

# **CMS' Programs and Initiatives to Reduce Racial and Ethnic Disparities in Medicare**

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## **ABSTRACT**

Medicare has substantially narrowed racial and ethnic disparities in health care, most dramatically in its first year when Medicare was responsible for desegregating the nation's hospitals—virtually ending this most visible form of health care discrimination in a year's time. Over nearly four decades, racial and ethnic gaps in utilization of health care services and quality of care provided to Medicare beneficiaries have been reduced, not eliminated. This paper provides an inventory of programs and initiatives implemented by the Centers for Medicare and Medicaid Services to reduce remaining disparities in the Medicare program. These include efforts to: (1) develop culturally appropriate education and outreach; (2) measure and reduce clinical health care disparities through beneficiary and provider-focused interventions; and (3) enhance providers' cultural competency. The paper describes the initiatives, the disparities they seek to reduce, efforts to evaluate them, and their actual and potential impact to reduce disparities both locally and nationally. The central finding is that, despite successes in some areas, ongoing efforts have had limited reach and limited impact on racial disparities. The paper identifies several ways to enhance these ongoing efforts to make more significant progress toward eliminating racial and ethnic disparities in Medicare, and identifies several key considerations for the development of future initiatives.

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## **Introduction**

Medicare's federal entitlement offers a set defined health benefits to more than 40 million elderly individuals and persons with disabilities. By virtue of their access to a social insurance program with uniform benefits that cuts across socio-economic, class, and racial and ethnic groups, Medicare beneficiaries are, in principle, assured access to mainstream health care. Hospitals, nursing homes, and other medical providers who receive Medicare funds—with the notable exception of physicians—are required by Title VI of the Civil Rights Act to provide care on a nondiscriminatory basis. Medicare's conditions of participation also mandate that care of equal quality be provided to patients regardless of their race or ethnicity.

Despite the promise of access to care that national benefits provide, not all populations fare equally well in Medicare. Numerous studies document that diverse racial and ethnic groups (African Americans, Hispanic/Latinos, Asian and Pacific Islanders, and others) experience greater difficulties than whites accessing care, are more likely to receive inferior care when they are diagnosed with an illness, and suffer worse health outcomes as a result. Elderly black Medicare beneficiaries are seen less often by specialists, and receive less appropriate preventive care, lower quality hospital care, and fewer expensive technological procedures (Fiscella et al. 2003). These disparities exist across a wide variety of clinical conditions (acute and chronic, and physical and mental illnesses), across health care settings (physician offices, hospitals, nursing homes, and other health care facilities), and services (preventive, diagnostic, rehabilitative, therapeutic). Disparities exist in both fee-for-service (Original) Medicare and Medicare managed care.

CMS has a number of opportunities within its current administrative structure to address disparities in Medicare and the health care system more broadly. This paper describes current programs and initiatives implemented by the Centers for Medicare and Medicaid services to reduce racial and ethnic disparities in Medicare. The first section briefly reviews the patient-, provider-, and system-related factors that contribute to racial disparities in access to care and the utilization of medical care. It also describes the types of activities that might be undertaken within Medicare to address these sources of disparities. Current programs and initiatives undertaken by CMS to narrow disparities are described in the second section. The third section

assesses the lessons learned in Medicare managed care plans and Medicaid that may provide lessons for CMS. A fourth section concludes.

### **Sources of Disparities in Medicare and Strategies for Narrowing Them**

Although the implementation of Medicare dramatically narrowed income- and race-related disparities in access to care and quality of care, financial access did not guarantee equity in access to and availability of services to all of Medicare's populations. In Medicare, and in the health care system generally, there are several recognized sources of disparities that persist even when beneficiaries have the same insurance coverage.

#### **Sources of disparities**

##### Poor neighborhoods

Racial and ethnic disparities in the amount and quality of care that beneficiaries receive arise in part because culturally diverse beneficiaries live in poor and racially segregated neighborhoods. Beneficiaries who are culturally and physically separated from the mainstream may not be willing or able to access the same hospitals and providers as high-income, white beneficiaries. The urban poor are more likely to receive care at public hospitals and other urban safety net hospitals. Culturally diverse beneficiaries are also more likely than whites to receive care in clinics, hospital outpatient departments, and emergency rooms and have more difficulty getting care from a usual provider at a consistent location (Smedley, Stith, and Nelson 2003, pp. 108-110). People in poor neighborhoods receive care in segregated and resource-constrained systems, receive less continuous care from a given provider, have more limited access to specialists, and are referred less often for intensive procedures. Recent surveys of the physicians who treat culturally diverse patients in Medicare reveal that primary care physicians treating black and Hispanic/Latino patients in Medicare have greater difficulty obtaining access for their patients to high-quality sub-specialists, high quality diagnostic imaging, and non-emergency admission to the hospital (Bach et al. 2004; Hargraves, Stoddard, and Trude 2001).

##### Poor people

Racial and ethnic disparities Medicare persist, in part, because African/American, Hispanic/Latino and other racial and ethnic groups tend to have lower incomes than whites and

greater difficulty affording Medicare's required beneficiary cost sharing. Minority beneficiaries in Medicare have lower incomes on average than white beneficiaries, and are less likely to have private supplemental (Medigap) coverage. They also are more likely to rely on Medicaid as a supplement to Medicare. Although studies of the impact of race and ethnicity generally "control" for income and supplemental coverage, they often do this crudely without accurately accounting for variations in the level of insurance coverage (Smedley, Stith, and Nelson 2003, p. 147).

Part of the affordability problem can be attributed to financial and non-financial barriers to barriers to enrollment in Part B (and Part A for certain eligibles) and to the design and implementation of the programs designed to assist poor and low-income beneficiaries with Medicare's cost-sharing responsibilities. Medicaid provides assistance with Medicare's premiums and cost sharing for certain poor and low-income beneficiaries, but research on enrollment in the Medicare savings programs has identified many general barriers to enrollment, including a lack of information about how to enroll, complicated enrollment forms, asset tests, and a lack of one-on-one assistance from a trusted source to help eligible individuals through the enrollment process.

Certain populations face substantial barriers to enrollment in the Medicare Savings Programs. For example, a recent CMS-funded research study shows that number of eligible American Indian or Alaska Natives (in 15 states with large AI/AN populations) significantly exceeds the number enrolled in Medicare. The research suggests that federal outreach and education for AI/AN populations is inadequate, and that the Part B premium is a substantial barrier to enrollment in Part B for these populations as well (Langwell et al. 2003). Research on Asian Americans confirms that lack of awareness of eligibility is a significant problem and suggests that Asian American elderly also have a limited understanding of and limited willingness to enroll in health insurance plans. "Cultural background affects people's understanding of the concept of insurance, their attitudes toward government programs, their willingness to trust information about Medicare, as well as their capacity to understand the information they receive." Administrative barriers—a lack of linguistic and cultural competence at federal, state and county offices where enrollment takes place—are also significant (Stevens, Yee, and Ortiz 2001).

