations are addressed to those who set policy for and administer the Medicare program. Some of the recommendations would require legislation, but most could be implemented by CMS and HHS within their current statutory authority. Most of the recommendations would require additional Medicare spending—especially for program administration—and the panel urges the Congress to appropriate the necessary funds.

Chapter 1:
Quality of Clinical Care

Efforts to reduce health disparities frequently concentrate on improving the quality of care, since the gap between actual and optimal quality is often the greatest for minorities. Nonetheless, the belief that improving the overall quality of care will reduce disparities remains a promising but largely untested hypothesis. To reduce disparities, quality for minorities must increase proportionately more than the average. Targeted efforts will likely be necessary to overcome the special barriers to improving the quality of care for minority beneficiaries.

Factors Affecting Disparities in Quality of Care

Disparities in the quality of clinical care received by Medicare beneficiaries arise from several sources. These include limitations in access to care, cultural and linguistic barriers, attitudes and behaviors of beneficiaries, and attitudes and behaviors of providers. Working papers prepared for the study panel by Ellen O'Brien and Timothy Stoltzfus Jost discuss the sources of disparities, and the CMS role in reducing them, in greater detail (O'Brien 2005; Jost 2005). These papers are available on the National Academy of Social Insurance's website.

Access to Care

Access to care is a critical determinant of quality. Access depends importantly on financial factors, such as insurance coverage and the ability to pay cost-sharing amounts. But it also depends on the number of providers in a community, the resources available to them, their office hours, the availability of transportation, and the absence of other institutional barriers. Medicare beneficiaries who are members of a racial or ethnic minority tend to receive care from different providers than do whites. These providers are more likely to be non-white than those who serve whites, though most minorities receive care from white providers. Providers who care for minorities are more likely to practice in public or teaching hospitals and in low-income areas, and many experience difficulties referring patients to specialists and to high-quality, high volume facilities and providers (Bach *et al.* 2004). Whether or a not a beneficiary has a primary care provider also influences access to care, and minority beneficiaries are less likely than whites to have a primary care provider. Access to care is addressed further in Chapter 2.

Cultural and Linguistic Barriers

Cultural and linguistic differences between providers and patients also contribute to disparities in quality of care. Providers whose cultural or socioeconomic background differs from a patient's may be less able to comprehend the patient's point of view or non-compliance with a provider's instructions. For patients with limited English proficiency, providers often lack adequate interpretive services, leaving beneficiaries to depend on the provider's employees, family members, or other patients who have no training in medical interpretation. Also, forms and explanatory materials may not be available in languages other than English.

Skepticism of the medical system may influence the relationship between the provider and patient. For example, blacks are more likely than whites to be mistrustful of medical care as a result of negative interactions with the health care system (Boulware *et al*. 2003; Brandon, Isaac, and LaViest 2005). Such mistrust may contribute to refusal of invasive procedures, non-compliance with a physician's instructions, or avoidance of the health care system.

Beneficiary Attitudes and Behaviors

The attitudes, knowledge, and behavior of beneficiaries may also contribute to racial and ethnic disparities. Minority beneficiaries are more likely to be uninsured before becoming eligible for Medicare and therefore more likely to lack established connections with the health care system and experience in finding and using health care services. In particular, they may be unaware of the preventive benefits available through Medicare and not know how to gain access to them (Jost 2005).

Because people differ in health status, parity in process measures (such as visits to providers or procedures performed) may not ensure parity in health outcomes. For example, smoking, drinking, poor diet, and lack of exercise all affect outcomes, and such behaviors are more prevalent among certain racial and ethnic groups (Westat 2006a; Ogden *et al.* 2006; Grant *et al.* 2006). Faced with a variety of social and economic challenges, some members of minority groups may require more extensive medical interventions in order to achieve comparable health outcomes. Time pressures on physicians exacerbate the problem, since cultural and language barriers increase the amount of time needed to make an accurate diagnosis and communicate effectively with patients (IOM 2002).

Provider Attitudes and Behaviors

Professional attitudes and behavior are another source of health disparities among Medicare beneficiaries. One frequently cited study finds, for example, that the race and sex of a patient influence physicians' recommendations for managing chest pain (Schulman *et al.* 1999). "There is ample, though not always uncontroverted, evidence," concludes Jost, "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" (Jost 2005).

Racial bias has been a major focus of the disparities literature, although the extent of its contribution to disparities is debated. Some studies have found that physicians perceive black patients less positively than white patients: they believe black patients to be less intelligent, feel less affiliation toward them, and hold negative beliefs about their likelihood of adhering to medical advice. Such biases and stereotypes may influence providers' diagnostic and treatment decisions and result in minorities receiving less care and achieving poorer outcomes than whites (IOM 2002).

Improving Physician Practice

Efforts to reduce disparities by improving the quality of care have generally focused on changing the way physicians practice medicine. It is usually assumed that quality of care is the result an individual patient-physician encounter and the personal characteristics that the patient and physician bring to the encounter. As Lawrence Casalino explains in a working paper prepared for the study panel, the U.S. medical system has traditionally relied on a patient deciding to visit a provider and on the physician doing whatever he or she thinks appropriate for the patient during a brief encounter in which multiple issues are addressed (Casalino 2005).

In its focus on the physician-patient encounter, *Unequal Treatment* considers at length the ways in which uncertainty in diagnosis and treatment can interact with the stereotyping of patients to lead to disparities in care. The report's primary recommendation relating to clinical care is to promote the quality and consistency of care through using evidence-based guidelines (IOM 2002). Adoption of guidelines among physicians, however, has been slow and difficult. Also, many beneficiaries have multiple chronic conditions (Westat 2006a), and few guidelines exist for the management of two or more coexisting conditions (Casalino 2005).

Improving Organizational Structures

Just as important as the physician's role in quality of care is the organizational structure of medical practice and the health care system. The Institute of Medicine's 2001 report *Crossing the Quality Chasm* found that physicians cannot be expected to do better unless the care system and care processes are redesigned to support a higher level of quality. Though capable physicians who feel accountable for patients' care are needed, quality also depends on organized processes, information technology, and infrastructure available to assist physicians and patients (IOM 2001; Casalino 2005).

Several avenues are available for improving the organizational structure within which physicians practice. First, physicians' office staff greatly affects quality of care and health disparities, though the training and processes for office staff is often ignored. Second, medical practices differ in the adoption of information technology, with few practices using computerized medical records and computer-based clinical decision support systems. Third, coordination of medical care and social supports is inadequate, as patients' multiple providers lack knowledge of the others' treatment plans, and many beneficiaries lack an ongoing relationship with a primary care provider. Fourth, no provisions are made for those who have not contacted the medical system.

The Centers for Medicare & Medicaid Services is undertaking research and demonstration projects that aim to improve the ability of providers, health plans, and the health system to provide quality care. Its projects include performance payments to hospitals, chronic care improvement, and other disease management initiatives. CMS also supports Quality Improvement Organizations (QIOs) in their provision of technical support to hospitals, physicians, and home health agencies. Under their current statement of work, which runs through 2008, QIOs will assist providers in measuring and reporting quality, using electronic clinical information to provide more effective care, and transforming organizational cultures to accelerate and broaden the impact of quality improvement (CMS 2005). In one of their assigned tasks, the QIOs are working to expand breast cancer screening, adult immunization, and diabetes care among underserved minorities. In another, they are helping educate some primary-care providers in the delivery of culturally and linguistically appropriate services.

Though most of CMS' quality-of-care projects are not focused on racial and ethnic minorities, the agency is supporting demonstration projects to improve the early detection and treatment of cancer among minority beneficiaries, as required by section 122 of the Benefits Improvement and Protection Act of 2000. Fostering the delivery of culturally and ethnically appropriate care is one goal of the Medicare health care quality demonstration, established by section 646 of the Medicare Modernization Act of 2003.

Improving Incentives

Giving providers incentives to improve quality has become a recent focus of the health policy community. Because most current payment arrangements offer no reward for providing high quality care and no sanction for poor quality care, many believe that providers would take measures to improve quality if they had an incentive to do so. Proposed incentives include direct financial rewards (for example, bonuses or higher fees), public reporting of quality measures, sanctions, reduced administrative requirements, and technical assistance for quality improvement.

How incentives for quality may affect health disparities has received little thought, however. Some incentives—particularly pay-for-performance—may have unintended negative effects. For example, incentives based on specific process measures may prompt providers to focus on these measures but pay less attention to those processes not being measured, even though they may be as important to quality care (Vladeck 2003). Incentives may also influence providers to avoid patients they believe are likely to lower their overall quality scores. In New York State, for example, reporting cardiac surgeons' quality scores contributed to an increase in the black/white disparity for cardiac surgery rates. Though efforts were made to risk adjust these quality scores, physicians may have believed that the risk-adjustment techniques failed to account adequately for the obstacles confronting the provision of optimal care (Werner and Asch 2005).

Incentives for providers may also widen the quality and income gap among physicians by penalizing providers who treat large numbers of disadvantaged minorities while rewarding providers with predominantly white patients. Groups of physicians who treat more affluent patients may be able to achieve higher quality scores because they have more resources to invest in training or infrastructure. A study of early experience with pay-for-performance in California found that physician groups with the highest initial performance improved the least but received the largest share of the performance payments (Rosenthal *et al.* 2005). The use of public reporting as an incentive or sanction could also widen disparities, as minority beneficiaries may be less able to access publicly reported quality measures or to switch providers.

Improving Cultural Competence

Cultural competence describes the ability of systems and providers to care for patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. Improving cultural competence has the potential to improve health outcomes, reduce disparities, increase the efficiency of clinical and support staff, and result in greater client satisfaction with services. To attain cultural competence, health care providers must become aware of the impacts of social and cultural factors on health beliefs and behaviors, be equipped with the tools and skills to manage these factors appropriately through training and education, and empower their patients to be active partners in the medical encounter (Betancourt, Green, and Carillo 2002). (Chapter 3 recommends strategies for educating providers to be culturally competent.)

CMS and HHS have issued regulations to improve providers' cultural competence, with most directed toward health plans and hospitals. Medicare Advantage plans are required to provide services in a culturally competent manner to all enrollees (42 CFR 112(a)(8)). In 2003, the plans were required to implement a Quality Assessment and Performance Improvement (QAPI) project, with the choice of reducing a clinical health disparity or enhancing their ability to provide culturally and linguistically appropriate services. CMS still maintains the QAPI program and requires reporting by plans, but it no longer mandates the type of projects the plans must undertake. Health plans and hospitals are also required to abide by guidelines for assisting patients with limited English proficiency. (See Chapter 4.)

Recommendations

Improve the ability of individual providers and the health care system to provide high-quality care to beneficiaries who are members of underserved racial and ethnic minorities.

1.1. Increase the focus of quality improvement programs on reducing disparities.

Quality efforts must be directed to the special characteristics and needs of minority beneficiaries. It cannot be assumed that improving quality overall will necessarily reduce disparities. To reduce disparities, the quality of care for disadvantaged racial and ethnic minorities must be a special focus of quality improvement efforts. Efforts should therefore be aimed at those conditions, procedures, or services that would most benefit minority beneficiaries. For example, efforts could focus on increasing utilization of preventive services and addressing chronic conditions that are most prevalent among specific minority groups.

Though CMS has undertaken a number of initiatives that seek to identify ways to improve quality, it should require all of its initiatives to monitor their impact on racial and ethnic health disparities. The Quality Assessment and Performance Improvement program for Medicare Advantage plans and the Quality Improvement Organizations should focus a significant portion of their activities on reducing racial and ethnic disparities.

1.2. Strengthen the capability of providers, medical groups, health care organizations, and the health system to improve quality and reduce disparities.

All levels of the health care system need to be strengthened in their ability to provide quality care. Initiatives should incorporate both the "individual physician" and "organizational" views of quality improvement, since the provision of quality care depends on both the clinical encounter and systemic processes.

Organized care management processes can do much to improve the capability of providers and should be encouraged. These may include providing reminders to physicians at the point of care, enhancing communication between providers and patients, and implementing information technology, including decision making support, electronic medical records, and electronic prescribing. The use of evidence-based guidelines should be promoted. Care coordination, self-care education for patients, and reminders for preventive health visits would also do much to improve medical effectiveness.

Providers should receive feedback to help them monitor the quality of their performance. All data systems should include information on race and ethnicity. Quality of care data should be compiled at the smallest feasible provider unit. (See Chapter 4.)