### Health system barriers

Disparities in clinical care also arise because culturally diverse populations face unique logistical and cultural challenges dealing with health care providers and health systems. Complex medical bills and forms, and complicated processes for obtaining necessary care, may deter patients with low literacy or limited English proficiency from seeking care (Smedley, Stith, and Nelson 2003, p. 140). Physician practices, medical institutions, and health care plans and systems may erect systems that create intentional and unintentional barriers to care for racial and ethnic groups. Hispanic/Latino beneficiaries, for example, are more likely than whites to have been uninsured before becoming eligible for Medicare. As a result, they may be less likely to have the skills needed to navigate a complex health care delivery and insurance system, and they may not have access to physicians willing to advocate strongly on their behalf when coverage is denied.

Marginal literacy and limited English proficiency create barriers in access to health information and health services. Recent research has shown that the elderly in Medicare with limited English proficiency were less likely to have a usual source of care, less likely to see a private physician and more likely to use a safety net provider (Ponce et al. 2004). In general, studies show that “LEP patients frequently defer needed medical care, have a higher risk of leaving the hospital against medical advice, are less likely to have a regular medical provider, have an increased risk of drug complications, and are more likely to miss follow-up appointments” (Ku and Flores 2004, p. 3). A significant part of the explanation for these difficulties rests with the fact that culturally diverse patients often rely on health care providers who are not sensitive to cultural differences and are not able to communicate effectively with patients with whom they do not share a common race or ethnicity, language, or culture.

### Provider bias

Physician behavior also contributes to racial disparities. In fact, most discussions of disparities in medical care focus not on the disparities that arise because minority patients are disproportionately poorer or less well insured than whites, or disproportionately affected by geographic and other logistical barriers to access. Rather, they focus on the fundamental inequity that arises because patients of color receive different diagnoses and treatments than patients who are white. Race and ethnicity influence providers’ beliefs and expectations about patients, how they interpret patients’ symptoms, refer for diagnostic tests, procedures

recommended, whether and how they provide patient education, and assess patients' intelligence and willingness and ability to adhere to treatment plans (van Ryn 2002). Provider prejudice, bias, and stereotyping by physicians and other providers may create disparities in the quality of care provided to white and non-white patients.

### Patient-related factors

Patients, too, may lack the tools they need to obtain needed care. Cultural differences may affect patients' willingness to seek medical attention and follow medical advice, and language barriers may interfere with patient-provider communication and the ability to comprehend and follow medical advice. Racial and ethnic groups, as noted above, may have less experience navigating health systems and may be less assertive in their dealings with physicians than white patients. Although many of the patient-related barriers to receiving timely and appropriate health care affect patients of all races and ethnicities, some barriers—lack of time, lack of knowledge, competing demands, and uncertainty about the benefits of health care—may affect some racial or ethnic groups more than others.

### Strategies and their impacts

Numerous tools are available to Medicare reduce or eliminate at least some of the disparities in access to care and quality of care for all of its populations. Recommendations for changes in Medicare tend to focus on: (1) data systems and information feedback; (2) structuring payment systems to limit provider incentives that may promote disparities or to reward providers whose reduce disparities; (3) appropriate screening and preventive services and adherence to other evidence-based, clinical care protocols, and (4) greater resources for interpretation services, multidisciplinary teams, community-health workers, and culturally appropriate patient education. Some of these activities and interventions would require legislative changes, some can be accomplished administratively by CMS, and most could be adopted by innovative managed care plans.

Interventions directed at physicians include efforts to educate physicians about disparities and provide formal training on how to deliver culturally competent care. Cultural competence describes “the ability of systems to provide care to patients with diverse, values, beliefs and behaviors, including tailoring delivery systems to meet patients' social, cultural, and linguistic needs” (Betancourt, Green, and Carrillo 2002, p. v).

Interventions targeted at culturally diverse communities and patients seek to educate and inform patients by providing culturally appropriate education and outreach about health care risks, the role of screening and preventive services, and health risk management. Projects may also seek to reduce financial and logistical barriers to receiving care.

Initiatives targeted at health systems focus on the organization of care and may seek to improve data collection systems (beneficiary race and ethnicity, primary language preferences, data on providers who may be bilingual, bicultural, or both), address cultural and linguistic barriers by improving access to interpretation, and address beneficiaries' ability to navigate the health care system through the use of community health workers or other kinds of interventions to improve patient-provider communication.

Although a range of approaches have been identified and tested in various settings, relatively little is known about the efficacy of alternative approaches to reducing disparities, or about the strategies that are effective within various racial/ethnic subpopulations. Some published reviews of these interventions have assessed the evidence on their impact on disparities (Beach and others 2004, Center for Health Care Quality 2002, Capitman and Bhalotra 2003).

These reviews conclude, for example, that physician tracking and reminder systems can be effective in improving preventive care and screening services for racial and ethnic minorities, as are initiatives that bypass the physician, and give responsibility for offering a service to a nurse or nurse practitioner (e.g. standing orders for adult immunizations). Multifaceted provider interventions may also be effective, but interventions that include only a provider education component are not generally found to be very effective in improving care or narrowing disparities.

There is very little evidence yet on the effectiveness of cultural competence training. A few studies found that trainings enhanced providers' knowledge, skills, and attitudes improved, but only a very few studies sought to evaluate the impact on patient outcomes, and those findings were limited to changes in patient satisfaction with care. There were no findings on patient adherence or outcomes (Beach et al. 2004).

A recent review of interventions to narrow disparities in cancer care finds that efforts to improve screening participation and adherence are worthwhile goals. For cancers without

accepted screening mechanisms, interventions need to address access to primary care. The literature review finds that there are few interventions that address racial/ethnic disparities in the timely completion of all recommended primary and secondary treatments. However, a key finding within this literature is that treatment management interventions that draw upon a “knowledgeable and trusted community health worker, serving as a patient navigator has the potential to increase the share of elders of color who receive the current standard of care” (Capitman and Bhalotra 2003).