1.3. Structure incentives for quality in ways that will reduce—not exacerbate—disparities.

Incentives for improving the quality of health care may have unintended effects that adversely affect minority beneficiaries. Incentives may influence providers to avoid minority patients if they believe such patients will lower their quality scores and may reduce the resources available to providers who serve large numbers of disadvantaged minorities. Efforts to assess providers' quality of care should therefore account for differences in the populations they serve, including differences in race, ethnicity, and socioeconomic status. Measures of quality based on health care processes, as well as measures based on health outcomes, require adjustment for differences in the patient population. Incentives should be provided for improvements in quality as well as for the absolute level of quality.

1.4. Ensure that beneficiaries have a primary provider of care.

Despite several decades of policy efforts, the American health care system still suffers from an aggregate shortage of primary care providers. This shortage has particular consequences for older Americans, especially older minorities. Because minority beneficiaries are less likely to have a primary provider of care, efforts should be made to ensure that they do. All Medicare Advantage plans, including the new preferred provider organization plans, should assure that their members have a primary provider of care. CMS should also develop innovative ways to assure that beneficiaries in traditional Medicare have a primary provider of care with well-defined expectations for that role.

Chapter 2: Access to Care

Disparate access to care plays a major role in the creation of health disparities. Because minority beneficiaries are disproportionately uninsured before securing Medicare coverage, they may lack established connections with providers and experience using the health care system. They may have more difficulty accessing care because fewer providers are located in areas in which they live. Health care costs not covered by Medicare are another barrier to care. Minorities may also be less apt to receive and use information from Medicare and other state and federal programs.

Expanding Financial Access

Medicare provides invaluable access to health care, but beneficiaries may still face financial barriers. Medicare does not cover certain services, can require significant cost sharing, and has no limit on out-of-pocket spending. Not only are minority beneficiaries less likely than whites to be able to afford Medicare's uncovered costs, they are less likely to have employer-sponsored insurance or individual Medigap policies to pay these costs.

A number of federal programs are available to help cover these costs, and minorities are more likely than whites to qualify for such coverage. These programs include Medicaid, the Medicare Savings Programs (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual programs), and the Medicare low-income prescription drug subsidy. However, a number of obstacles prevent many eligible individuals from enrolling, including a lack of information about how to enroll, complicated enrollment forms, asset tests, and a shortage of one-on-one assistance. The National Academy of Social Insurance's Study Panel on Medicare/Medicaid Dual Eligibles has recently presented several approaches for increasing enrollment in the Medicare Savings Programs and the low-income drug subsidy (Ebeler, Van de Water, and Demchak 2006).

CMS has undertaken initiatives to educate and provide beneficiaries with information about Medicare and programs that provide supplemental benefits. It has made efforts to incorporate culturally and linguistically appropriate information. It funds the State Health Insurance Assistance Programs (SHIPs), a Medicare information website, a 1-800-MEDICARE call line in English and Spanish, a language interpretation line in more than 160 languages, the *Medicare and You* handbook in Spanish as well as English, and literature in several other languages. Its HORIZONS (Health Outreach Initiative Zeroing In On Needs) program is designed to improve the effectiveness of communications to minority groups and has developed Communications Toolkits for Servicing Diverse Communities. Its REACH (Regional Education About Choices in Health) initiative supports CMS regional offices' work with local partners (O'Brien 2005). As part of its efforts to promote enrollment in the Medicare prescription drug benefit and low-income subsidy, CMS has conducted targeted outreach to minority beneficiaries and has worked with a wide range of local and national partner organizations.

Nonetheless, CMS could do more to develop culturally appropriate outreach and educational activities. Most SHIPs target a mainstream audience and are not effective at reaching populations separated from the mainstream by linguistic, educational, and cultural barriers. The language interpretation line at 1-800-MEDICARE is not fully implemented or actively publicized. There has also been little systematic testing of the effectiveness of specific messages and channels in reaching beneficiary groups (O'Brien 2005).

Increasing Access to Providers

Access to care is also limited by the geographic structure of the health care system. Largely because of residential patterns, members of minority groups tend to seek care from different providers than non-Hispanic whites (Chandra and Skinner 2004). At all levels of the health care system—primary care providers, specialists, hospitals, and nursing homes—the ratio of providers to the population is lower in predominantly minority areas. The shortage of providers limits access to care and narrows the type and quality of care available.

Minorities tend to be treated at different hospitals. In recent years, some hospitals have relocated from urban areas with high minority populations to suburbs with smaller minority populations. For example, physician-owned cardiac and orthopedic specialty hospitals have proliferated in some suburban areas, and a 2005 MedPAC study found that physician-owned cardiac specialty hospitals had a significantly smaller share of black Medicare patients relative to community hospitals in the same market (MedPAC 2005). A study of hospital admissions for Medicare patients following a heart attack found that 50 percent of black patients were admitted to hospitals that accounted for only 14 percent of nonblack admissions (Chandra and Skinner 2004).

Outpatient care is even more concentrated than hospital care. Eighty percent of the visits of black Medicare beneficiaries are accounted for by 22 percent of physicians, and these physicians are less likely to be board-certified and more likely to report difficulty in obtaining access to specialists and diagnostic services (Bach *et al.* 2004). As private providers have moved to the suburbs, minorities in metropolitan areas have come to rely heavily on medical schools and teaching hospitals for their care (Smith 2005). Minority Americans are less likely to receive care at a doctor's office or to have a regular source of care. Those without a regular doctor are more likely to use an emergency room for care, and they are less likely to be satisfied with the quality of their health care (Collins *et al.* 2002).

To attract and maintain providers in underserved areas, Medicare provides payment incentives. Physicians who render services in a designated Health Professional Shortage Area receive a 10-percent bonus payment. These incentives have been focused on rural areas, though urban areas may also be designated. They have not been applied to underserved communities as defined by race and ethnicity. Section 413(a) of the Medicare Modernization Act (MMA) provides a new 5-percent incentive payment for physicians providing services in designated physician scarcity areas. These areas are defined at the county level, however, thereby excluding many urban sections where minorities live (Jost 2005).

Medicare beneficiaries who are also eligible for Medicaid (so-called dual eligibles) may face more difficulty accessing care. Most states take advantage of the flexibility offered by the Balanced Budget Act of 1997 not to pay full Medicare cost-sharing amounts. The law permits states to limit the payments for dual eligibles so that health care providers receive no more than Medicaid's payment rates, which are typically lower than Medicare rates. Though hospitals that accept Medicare reimbursement are required to serve as Medicaid providers (except in California), physicians and facilities that accept Part B of Medicare are not. Thus, dual eligible Medicare beneficiaries may experience access challenges similar to those faced by Medicaid-only beneficiaries. Specialists are less likely than primary care physicians to accept Medicaid.

Because Medicare Advantage (MA) plans generally have lower out-of-pocket costs than traditional Medicare, enrollment in MA plans could theoretically help improve beneficiaries' access to care and reduce financial barriers to care. With their potential to emphasize preventive, chronic, and coordinated care, MA plans could benefit many minorities. Although some have expressed concern that minority beneficiaries do not have equal access to MA plans, minorities are enrolled in Medicare health maintenance organizations (HMOs) at above average rates. Among Medicare beneficiaries in 2002 (the latest year for which data are available), 14 percent of non-Hispanic whites, 15 percent of non-Hispanic blacks, 24 percent of Hispanics, and 17 percent of other racial/ethnic groups were enrolled in Medicare HMOs (Westat 2006b).

To assure equal access to Medicare Advantage plans, CMS has improved its regulation of plans' service areas, marketing practices, and the geographical distribution of providers. Nevertheless, black doctors have complained of discriminatory treatment from private insurance networks (Rockeymoore and Hawkinson 2004). Indeed, there is some evidence that managed care organizations are refusing to contract with minority providers and are terminating the contracts of black doctors more often than whites (Elder and Miller 2004). Concern also continues that some Medicare managed care plans might be designing their marketing efforts to avoid areas with many minority beneficiaries (Perez 2003).

CMS is also undertaking other projects to increase access to care, particularly to preventive health services. Preventive health initiatives are conducted through Medicare's Quality Improvement Organizations, which are collaborating with provider, government, and community groups to design interventions to reduce disparities. The current efforts are focusing on administration of flu and pneumonia immunizations, mammography screening for breast cancer, and diabetes management (CMS 2005).

In recent years, efforts have been made to expand the number of community health centers. Health centers are located in medically underserved areas, use a model of care that is culturally competent, and serve many Medicare/Medicaid dual eligibles.

Although Medicare has special payment policies for community health centers, Medicare is a relatively small revenue source for health centers because beneficiaries make comparatively little use of them (Taylor 2004).

Recommendations

Increase the access of underserved minority beneficiaries to health care by promoting programs that provide supplementary coverage, improving access to providers, and expanding educational and outreach activities.

2.1. Ensure that minority beneficiaries are enrolled in existing programs that supplement Medicare coverage.

Medicaid, the Medicare Savings Programs (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual programs), and the Medicare drug subsidy provide important additional financial assistance to low-income Medicare beneficiaries, and efforts should continue to enroll everyone who is eligible. CMS should work to make the current programs better by improving the targeting of mailings to potential beneficiaries, providing targeted information to the states, offering personal assistance to probable eligibles, and adopting specific enrollment goals. The Congress should also consider allowing for federal administration of the Medicare Savings Programs at state option and providing additional federal financing (Ebeler, Van de Water, and Demchak 2006).

2.2. Set deductibles and copayments to encourage the use of services that have the potential of reducing disparities in care.

When setting deductibles and copayments, Congress and CMS should consider disparities in the utilization of services by minorities and how costs will affect utilization. In the past, the Congress has eliminated or reduced copayments for preventive health services such as mammography, immunizations, prostate tests, and pap smears as a means of encouraging their use.

2.3. Improve access to providers for minority beneficiaries.

Increasing the number of providers who participate in Medicaid should be given high priority. State Medicaid programs should be required to assure that adequate numbers of providers are available to meet the needs of beneficiaries dually eligible for Medicare and Medicaid. The Congress should require state Medicaid programs to pay full Medicare copayments for dual eligible beneficiaries.

CMS should ensure that minority beneficiaries have access to Medicare Advantage plans and providers. CMS should tighten, monitor, and enforce its regulations, including its process for approving service areas, marketing practices, the extent of provider networks, and the inclusion of minority providers. Private plans should be required to assure racial and ethnic diversity in their provider networks and to publish the data.

Improving access to care depends on increasing the number of physicians practicing in underserved areas. Medicare should provide financial incentives for providers to locate in areas with a high percentage of minority beneficiaries, as it does for other underserved areas. The Congress should amend section 413(a) of the MMA, which provides a new 5-percent incentive payment for physicians' providing services in physician scarcity areas, to include urban areas smaller than a county so that providers in urban areas with large numbers of minority beneficiaries may receive these payments.

2.4 *Educate beneficiaries and their families about promoting good health and accessing health care services.*

To ameliorate disparities, beneficiaries need to be better informed about healthy behaviors, the value of preventive services (such as screenings and immunizations), the signs and symptoms of disease, and the services available to them through Medicare and other public programs. CMS should expand its educational and outreach efforts to low-income and minority beneficiaries and their families. Section 924 of the Medicare Modernization Act establishes a 3-year demonstration program for stationing Medicare specialists at local Social Security offices. In addition, CMS should experiment with a variety of other approaches and settings, such as senior centers and houses of worship. Family members or others could also be encouraged and trained to serve as advocates for beneficiaries who need assistance in navigating the health care system or resolving problems with benefits. These educational efforts could be made part of the new CMS outreach campaign, “My Health. My Medicare,” which was announced in September 2006.

Chapter 3:
Education of Health Professionals

Increasing diversity among health professionals and ensuring cultural competence at all levels of the health workforce are complementary strategies for reducing health disparities. Diversifying the racial and ethnic composition of the health care workforce and educating the workforce to be culturally competent will help improve health care access and quality for minorities, enhance the educational experience of students in the health professions, and promote relevant research and needed changes in health policy.