### **CMS’ Programs and Initiatives to Reduce Disparities**

CMS has implemented several programs to address racial and ethnic disparities in Medicare, focusing on recognized problems such as the lack of language-appropriate education, provider behaviors and practices that may contribute to disparities, cultural competence, and beneficiary health education. These include efforts to:

- Develop culturally appropriate education and outreach through national, state, and local initiatives;
- Reduce disparities in the use of preventive services through Medicare Quality Improvement Organizations;
- Address health risks and behavior and chronic disease management through community-based organizations and academic institutions, such as Historically Black Colleges and Universities;
- Address disparities in diagnosis and treatment of cancer and other chronic diseases through Medicare demonstration programs; and
- Enhance the cultural competence of Medicare managed care organizations through the quality regulations for managed care plans.

### **Culturally appropriate outreach and education**

In an effort to reduce disparities in knowledge about Medicare and expand enrollment in and access to Medicare services, CMS has developed initiatives to assess the information needs of Medicare beneficiaries, develop culturally appropriate materials and communication strategies,

and—to a much more limited extent—test the efficacy of different approaches to education and outreach.

Historically, information about Medicare was provided to beneficiaries in print form, written in English, at an eighth-grade reading level. Recently, there have been some efforts to improve this communications strategy. These activities originated in the National Medicare Education Program (NMEP), developed by the agency in 1998 to raise awareness about and facilitate enrollment in the Medicare+Choice Program. The NMEP produced an annual *Medicare & You* handbook, a national Medicare customer service line (1-800-Medicare), and an Internet website that beneficiaries and counselors could use to get information about Medicare benefits, choices, and providers.

Part of this effort focused on the need to communicate more effectively with vulnerable Medicare populations, including racial and ethnic minority groups. The Medicare handbook and other brochures were translated into Spanish, and the customer call center has a Spanish language line. A more comprehensive language line service, which provides interpretation in more than 160 languages, is available, but CMS does not publicize the availability of that service.<sup>1</sup>

Beyond these translation efforts, CMS initiated “an extensive social marketing research effort” in the early stages of the NMEP campaign. “Market research profiles” were prepared to understand the knowledge gaps, information needs, preferred modes of communication, and communications outlets of African American and Hispanic/Latino beneficiaries. The researchers identified significant needs among culturally diverse beneficiaries for information about health care concerns, including chronic conditions, such as diabetes; a greater need for information about preventive care services in Medicare; and information about supplemental insurance and managed care. They found that the health care system is daunting for those with limited English proficiency and low health literacy, and suggested that tailoring an effective research strategy should use culturally appropriate materials and rely on non-print media (TV and radio), as well as churches, schools, and other community organizations (Barents Group, Project HOPE-Center

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<sup>1</sup> More effective publicity could reduce overall costs for the language line service. If the number of calls in a given language meets a particular threshold, the contractor will hire bilingual response staff to replace the need for the more costly language line transaction. (Conversation with Michael Katz, CMS).

for Health Affairs, and WESTAT 1998; Barents Group, Project HOPE-Center for Health Affairs, and WESTAT 1999).

A number of subsequent initiatives have built on these efforts, documenting the communications barriers faced by different racial and ethnic groups, including those with limited English proficiency, low literacy, and low health literacy. With grant funding from CMS in the late 1990s, a coalition of community and research organizations addressed a wide range of information and communication issues facing racial and ethnic groups and developed culturally appropriate materials, including a focus on Asian populations (PROWEST 1999).

These efforts were further developed under the HORIZONS (Health Outreach Initiative Zeroing In On Needs) Project launched in 1999 as part of NMEP. Under Horizons, CMS sought to “improve health education communication to Medicare beneficiaries from diverse populations and with barriers to access due to language, location and low literacy,” including beneficiaries who typically do not receive Medicare information through conventional channels (Centers for Medicare and Medicaid Services 2002, p. 11). This was a much larger, systematic initiative to identify information needs and outreach strategies for racial and ethnic groups.

Three minority-owned marketing firms received contracts to enhance the agency’s ability to communicate effectively with three groups of beneficiaries: African Americans, Hispanics, and Asian American/Pacific Islanders.<sup>2</sup> During the first phase of the project, the contractors developed descriptive reports on the populations—where they reside, their information needs and health care needs, communication preferences, and media outlets used by minority populations. Next, linguistically and culturally appropriate materials were developed. These materials, the “Communications Toolkits for Serving Diverse Communities,” provide guidance on developing and delivering culturally and linguistically appropriate information products about Medicare benefits, options, and resources (CMS 2003). Although the Toolkits represent an important effort, the materials have not been actively disseminated, nor have outreach approaches been implemented or evaluated.

There are some efforts within Medicare’s traditional outreach efforts to design and implement culturally appropriate outreach to underserved groups. Through the Regional Education About Choices in Health (REACH) initiative, a component of the larger NMEP, CMS

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<sup>2</sup> Separately, CMS collaborated with the Social Security Administration and the Indian Health Service to address the needs of American Indians and Alaskan Natives.

Regional Offices work with local partners to develop outreach efforts for specific racial and ethnic groups (CMS 2002).<sup>3</sup> CMS also provides grant funding a network of State Health Insurance Assistance Programs (SHIPs) who provide information and counseling to Medicare beneficiaries about Medicare (including MSPs and Medigap).

SHIPs operate in all 50 states and the District of Columbia, provide local, individual in-person and phone counseling, and group outreach and education through a local, largely volunteer, network. These sponsors include hospitals, community-based organizations, community action organizations, and area agencies on aging, some may have relationships with individuals with different cultural backgrounds – tribal organizations, centers serving rural immigrants, Asian social service organizations, and the like.<sup>4</sup> As a condition of their federal grants, SHIPs must target “underserved” beneficiaries, but they may define “underserved” however they choose. Typically, they have chosen to focus on low-income beneficiaries.

There have been some efforts to foster greater cultural and linguistic competency in the health insurance counseling programs. CMS has developed training materials for SHIPs to use to educate their paid staff and volunteers, and in 2001, CMS expanded the training effort to include a Spanish translation of the basic training module<sup>5</sup> (Gaumer and Korda 2001, p. 40). In addition, a training manual on cultural competency was developed as part of a CMS initiative to expand enrollment of in the Medicare Savings Programs and Medicaid.

Advocates often point out that SHIP funds go to state agencies on aging and insurance departments that rarely interface with diverse, “hard-to-reach” communities. Some states, however, and some programs within states, have been more successful. Senior Rights Assistance, a SHIP in King County, Washington, is an example of an existing peer counseling

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<sup>3</sup> For example, CMS Regional Office staff received training on the HORIZONS research and findings for diverse populations.

<sup>4</sup> Federal funding was \$12.5 million in 2003, but CMS significantly increased federal SHIP funding to \$21.1 million in 2004 and \$31.7 million in 2005. In 2003, the SHIPs had about 12,000 staff and volunteers. They served about 1.2 million individuals through one-on-one counseling sessions and approximately 800,000 individuals through presentations and public education programs “Overview of the State Health Insurance Assistance Program,” [www.shiptalk.org](http://www.shiptalk.org)

<sup>5</sup> “In 2002, seven modules were developed: (1) All about Medicare in 2002, (2) Rights and Protections for People with Medicare; (3) Medigap and Other Supplemental Insurance, (4) Current Medicare Topics, (5) Coordination of Benefits, (6) Medicare Entitlement Because of a Disability, (7) Medicare Coverage for Kidney Dialysis and Transplant Services. Modules 1 and 3 were translated into Spanish.

program sponsored by a mainstream organization that has made a commitment to include Asian and Pacific Islander elderly among those they serve (Yee, Sanchez, and Shin 1999, p. 11).

Advocates point out that people have to be empowered with formal training, recognition, and a certain level of funding for SHIPs to work where they are needed most (Summit Health Institute for Research and Education 2003, p. 5). CMS has sought to address these gaps in a limited way, providing \$950,000 in funds in 2001 to five SHIPs to support “innovative outreach campaigns” for the Medicare Savings Programs. Three of the five grants awarded were to states proposing to develop and enhance outreach initiatives to culturally diverse beneficiaries. For example, the Connecticut SHIP proposed to target eligible African American and Hispanic/Latino populations using a simplified application process in conjunction with outreach initiatives carried out through partnerships at the local and community level, including outreach campaigns coordinated through local churches. The Montana SHIP proposed to focus on Native American elders living in rural tribal areas, and to develop culturally appropriate materials including a video using Montana Native Americans—distributed throughout the state’s public assistance network, and to non-profit organizations where Medicare-eligible individuals are provided services. The state proposed to produce “easily readable program information” to be printed on placemats and paper napkins and distributed to senior citizen congregate and home-based meals programs throughout Montana. Both Connecticut and Montana proposed to use out-stationing of eligibility workers to assist with the application process. A grant awarded to the Washington SHIP was to be used to target tribal beneficiaries, Hispanics, African Americans, and Asian-Pacific Islanders. The programs proposed to select a lead community organization for each target population. That organization would identify the needs of unique communities, and design and implement an intervention “to increase culturally appropriate outreach and enrollment.” The project would involve key community leaders to serve as “gatekeepers,” providing cultural bridges and translations to help people understand and apply for the Medicare Savings Programs” (CMS 2000a).

There is very little monitoring or evaluation of the materials or strategies used to reach vulnerable racial and ethnic populations in Medicare. There is no agency-sponsored, ongoing evaluation of SHIPs’ efficacy in reaching culturally diverse populations. However, past evaluations of the NMEP have assessed whether Medicare’s traditional infrastructure reaches underserved groups.

A recent evaluation of the NMEP concluded: “special populations are not a primary focus of local information suppliers,” most of whom “do not have a systematic approach or strategy for targeting special populations and the information networks...that may serve them.” At the same time, the report identified an “evolving mission and a maturing approach towards special populations,” and “more active partnering and collaboration with community organizations to special populations” including racial and ethnic subpopulations (Gaumer and Korda 2001, p. 69). Greater attention is being paid to dissemination strategies that target community-based intermediaries who can assist non-English speaking beneficiaries. Translated materials are more widely available through CMS than they have been, and are disseminated when their availability is known, but the availability of these materials is not widely known by information suppliers and intermediaries (Gaumer and Korda 2001).

The print materials alone are likely ineffective in reaching many vulnerable populations with LEP and low literacy. The authors concluded that minorities and other socio-economically vulnerable groups are less satisfied with their stock of information about Medicare, and are less knowledgeable about Medicare than other groups. As a result, “they experience choice difficulties and access problems for services (Gaumer and Korda 2001, p. iv).

The evaluation highlighted important variations across groups, with Asian Americans identified as more likely than other minority groups to use available information sources. Current structures reach African Americans better than other racial and ethnic minority groups, while reaching Hispanic/Latinos and others “will require close work with community organizations and trusted by these sub-groups” (Gaumer and Korda 2001, p. a-15). However, SHIPs’ interest and ability to conduct effective outreach to diverse populations varies considerably across states. Different SHIPs have more or less generous funding streams, and greater and lesser degrees of commitment to minority outreach. A very few are “on a mission to eliminate health care disparities,” actively recruit bilingual, bicultural volunteers representative of the population demographics in their service area, and work to establish trust in diverse communities. Most, however, are mainstream organizations reaching a mainstream audience and are not very effective at reaching populations separated from the mainstream by linguistic, educational, and cultural barriers.

Overall, CMS’ initiatives to develop more culturally appropriate outreach and education remain underdeveloped. Although the HORIZONS program had lofty goals, the objectives of

that program were not met. There has been little systematic testing of the effectiveness of specific messages and channels in reaching beneficiary groups. At the same time, the agency has contributed to the development of culturally appropriate materials that have been disseminated in particular communities with important results (e.g. breast cancer screening brochures for Asian subpopulations). However, there is no organized or systematic national effort or coalition to develop language appropriate materials for Medicare.

In light of the general lessons that have been learned about the role of education and outreach in improving knowledge, and, more significantly, the role of improved knowledge in reducing barriers to accessing services for the average Medicare beneficiary, there is clearly a need for a more targeted set of initiatives to develop effective outreach and education strategies for racial and ethnic minorities in Medicare. The case for more substantial investments is clearly articulated by Donna Yee and her colleagues:

“Information is a cornerstone for building the capacity of communities to support and empower their members, whether old or young. There is consensus among providers and community leaders that special efforts are needed to assist limited English proficient elderly to assure that beneficiaries are well informed about Medicare and health care, enable them to exercise informed choice in the context of program parameters, and assure that they understand and seek protections available to all program participants. Unless these special efforts are made, API elders will be increasingly less informed about Medicare and health care and more overwhelmed by the service system complexity and barriers...and experience poorer health status and demonstrate ...lower level of health care utilization because information about Medicare and Medicaid is unavailable” (Yee, Sanchez, and Shin 1999, p. 11).

There are a number of things that CMS does not do now that it could do to communicate more effectively with racially and ethnically diverse populations.

- CMS should assure that reliable and comprehensive data are collected and reported on beneficiaries’ race, ethnicity, and primary language preference.
- CMS should fully implement and actively publicize the language interpretation line at 1-800-Medicare.
- The agency should translate and disseminate standard forms, such as the Advanced Beneficiary Notice.