Diversifying the Health Professions

Increasing the diversity of the health care workforce will contribute to reducing disparities in several ways. As noted in Chapter 1, minority health care professionals are more likely than whites to serve in minority communities, thereby increasing minorities' access to care. Pairing providers and patients from similar racial and ethnic backgrounds often leads to better communication, higher patient satisfaction, and potentially better outcomes. Interaction among professionals of diverse backgrounds, both in educational settings and on the job, will also help broaden perspectives regarding racial, ethnic, and cultural differences (IOM 2004).

Minority professionals play an important role in focusing attention on the existence of disparities and in taking steps to reduce them. According to a 2001 survey, African American physicians are much more likely than others to be aware of disparities in treatment between blacks and whites for heart disease and HIV/AIDS. The survey also found that physicians of different racial and ethnic backgrounds have different perspectives on the source of disparities. Seventy-seven percent of black physicians believe that the health care system treats people unfairly based on race and ethnicity very or somewhat often. The rate is 52 percent for Latino physicians, 33 percent for Asians, and 25 percent for whites (Kaiser Family Foundation 2002).

The lack of diversity in the health professions starts in school. Together, blacks, Hispanics, and Native Americans make up 27 percent of the U.S. population but only 14 percent of the medical school class of 2008 and 7 percent of medical school faculty members (AAMC 2005). The picture in nursing and dentistry is similar.

Increasing diversity is not simply a matter of recruiting more minority students, however, but is an issue throughout the health care system. Minorities are underrepresented not only in the direct provision of medical care but also in non-clinical areas, including educational faculty and administration, hospital administration, research, and public policy (Sullivan Commission 2004).

What can Medicare do to increase diversity in the health professions? Increasing the number of minority providers depends primarily on increasing the number of minority students graduating from medical and other health professions schools. Although obstacles along the pipeline to professional school begin with primary and secondary education, some providers have succeeded in overcoming these limits. Hospitals struggling to hire nurses, for example, have supported the education of local nursing students in return for their commitment to work for the hospital after completion of their degree (May, Bazzoli, and Gerland 2006).

CMS has opportunities for leverage with regard to residency training and hospital staffing. CMS and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have substantial discretion and authority to define residency slots and the characteristics of medical staff, though they have not addressed the diversity of residents and medical staff. CMS could require hospitals to collect and report the number of minority residents and medical staff, as well as the number of medical staff who are fluent in a language other than English. Such collection and reporting requirements may influence those hospitals with affiliated medical schools to increase medical schools' recruitment of minorities. Some have suggested that Medicare's graduate medical education payments could be used as leverage, although the study panel and others believe that such a step would face significant political challenges (Gonzalez and Stoll 2002).

Educating for Cultural Competence

Cultural competence offers a variety of benefits, including improved patient care and satisfaction and a reduction in disparities. To be culturally competent, providers should understand the communities they serve, the socioeconomic and cultural influences on patients, and how these factors may interact with the health system to impede minorities from obtaining quality care. They must also be trained to serve minority beneficiaries effectively by recognizing the impact of race and ethnicity on clinical decisonmaking and developing skills for cross-cultural assessment and communication (Betancourt, Green, and Carillo 2002). Knowledge of a language other than English is desirable, and facility in using interpretive services is essential.

Multiple tactics are needed to educate health professionals to be culturally competent. Training should target the full range of provider types, including nursing and medical students, residents, providers, office staff, and interpreters. Different learning styles call for different types of training. Kaiser Permanente, for example, has found that nurses tend to prefer structured training, so it offers them courses in four-hour sessions, each with its own topic. It has also found ongoing and informal training methods to be effective—for example, the distribution of cultural competence pocket cards and handbooks, short videos, journal articles, and newsletters of health providers and plans.

Many providers receive training in cultural competence through hospital-based health professionals' education and training, new employees' orientation as a JCAHO hospital accreditation requirement, Continuing Medical Education (CME) courses, and health plans' in-service training. CMS's 2005-2008 statement of work for the Quality Improvement Organizations requires the QIOs to promote the use of *A Family Physician's Practical Guide to Culturally Competent Care*, a computer-based training course in cultural competency developed for the Department of Health and Human Services' Office of Minority Health (CMS 2005). In 2005 the State of New Jersey began requiring that all health professionals undergo training in cultural competence as a condition for licensure or relicensure (New Jersey 2005).

Although the possible rewards of improving providers' cultural competence are substantial, strategies for defining and improving cultural competence, and how to measure and evaluate it, are in their infancy. A 2003 review of culturally competent health care systems assessed the effectiveness of five interventions to improve cultural competence in health care systems, including programs to recruit and retain staff members who reflect the cultural diversity of the community served, and training in cultural competence for providers. It concluded that it could not determine the effectiveness of these interventions because there were either too few comparative studies, or the studies did not examine appropriate outcome measures (Anderson *et al.* 2003).

In addition to training in cultural competence, other types of training could be used to reduce disparities. For example, providers could be trained in the importance and use of electronic medical records, evidence-based guidelines, and the retrieval of clinical information. If properly focused, these interventions could reduce disparities as well as improve the overall quality of care.

Recommendations

Educate health professionals to improve the health system's diversity and cultural competence.

3.1. Increase the number of minority providers, medical staff, and medical school faculty.

CMS should take steps to increase the number of underrepresented racial and ethnic minorities in the educational pipeline that leads to jobs in the health sector. It should work with the Department of Education and other organizations to draw attention to the need for health care professionals and encourage courses of study that will equip students for entering the health professions.

CMS should exert its leverage to increase the number of minority professionals serving as residents and on hospital staffs. CMS and the Joint Commission on Accreditation of Healthcare Organizations should establish requirements for residency slots and medical staff that would enhance their diversity. Hospitals should be required to collect and report the racial and ethnic composition of their residents and house staff and compare it to the composition of their service area. They should also report the number of medical staff who are proficient in a language other than English.

3.2. Encourage and enhance training in cultural competence for providers.

Cultural competence—the ability of health care providers to work effectively with patients and colleagues in cross-cultural situations—has many aspects. Among other things, training in cultural competence should educate providers about the interconnections between race and ethnicity, inequalities in education and income, and disparities in health care and outcomes. It should also teach communications skills, including proficiency in another language and in the use of interpretive services.

The Joint Commission on Accreditation of Healthcare Organizations should augment its requirements for training in cultural competence. It should require annual training and interim refreshers. It should also recognize the achievements of those institutions that maintain high standards. In addition, it should provide hospitals with guidance for conducting education in cultural competence.