- CMS should assure that Medicare’s usual information suppliers (SHIPs, QIOs, fiscal intermediaries, and carriers) have access to culturally appropriate materials and can deliver culturally competent services.
- CMS should test the efficacy of culturally appropriate materials and outreach strategies for different racial and ethnic groups, including evaluation of SHIP outreach efforts.
- CMS should disseminate evidence about outreach approaches that are shown to be effective.

### **QIO efforts to reduce disparities**

The most significant ongoing initiative to reduce racial and ethnic disparities in clinical care in Medicare is conducted through Medicare’s network of Quality Improvement Organizations (QIOs). In separate projects in 32 states, QIOs collaborate with provider, government, and community groups to design interventions to reduce disparities, focusing on diabetes screening and mammography utilization for African American and Hispanic populations.

Medicare’s QIOs are “largely not-for-profit community-based organizations whose mission is to collaborate with beneficiaries and health care providers to achieve significant and continuing improvement in the quality and effectiveness of health care at the community level.” Traditionally, QIOs have pursued clinical quality improvement initiatives in hospitals. However, QIOs have now expanded their efforts to include nursing homes, home health care settings, and physician offices. The work of providers in each setting is focused on selected priority topics that represent important causes of morbidity and mortality among the Medicare population and the U.S. population as a whole. Priority improvement areas are selected based on the demonstrated feasibility of using these measures to document improvements in quality of care (MedQIC 2004).

In the physician office setting, priority clinical areas include diabetes, breast cancer, and immunizations. QIOs seek to reduce late stage breast cancer by increasing the rate of screening mammography, to reduce the rate of poor outcomes for people with diabetes by increasing the proportion of patients having annual hemoglobin A1c test, a biennial lipid profile, and/or a biennial eye exam, and to reduce hospitalizations for flu and pneumonia by increasing immunization rates. In the hospital setting, QIOs seek to improve the quality of care for patients with acute myocardial infarction (heart attack) through early administration of aspirin, improve

outcomes through the timely administration of antibiotics for patients with pneumonia, and reduce postoperative infection rates for patients undergoing surgery through appropriate and timely administration of antibiotics, among other topic areas.

In 1999, the priority areas for quality improvement were expanded include efforts to reduce health care disparities for underserved populations in inpatient and physician office/outpatient settings. The underserved populations addressed by the QIOs include racial and ethnic minorities (African-Americans, Hispanics, American Indians and Alaskan Natives, Asian Americans and Pacific Islanders), and rural beneficiaries.

QIOs pursue quality improvement in the same clinical priority areas using the same quality indicators that they seek to improve for the whole Medicare population. They must identify a service or pattern of care for which there is a measurable racial/ethnic disparity (of at least seven percentage points) for a given population, and they must design interventions to achieve measurable reductions in the disparity. Unlike other QIO quality improvement efforts, QIOs need not target their interventions statewide, but may focus on a more narrow geographical area.<sup>6</sup> Over a three-year contract period, QIOs must design a single project to improve processes of care for an underserved population.<sup>7</sup>

QIOs develop intervention strategies that focus on barriers specific to the population and the local system of care, drawing on somewhat limited available evidence of what works—evidence of the efficacy of interventions designed to increase the use of mammography screening among African American and Hispanic/Latino elderly women, for example (Shekelle and Stone 1998). Information on disparities and evidence-based strategies was developed by the Tennessee QIO which functions as a support center for all of the underserved projects.

Thirty-two underserved projects were conducted during the 6<sup>th</sup> scope of work (the contract that governed QIO activity between 1999 and 2002).<sup>8</sup> The majority of these projects (26

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<sup>6</sup> If there are 10,000 female African American Medicare beneficiaries in a state, the QIO underserved project must target at least 25 percent or 2,500 of those women.

<sup>7</sup> These clinical conditions overlap with the six conditions/services identified in the 1998 Presidential Initiative on Race: cancer screening and management, cardiovascular disease, diabetes mellitus, HIV/AIDS, infant mortality, and immunizations.

<sup>8</sup> Although QIOs operate in the 50 states, D.C. and the territories, many states sought to reduce disparities for dual eligibles rather than racial/ethnic minority population. Because of the difficulties measuring and achieving performance improvement for dually eligible populations, the duals were removed from the definition of underserved populations in the 7<sup>th</sup> Scope of Work.

out of 32) sought to improve access and reduce disparities for African Americans. The rest of the projects targeted Hispanic/Latinos (3 projects), American Indians (2 projects), and Pacific Islanders (1 project). Although QIOs could pursue a wide range of both inpatient and ambulatory care indicators, most focused their efforts on narrowing disparities for diabetes screening and prevention (13 projects), mammography screening (10 projects), and flu or pneumococcal vaccines (8 projects). One project sought to reduce disparities in inpatient setting to improve treatment for heart failure – early administration of aspirin for African American patients with heart failure (QSource 2004).

Under the 7<sup>th</sup> scope of work (2002-2005), there is a similar focus on African American populations, and diabetes and mammography screening. Thirty of the 52 underserved projects focused on racial and ethnic disparities. Most of the projects (22) are focused on narrowing disparities for African Americans. The rest of the projects targeted Hispanic/Latinos (4 projects), American Indians (3 projects), and Pacific Islanders (1 project). Among these groups, more than half of the projects (18) seek to reduce disparities in diabetes screening; the rest target disparities in mammography screening rates (6 projects), immunization rates (4 projects), and processes of care for hospital inpatients with heart failure (1 project).

QIO interventions often focus on efforts to increase beneficiary knowledge, motivation, and adherence to physician's recommendations. Interventions address sociocultural disparities by “working with communities and beneficiary belief systems” to encourage beneficiaries to use Medicare preventive and screening services. QIOs also develop healthcare system interventions, focusing on educating providers or “refining office practices that lead to successful file and case history management” to reduce disparities in diabetes testing. QIOs work with physicians to increase recommendations for the use of covered services (through standing orders, for example) and to ensure individual follow-up.

QIOs work in partnership with community-based organizations and providers to identify population needs and sources of disparities. They draw on the experience and knowledge of community members to identify interventions and to develop culturally appropriate materials and strategies. These partnerships involve state organizations, churches and other faith-based organizations, and advocacy organizations that focus on a particular health condition, such as diabetes or breast cancer. For example, under the 6<sup>th</sup> Scope of Work, 41 QIOs worked with state agencies, 34 worked with medical condition-based organizations, and 22 QIOs worked with

churches to learn about their target population and design and implement interventions (QSource 2004, p. 22).

Although the QIOs' success in narrowing disparities is measured, the measurement approach falls short of a scientific standard for program evaluation. The QIOs' efforts are evaluated using pre- and post-intervention measurements of the selected indicator for the target population and a reference group of Caucasian beneficiaries in the state. The QIOs and CMS interpret these baseline and follow-up measures as indicators of the impact of the QIO interventions. For example, there were eight projects under the 6<sup>th</sup> scope of work that sought to reduce disparities in mammography screening for African American women. The QIO data for these projects suggest that the interventions were modestly effective in reducing the black-white gap in mammography screening rates (which were roughly on the order of 10 to 11 percentage points). In six of the eight states, the mammography screening rate increased for the targeted population, and increased by more than rate for the white reference population, with the black-white disparity falling by between 1 and 4 percentage points. However, because mammography rates have been rising for all populations, and because QIOs also pursue broad-based efforts to increase breast cancer screening for the entire population, it is not possible to isolate the effect of the QIO efforts for their underserved projects. QIO intervention strategies may contribute significantly or not at all.

Nevertheless, it seems fair to conclude that certain interventions in certain communities have had a significant impact that is worth documenting, understanding, and replicating in other communities. The projects have undoubtedly provided some useful lessons, even though the empirical data are limited. [See descriptions of three QIO projects in Figure 1].

At the same time, the impact of the QIOs varies considerably and their national impact is small relative to the scope of disparities in Medicare. First, they target a limited subset of the minority populations, health conditions, and services for which racial and ethnic disparities are observed. They also typically have limited geographic reach, targeting a particular urban area or one or more counties within a state. As such, their impact nationally is likely small. Their actual impact is difficult to assess because the impact of the intervention is poorly measured.

There are a number of ways to improve and redirect QIO efforts to enhance their potential impact. Most importantly, more careful measurement and more carefully crafted interventions can help to identify and disseminate information about best practices so that these

interventions can be replicated in other locations. To date, the interventions are not described and measured in a way that would allow this to happen. The QIO projects are focused on only a narrow subset of minority beneficiaries in Medicare and a narrow range of clinical conditions and quality indicators. Projects tend to focus on African Americans; other racial and ethnic groups receive less attention. In addition, preventive services and cancer screenings are important, but projects to date have by and large overlooked disparities in acute care, post acute care, mental health care, and long-term care. Although beneficiary outreach and education have been central components of QIO interventions, and that work needs to continue, QIOs should address barriers to changing physician behavior, such as reluctance to sign standing orders, offer case management services, work in multidisciplinary teams, or use interpreter services for patients with limited English proficiency.

CMS has an opportunity to redirect and enhance QIO activities to narrow disparities during the next contract period. The 8<sup>th</sup> Scope of Work, which will govern QIO activities between 2005 and 2008, has not yet been finalized. In crafting that Scope of Work, CMS should broaden the focus of intervention strategies that will generate more substantial progress toward narrowing disparities, focusing on physician behavior and health care system interventions. To summarize:

- CMS needs to refine existing measurement approaches to effectively evaluate the QIOs' performance in improving the quality of care and narrowing racial and ethnic disparities.
- CMS should consider expanding the disparities projects into the other clinical care settings in which QIOs operate, including nursing homes and home care agencies.
- QIOs should address barriers to changing physician behavior.
- CMS and QIOs need to enhance efforts to identify and disseminate successful approaches to reduce racial and ethnic disparities.

### **Demonstration and pilot projects**

CMS has a number of other disparities initiatives that share similarities with the QIO projects that are worthy of mention. CMS provides grant funding to historically black colleges and universities, and other academic institutions and organizations with roots in certain minority

communities, to conduct and evaluate community interventions to improve access to care and quality of care for racial and minorities. These projects tend to focus on health risks and behavior, screening, and chronic disease management. In addition, a number of ongoing and new demonstration programs are intended to assess the impact of interventions to reduce racial and ethnic disparities in care, including legislatively mandated demonstration that will focus on narrowing disparities in cancer screening, diagnosis, and treatment. CMS, through its Regional Offices, also participates in smaller projects around the nation, collaborating with the Centers for Disease Control and Prevention, as well as QIOs, in a number of disparities projects.

#### Colleges, universities, and community organizations as institutional resources

Through small contracts with community-based organizations, and through its initiatives with colleges and universities representing underserved racial and ethnic minority groups, CMS has funded several projects to raise awareness about health risks, expand the use of preventive services, reduce behavioral risk factors, and enhance patient self-management of chronic disease (e.g. diabetes self-care, cardiovascular disease initiatives). CMS began a partnership with the nation's Historically Black Colleges and Universities (HBCUs) in 1996 to increase understanding of racial and ethnic barriers in health, and develop and evaluate strategies to reduce them. CMS funds similar projects with Hispanic-Serving Institutions (HSIs), and Tribal Colleges to develop projects targeting Hispanic and American Indian populations. Small grants have also been provided to community groups representing Asian and Pacific Islander populations.

An early (1997) project established a partnership among seven HBCUs and several QIOs to increase flu immunization rates for a target population of more than 700,000 beneficiaries. Most of the interventions, however, are significantly smaller in scale, reaching several dozen to several hundred people. In 2005, Tennessee State University will implement and evaluate a church-based prostate cancer education program for 400 African American men randomly selected from 40 African American churches in Nashville, Tennessee. North Carolina A&T University will develop an intervention to assess the impact of relaxation techniques on stress, coronary heart disease risk, and mortality in Guilford County, North Carolina. Four universities will implement a Community-Based Diabetes Self-Management Education Program for use in the African American and Hispanic communities, targeting African American and Hispanic men

and women age 45 and above who are diagnosed with diabetes or at high risk of developing the disease. These grants generally include an evaluation component and there are some efforts to synthesize and disseminate (albeit in a limited fashion) the findings across the HBCU/HSI network of research grantees.

### Regional office initiatives

CMS also partners with the Centers for Disease Control and Prevention on their Racial and Ethnic Adult Disparities in Immunization Initiative (READII). The READII projects, operating five U.S. cities, seek to reduce disparities in flu and pneumococcal immunization rates for African and Hispanic elders through collaborative efforts between state or local health departments, community-based organizations, providers, and QIOs. As part of the overall evaluation plan for the READII project, CMS is funding a beneficiary survey in the 5 READII sites (CMS 2004a, p. 103). Preliminary assessments have found that health departments, though experienced in dealing with childhood vaccination outreach efforts, are not as well equipped to reduce disparities in adult immunization rates. Many have had a difficult time identifying and establishing relationships with the providers who care for large numbers of underserved adults.