Medicare Advantage plans work should collaboratively with CMS to provide training in cultural competence on a stepped up and ongoing basis for all health care providers with whom they contract in their delivery system. The National Committee for Quality Assurance (NCQA) should incorporate this requirement into its process for accrediting health plans.

The efforts of the Quality Improvement Organizations to educate providers in cultural competence should be strengthened. The new computer-based training in cultural competency for family physicians should be monitored, evaluated, and its lessons disseminated. Other training tools should also be developed for other categories of providers.

3.3. *Ensure that all types of training promote reductions in disparities*

In addition to training in cultural competence, other types of training (for example, training in the use of electronic medical records, evidence-based guidelines, and clinical information retrieval) should include an emphasis on monitoring and reducing disparities.

Chapter 4:
Capability and Practice of Institutions

To be effective in reducing racial and ethnic health disparities, providers and their accrediting organizations must ensure they have the institutional capabilities necessary to meet the needs of minority beneficiaries. Clear expectations must be set, and providers held accountable for achieving them. Accomplishing these tasks requires accurate data on the race and ethnicity of Medicare's beneficiaries.

Collecting Data on Race and Ethnicity

Medicare's databases contain a vast amount of information about its 43 million beneficiaries. They allow extensive analyses of beneficiaries' health, quality of care, and health care utilization and costs. These databases have been instrumental in documenting disparities, particularly in the use of preventive services, outpatient and inpatient surgical procedures, hospital admissions, and treatment outcomes (McBean 2005).

As valuable as these data have proved, the quality of the race and ethnicity information leaves much to be desired. Analyses of 2002 Medicare administrative data show that although the quality is high for whites and blacks, only 52 percent of Asian beneficiaries and 33 percent of both Hispanic and American Indian/Alaskan Native beneficiaries were correctly identified. CMS has made major improvements in the quality of these data but faces several inherent problems. In a working paper prepared for the study panel, A. Marshall McBean describes the efforts that CMS has taken to improve Medicare's data on race and ethnicity and details their limitations and possibilities (McBean 2005).

The Social Security Administration (SSA) is responsible for certifying that a person is eligible for Medicare and for transmitting demographic information about that person to CMS. SSA collects this demographic information when a person applies for a Social Security card or for a replacement card. For those who applied for a card before 1980, the race and ethnicity information is limited to white, black, and other. In 1980, the Office of Management and Budget (OMB) revised its standards, replacing the “other” category with Asian, Asian American, or Pacific Islander; Hispanic; and American Indian or Alaska Native. This more detailed information is not available for most Medicare beneficiaries, however, because they applied for their Social Security card long before 1980.

In 1997, OMB announced further changes to the standards for federal data on race and ethnicity. Henceforth, there were to be five racial categories and a separate question for ethnicity with two categories—Hispanic or Latino, and Not Hispanic or Latino. SSA has not yet revised the application for a Social Security card to reflect these new categories. Even if SSA did so, however, Medicare would not benefit from the change for decades.

Medicare’s databases have other limitations for analyzing health disparities. One is that analyses of health care utilization cannot be done for members of Medicare Advantage plans (11.5 percent of beneficiaries in 2003), as the health plans do not provide CMS with health care utilization information on their members. The five racial categories and two ethnicities are too broad for the targeting of clinical initiatives by subgroup. Further, CMS’ administrative database does not include information on socioeconomic status, which restricts the depth and quality of race and ethnicity analyses.

In addition to compiling administrative data, CMS also conducts the Medicare Current Beneficiary Survey, which collects socioeconomic and health information from a sample of beneficiaries; the Health Outcomes Survey (HOS); and the

Consumer Assessment of Health Providers and Systems (CAHPS). It also requires health plans to provide the Health Plan Employer Data and Information Set (HEDIS), a set of standardized performance measures maintained by the National Committee for Quality Assurance. These databases may be linked with each other and with CMS' administrative data to capture the broad picture of beneficiaries' health.

Though Medicare Advantage plans have the organizational structure to coordinate care (which could be particularly important for minority beneficiaries), their efforts are hampered by their lack of data on race and ethnicity. They are not required to collect race and ethnicity information on their enrollees, although HHS has the authority to impose such a requirement. A few health plans have voluntarily begun collecting this information. Aetna, for example, has made the collection of race and ethnicity data one of its major initiatives and by mid-2005 had this information for 2 million members (15 percent of its membership). A number of other plans have begun or are planning to collect data. Without a standardized format, however, these data cannot be compared across health plans. Either HHS or CMS is the logical agency to set the standards for data collection (Rosenbaum *et al*. 2006).

Data on race and ethnicity not only should be collected, but they should also be used to monitor and reduce disparities. In the case of mortgage lending, for example, the Home Mortgage Disclosure Act (HMDA) of 1975 required the collection of data on race on home mortgage applications. Until 1989 it had little effect on lending practices, because the data were not widely publicized or made available in an accessible format. In 1989, after HMDA was amended to make the data public, social scientists could assess the extent of disparities, and advocacy groups were then able to put pressure on lenders.

Providing Culturally and Linguistically Appropriate Services

Limited English proficiency (LEP) poses barriers to access and quality of care for many minority beneficiaries. Beneficiaries who are not fluent in English may have difficulty understanding Medicare's benefits, finding health care providers, and making appointments. Their lack of ability to communicate with providers—and of providers to communicate with them— affects the delivery of care and may result in medical errors through poor exchange of information, misunderstanding of physician instructions, poor shared decision making, or difficulty obtaining informed consent. It may also result in decreased adherence to medication regimes, failure to keep appointments, and poor satisfaction with medical services (IOM 2002).

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in any program receiving federal financial assistance. A Supreme Court decision in 1974 held that title VI prohibits conduct that has a disproportionate effect on patients with limited English proficiency because such conduct constitutes national-origin discrimination. The Office for Civil Rights at HHS enforced this requirement, although it did not issue formal guidance until 2000. In 2002, HHS issued revised guidance, specifying that providers under Part A of Medicare must take "reasonable steps" to ensure meaningful access to their programs and activities by people with limited English proficiency. Providers who receive payments only under Part B were exempted. Those who receive other federal dollars, for example, from Medicaid or the State Children's Health Insurance Program, were required to comply for all patients. No additional federal funds were to be paid for interpreters.