### Demonstration projects

CMS has opportunities through the Medicare and Medicaid demonstration authorities to test approaches to narrowing racial and ethnic disparities. Although few demonstration projects have specifically addressed racial disparities, the 2000 Medicare, Medicaid and SCHIP Benefits Improvement and Protections Act (BIPA) requires the Secretary of Health and Human Services to undertake a major demonstration program--the Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities--to assess whether program enhancements could reduce racial and ethnic disparities in Medicare. CMS must conduct at least nine projects for targeted ethnic and racial minorities for the purpose of developing models and evaluating methods that improve the quality of services disparities in early detection and treatment of cancer; improve clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services and referral patterns among those target individuals with cancer. The nine demonstration projects include two projects for each of the following four major racial and ethnic minority groups: American Indians, including Alaskan Natives, Eskimos, and Aleuts; Asian Americans and Pacific Islanders; Blacks; and Hispanics. The two projects within each of

the four categories must target different ethnic subpopulations. In addition, one project must occur within the Pacific Islands. At least one project each must be implemented in a rural area and one must be implemented in an inner-city area. The legislation provides \$25 million from the Medicare Trust Fund (beyond the amount the Secretary would have paid under the Medicare program for the prevention and treatment of cancer) for this effort.

CMS recently released the solicitation for sites to participate in randomized controlled trials testing promising models and approaches, inviting participation from a number of entities including chronic care management organizations, health insurers, physician group practices, academic medical centers, community health centers, and “minority institutions.”

A Brandeis University research team conducted a comprehensive review and synthesis of evidence about models that promote cancer detection and treatment interventions that have a high probability of reducing risk factors, increasing the use of Medicare-covered services, and improving health and cancer-related outcomes among the targeted ethnic and racial minority populations. The Brandeis University report recommended that the Secretary of HHS evaluate the efficacy of new patient tracking and decision support tools (health risk assessment) and an enabling services staff intervention model (such as community health workers, *promotores de salud*, or patient navigators) as a promising strategy to effectively address both cultural and health care system barriers associated with cancer disparities.

Community-centered, culturally tailored programs can increase primary prevention, screening adherence, and screening-to-diagnosis facilitation. Healthcare facilitators (e.g., community health workers, health aides, case coordinators, etc.) are effective support agents who can provide culturally tailored health risk management services as a strategy for engaging elders of color in appropriate cancer prevention, detection and treatment behaviors. The opportunity to improve the health status of the target racial and ethnic groups will require working more closely with communities to identify culturally sensitive implementation strategies and will necessitate enhanced efforts toward preventing disease, promoting health, and delivering appropriate care.

Significantly, the demonstration will address disparities in clinical treatment that have not been addressed by the QIOs. In addition, the demonstration will focus on disparities within racial and ethnic groups, which research has shown are often large. Within the Hispanic population, for example, screening mammography rates vary widely across four distinct subgroups. A study that assessed geographic and racial/ethnic disparities identified wide

differences in the experiences of Central American, Mexican-American, Cuban, and Puerto Rican women depending on where they live, with differences attributable to a variety of factors including differences in local health care systems and structure of care, as well as differences in individual-cultural factors such as immigration status and cultural beliefs (Capitman and Bhalotra 2003, p. 3-28).

Two other demonstration activities, though not explicitly focused on racial and ethnic disparities, are ongoing. Officials in CMS point out that various disease management demonstrations may disproportionately affect minority beneficiaries in Medicare who have higher rates of chronic illness than whites. In addition, a Medicare quality of care demonstration required by the MMA (section 646) requires CMS to conduct a five-year demonstration project to examine factors improve the quality of (and reduce variations in) the quality of care provided to Medicare beneficiaries. Though not the sole focus of the demonstration, the “appropriate use of culturally and ethnically sensitive care” is mentioned in the legislation as a factor to be studied.

### **Cultural competency in managed care plans**

Medicare regulations require that Medicare managed care plans have policies in place to assure equal access to care for all Medicare beneficiaries regardless of their race or ethnicity.<sup>9</sup> Specifically, Medicare regulations require managed care plans to “implement procedures to ensure that enrollees are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.”<sup>10</sup> They are also required to “ensure that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner including those with Limited English Proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.”<sup>11</sup> With regard to language access, plans must have

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<sup>9</sup> Managed care plans receiving federal funds are required under Title VI of the Civil Rights Act to prevent discrimination in their programs. “Under the rules governing grants, loans, and contracts no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

<sup>10</sup> 42 CFR 422.110; Manual, Chapter 4, Section 100.1 and 100.3.

<sup>11</sup> 42 CFR 422.112(a)(9); Manual Chapter 4, Section 120.2.

procedures for both ascertaining the primary language of potential enrollees in their service area and making enrollment materials available in the primary language of a significant proportion of the population in the service area.<sup>12</sup>

Beyond these structural standards, plans are also held accountable for improving care. Plans required to show demonstrable and measurable improvement in specified broad clinical areas through Quality Assessment and Performance Improvement (QAPI) projects. Partly to address criticisms that they were not adequately fulfilling these obligations (and were vulnerable to Title VI enforcement actions) plans agreed to implement a national quality assessment and performance improvement (QAPI) projects to enhance their cultural and linguistic competence.<sup>13</sup>

The 2003 national QAPI project required plans to choose a project to improve their cultural competence. Two separate options were provided. Although QAPI projects tend to require projects that are clinically focused, with quantifiable outcomes, the 2003 national project offered plans a choice of a quantitative traditional PI project and a less traditional project under which they would improve the structure and process of care and to report improvement in more qualitative terms. Under the first option, plans were to design a project to reduce a clinical health care disparity (CHCD), but they also had an option to developing initiatives to enhance their ability to provide culturally and linguistically appropriate services (CLAS) (CMS 2004c).

Plans selecting the CHCD task must measure and demonstrate improved quality of care in one of four clinical areas – pneumonia, mammography, diabetes, or congestive heart failure. They must identify a racial/ethnic group for improvement, and may include individuals in one, some, or all of five racial/ethnic groups: American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Pacific Islander, and Hispanic/Latino. Racial and ethnic data on plan enrollees (from SSA) was provided to plans that requested it for the purposes of implementing these projects. Plans could also use other data sources (e.g. census data on racial ethnic population by zip code) to identify a target population. Although plans must demonstrate

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<sup>12</sup> Revisions to the original QISMC standards have significantly reduced requirements for language access. Those standards required the organization to “have a procedure for ascertaining the primary language of enrollees and for making information materials available in any language that is the primary language of the geographic area (contracted service area).” And suggested that, as a rule of thumb, consideration should be given to providing information materials in other languages when more than 10 percent of the those eligible for enrollment have a primary language other than English. (OPL 98-72,QISMC requirement 2.3.3.2 ).