In 2003, following a directive from the Department of Justice, the HHS guidance was softened to take providers' resources into account. The new standards list four factors that providers must weigh in determining the extent of services that should be made available for patients with limited English proficiency:

1. The number or proportion of LEP persons eligible to be served or likely to be encountered,
2. The frequency with which the LEP individuals come in contact with the provider,
3. The nature and importance of the service provided to people's lives, and
4. The resources available to the provider and costs.

HHS is striving for voluntary compliance with the LEP guidelines. Investigations will be conducted only if complaints are made. HHS plans to resolve noncompliance informally, although it has the power to terminate federal assistance (DHHS 2003).

In 2000, the Office of Minority Health at HHS issued national standards for culturally and linguistically appropriate services (CLAS) in health care. The 14 standards are organized into three themes: culturally competent care, language access services, and organizational supports for cultural competence. Two of the standards for language access services incorporate the mandatory LEP guidelines. The other standards are presented as recommendations for adoption as mandates by accrediting agencies or for voluntary adoption by health care organizations.

Holding Institutions Responsible

Health plans, providers, and their accrediting organizations all have a role in reducing health disparities. 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. Hospitals may be accredited on the basis of Medicare's certification requirements or on the basis of their compliance with accreditation standards promulgated by the Joint Commission on Accreditation of Healthcare Organizations (IOM 1990). Similarly, Medicare Advantage plans can be accredited through CMS directly or through the National Committee for Quality Assurance or URAC (formerly the Utilization Review Accreditation Commission). Most hospitals and health plans choose to receive their accreditation through JCAHO or NCQA.

Both of these accreditation organizations have taken steps to foster and support participating organizations' efforts to reduce disparities. Several JCAHO standards aim to support the provision of care that is culturally and linguistically appropriate. Effective in January 2006, hospitals are required to document patients' primary language in the medical record (JCAHO 2006). With funding from The California Endowment, JCAHO is also undertaking a project on Hospitals, Language, and Culture, which is examining how hospitals are addressing patients' cultural and linguistic needs and seeking to identify reasonable expectations for different types of hospitals.

NCQA is conducting three projects, also funded by The California Endowment, that focus on disparities. One is investigating trends in health disparities for Medicare managed care enrollees and examining the feasibility of stratifying HEDIS measures by race and ethnicity. Another is developing recommendations on whether and how to evaluate health disparities and the provision of culturally and linguistically appropriate services in health plans. A third will recognize health plans that have demonstrated innovative approaches in providing culturally and linguistically appropriate services and reducing disparities.

Although these efforts are commendable, reducing disparities will ultimately require accreditation organizations to tighten existing standards or add new ones. At a minimum, hospitals, health plans, and other providers should be asked to maintain data on patients' race and ethnicity. Health care organizations could also be required to provide training for their staff in the delivery of culturally and linguistically appropriate services. Finally, providers could be required to monitor selected process and outcome measures by race and ethnicity. CMS can encourage accrediting organizations to adopt such standards voluntarily, or it can strengthen its own requirements.

Recommendations

Hold individual and institutional providers responsible for reducing racial and ethnic health disparities.

4.1. Collect the data necessary for assessing, monitoring, and targeting disparities.

CMS and SSA should promptly implement the recommendations of the National Research Council's Panel on DHHS Collection of Race and Ethnicity Data. The panel recommended that CMS develop a program to collect racial, ethnic, and socioeconomic position data at the time of enrollment and for current enrollees in the Medicare program. It also recommended that, to obtain more detailed information on socioeconomic position, CMS seek data on enrollees' earnings and employment histories from the wage history files of the Social Security Administration (National Research Council 2004).

Hospitals, Medicare Advantage plans, and other providers should be required to collect data on the race and ethnicity of their patient populations, regularly analyze these data, and devise and implement a plan to reduce disparities. HHS and CMS should develop guidelines to standardize this data collection to assure comparability across providers. The data should be made publicly available at the provider and health plan level and aggregated at the smallest level that is statistically reliable and does not raise confidentiality issues.

4.2. Strengthen the role of accreditation organizations in reducing disparities.

The Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance should require that the hospitals and health plans they accredit take steps to identify and reduce disparities. If JCAHO and NCQA do not tighten their requirements voluntarily, CMS should tighten its own certification requirements. Accreditation organizations should apply sanctions to those institutions that fail to meet standards.

4.3. Ensure that all providers comply with the guidelines for services to patients with limited English proficiency and the standards for providing culturally and linguistically appropriate services issued by the Department of Health and Human Services.

The Office for Civil Rights in the Department of Health and Human Services should take a more active approach towards enforcing LEP guidelines. CMS should require all Part B providers of a reasonable size to comply with LEP guidelines, and it should assist smaller providers in meeting the guidelines. CMS and the accrediting organizations should require compliance with CLAS standards.

Chapter 5:
Administrative Priorities and Structure

Federal agencies need to place a higher priority on reducing health disparities. The Centers for Medicare & Medicaid Services has not set performance goals for reducing disparities, and no single person or office at CMS is responsible for addressing the problem. The Department of Health and Human Services has been lax in enforcing the prohibition of discrimination in the provision of health care services.

Making Reduction of Disparities a Priority

Reducing racial and ethnic disparities in Medicare appears not to be a priority in the HHS and CMS strategic planning process, which is required by the Government Performance and Results Act. Objective 3.4 of the *HHS Strategic Plan* is to "Eliminate racial and ethnic health disparities" (DHHS 2004). Yet this objective is not mentioned in the *HHS Annual Plan* for fiscal year 2007 (DHHS 2006). Nor is the goal reflected in CMS' own performance budget for 2007 (CMS 2006).

While researching his paper for the study panel, Jost concluded that the top priority of CMS at the moment is implementing the Medicare Modernization Act, and that addressing racial and ethnic disparities has lagged behind (Jost 2005). However, implementing the MMA and addressing racial and ethnic disparities need not be incompatible. In a speech before the National Minority Health Month Foundation in September 2006, the Administrator of CMS summarized the activities that the agency is currently undertaking to help reduce disparities.

Although the Medicare Modernization Act does not explicitly address health disparities, several provisions point in the right direction. Sections 109(d) and 238 direct the Institute of Medicine to study options for improving performance measures, performance incentive programs, and quality improvement programs. Section 646 establishes a health care quality demonstration program that permits the Secretary of HHS to approve projects that improve the quality of patient care, including examining "the appropriate use of culturally and ethnically sensitive health care delivery." And section 722 requires Medicare Advantage plans to maintain an ongoing quality improvement program, with special attention to improving the management of chronic care—a provision that could disproportionately benefit minorities (Rockeymoore and Hawkinson 2004).

Establishing measurable goals for the reduction of disparities would entail both advantages and disadvantages. Setting specific goals would give clear direction to the management and staff at CMS and would create accountability for what is or is not accomplished. However, some of the most effective ways of reducing disparities might not be amenable to quantification. A balance is needed to ensure that measurable goals and objectives do not excessively narrow the agency's focus.

Removing Structural Barriers

The Department of Health and Human Services has an Office of Minority Health, headed by a deputy assistant secretary, which is responsible for the development of policies to reduce health disparities at the department-wide level. In contrast, CMS has neither its own office of minority health nor a dedicated budget for funding initiatives to reduce disparities. No designated office or individual is charged with leading disparity-reduction initiatives within CMS. CMS has established a disparities workgroup that reports to the agency's Quality Council for the purpose of coordinating such efforts, but there is no identified contact point for those from outside the agency who seek information about disparities. An office of minority health at CMS would provide a visible, central staff to focus on reducing disparities. At the same time, creating a separate office would run the risk of making other agency staff feel even less responsible for reducing disparities and further marginalizing the effort (Jost 2005).

Although CMS can do much on its own to reduce health disparities, other federal organizations have complementary responsibilities. The Health Resources and Services Administration, another agency within HHS, funds community health centers and programs to increase the number of minority providers, including support for education of medical students and fellowships for faculty members. Discrimination in health care is also within the scope of the U.S. Department of Justice and the U.S. Commission on Civil Rights. There is, however, little communication and interaction between CMS and these other agencies. Because of its traditional focus on the payment of claims, CMS has rarely encouraged other agencies to adopt programs or regulations to support its initiatives, although this situation has begun to change as the responsibilities of CMS have grown.

Enforcing Civil Rights

In some cases, disparities in the provision of health care raise issues of civil rights. Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. Title VI applies to both intentional and unintentional discrimination on the part of physicians, providers, and other parts of the health care system. Title VI can be applied to a range of discriminatory concerns, including access to health care, redlining, physician staff privileges, participation in managed care, and provision of interpretive services. Federal agencies are authorized to set nondiscrimination standards, investigate claims of discrimination, and terminate federal assistance to any entity found to have violated the law (Matthew 2005).

Since the desegregation of hospitals in 1965, the federal government has not used civil rights laws aggressively to reduce disparities. It never required the desegregation of Part A providers other than hospitals (such as nursing homes). Physicians who accept Part B of Medicare but do not participate in other federal programs are still not required to comply with title VI, because the Medicare beneficiaries, not the physicians who care for them, are—at least in legal theory—considered to be the recipients of federal financial assistance.

Although title VI provides a statutory framework for addressing racial and ethnic disparities, the courts have limited its use. In the 1970s, as urban hospitals were closed and relocated to the suburbs, a series of cases charging hospitals with discriminatory practices were resolved in favor of the defendants. In 2001 the Supreme Court gave another blow to title VI when, in *Alexander v. Sandoval,* it eliminated the right of individuals to sue for unintentional, disparate impact of superficially neutral policies and practices. In the wake of *Sandoval*, charges of disparate impact can be brought only by federal agencies (Matthew 2005).

The Office for Civil Rights (OCR) in the Department of Health and Human Services has received repeated criticism for its lax enforcement of title VI. Recently, OCR has focused on privacy and language issues and undertaken little, if any, enforcement activity involving discrimination. Though federal agencies were given the sole responsibility for bringing cases of disparate impact after *Sandoval*, OCR was given no additional resources and has not pursued such cases. CMS also has an Office of Equal Opportunity and Civil Rights, but its primary task is to address complaints of discrimination in employment (Jost 2005; Matthew 2005).

In addition to strengthening OCR, HHS and CMS could signal their seriousness about reducing disparities in other ways. A simple but dramatic step would be to amend the compliance guidance issued by the HHS Office of Inspector General (OIG) to identify compliance with title VI as an issue to be addressed by all

Medicare providers in their compliance plans and programs. OIG could encourage each provider or contractor that participates in Medicare to demonstrate compliance with the nondiscrimination requirement of title VI and could set forth for each type of entity what compliance might involve in terms of addressing racial and ethnic disparities. CMS could also revise the billing forms to require that providers state explicitly they have complied with relevant civil rights laws. These forms now require only that providers certify general compliance with the law (Jost 2005).

Recommendations

Make the reduction of disparities a top priority and administrative focus at the Centers for Medicare & Medicaid Services.

5.1. Establish CMS performance goals for the reduction of racial and ethnic disparities among Medicare beneficiaries.

CMS should establish measurable performance goals for reducing health disparities as part of its annual performance planning and budgeting process. It should choose a range of clinical and other quality indicators, possibly tied to measures in the *National Healthcare Disparities Report*. Executives should be held responsible for meeting these goals as part of their annual performance plans.

5.2. Enhance the organizational structure of CMS to support the reduction of disparities.

CMS should create an office of minority health to serve as the focal point for initiatives to reduce disparities. Reduction of disparities, however, must remain a responsibility of the entire agency. CMS should also encourage federal leaders and other federal agencies to do more to reduce disparities.

5.3. Address racial and ethnic disparities as a civil rights compliance issue.

The Office for Civil Rights in the Department of Health and Human Services should actively pursue its responsibility to identify and prosecute cases of discrimination in the delivery of health care services financed by federal programs. OCR should receive additional funding and staffing for this purpose. In addition, CMS should create the position of civil rights compliance officer within its Office of Equal Opportunity and Civil Rights.

All health care providers should be required to comply with civil rights laws. Part B providers should be included within the scope of title VI of the Civil Rights Act, if possible through an administrative interpretation of the statute. CMS should revise its billing forms to require that providers state explicitly they have complied with relevant civil rights laws. The Office of Inspector General at HHS should require providers to address compliance with title VI in their compliance plans and programs.

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