<sup>13</sup> Conversation with Bob Berenson.

improvement in the care provided to a racial and ethnic minority population, the QAPI regulation neither requires plans identify a disparity between a minority and a white population, nor reduce it. They did, however, have to identify a minority population and demonstrate improvement in the quality of care for that population.

Plans selecting a CLAS project have a number of different options. CMS provided technical assistance to plans to help them design and implement CLAS projects. With AHRQ funding, CMS contracted with the Lovelace Clinic Foundation to develop two cultural competency guides, one manual provides “a practical step-by-step process for the improvement of oral language services to patients with limited English proficiency” (Paez 2002b). A second manual provides tools for health plans to use in evaluating the ethnically diverse populations they may serve and assessing their own cultural competency (Paez 2002a). As described in the training manuals and regulations, a plan could focus on improving language services, compiling and making available to enrollees a provider directory that identifies the plan’s bilingual or multilingual practitioners. A more ambitious project might establish a mechanism for identifying LEP enrollees, and create a system for accessing and using that information. Another option would be to inform enrollees of their right to language services. Plans could limit their activity to evaluating existing processes and identifying where language assistance is needed. Or, they could go further and expand existing capacity to provide oral linguistic services through the use of interpreters, community volunteers, telephone interpreter services. Plans could choose to define cultural competency more broadly, and implement organizational changes such as seeking to recruit more diverse staff and practitioners “who reflect the dominant racial, ethnic and linguistic minorities served,” undertaking a “cultural competency organizational assessment,” providing CLAS training for staff and providers, or developing a strategic plan for organizational and clinical cultural competence (CMS 2004c).

Although the projects were initiated in 2002 and 2003, there is little information yet available on the projects plans are undertaking to meet the QAPI project requirement. Plans are not required to report to CMS until their projects end, with the earliest reports due in October 2005.<sup>14</sup> However, preliminary discussions with individuals inside and outside of CMS suggest

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<sup>14</sup> Some plans have submitted projects for review. These are plans that had ongoing initiatives that would qualify as 2003 QAPI projects. Since these projects would have an earlier than usual baseline, they may have already reported the results of their efforts for CMS review.

that many plans have selected CLAS projects. Availability of the CLAS guides influenced decision to select a CLAS project, rather than a clinical health care disparities project, for which no technical assistance was provided. In addition, it appears that plans adopting CLAS projects have tended to define them narrowly, collecting language information from providers and disseminating a revised provider directory. Other plans have elected to undertake cultural competency organizational assessments. For example, five California plans working with Lumetra, the California QIO, participated in a cultural competence organizational assessment.

Although it is too soon to say what impact these performance improvement projects may have, CMS officials suggest that that have raised awareness of linguistic and cultural competence among plans. The guides also made plans aware of the wide range of projects that could be undertake to provide linguistically and culturally appropriate services.

These finding received some confirmation in a small pilot study conducted to assess managed care organizations' perceptions of the two CLAS training manuals. Perceptions of the CLAS guides and projects varied. Some plan interviewees said the CLAS project had had a positive impact on the plan and was well received in the organization; others were neutral or negative. One interviewee observed that: "We are a diverse organization in a diverse city. We never thought of CLAS as an issue. Reading through the guides, we realized that we might not be as culturally competent as we think we are." Another plan, "initially resistant to the 2003 QAPI project because they believe their minority membership was small, found that the guides made them aware of what they were and were not doing." Yet another observed that an "initial negative turned to positive because the legal issues were brought to light and helped to define why a process was needed for language services" (Lovelace Clinic Foundation 2004, p. 7).

As CMS collects information on the outcomes of the 2003 CLAS projects, at least one agency representative suggested that they would hope to disseminate information on the impacts of cultural competency assessment and training and revise program and training materials. However, past reporting on QAPI projects is designed only to give plans some overall sense of how plans fared nationally. The report is simple accounting of the number of projects meeting the minimum criteria for compliance with the QAPI requirements, with a short assessment of the factors that led to poor results, and some very general guidance on the design and implementation of successful QAPI projects.

The 2003 national QAPI project on disparities falls short of the requirements and standards for accountability to which plans could be held. The effort to require equity-focused performance improvement was undermined from the start since plans were not required to identify or narrow a disparity. The potential impact of the performance improvement mechanism has not been exploited. Since 2002, “CMS has taken no further steps to incorporate race and ethnicity measures into ongoing QAPI programs or to require equity-focused performance improvement initiatives” (Watson forthcoming, p. 17). However, CMS has eliminated the requirement that plans participate in a national QAPI project in 2005 as the agency seeks to reduce regulatory burdens on plans (CMS 2004a).

### **Lessons from Medicare Advantage and Medicaid**

This section discusses whether there are experiences in Medicare Advantage and Medicaid that could provide useful lessons for CMS.

#### **What can be learned from Medicare Advantage?**

As in Original Medicare, there are persistent disparities in the care receive by white beneficiaries and minority beneficiaries in Medicare managed care plans. American Indians enrolled in Medicare managed care plans, for example, are less likely to see a primary care physician or specialist physician than other enrollees, but are more likely to be hospitalized or to use emergency room services (Langwell, Moser, and Alcala-Levy 2001). Elderly black Medicare beneficiaries in managed care are less likely than whites to receive breast cancer screening, beta-blocker medications after heart attacks, or follow-up visit after hospitalization for mental illness (Schneider, Zaslavsky, and Epstein 2002).

Studies that compare the performance of managed care and fee-for-service also find that racial disparities persist in managed care despite opportunities for innovation. A recent study finds that managed care does not narrow racial and ethnic disparities in preventive services relative to fee-for-service. The study documented that rates of influenza vaccination among elderly Medicare beneficiaries were higher for blacks and whites in managed care plans compared to fee-for-services, but the racial disparity between blacks and whites nevertheless remained (Schneider et al. 2001).

Although one can imagine a range of possible interventions that managed care plans could undertake, there is very little evidence that many plans have made substantial progress in pursuing these opportunities. Some plans, however, have made substantial investments. Kaiser Permanente an Institute for Culturally Competent Care that is responsible for developing tools and resources and for training providers and clinicians to assure that its plans across the nation provide culturally competent care to its diverse enrollees. The Institute also selects and supports Centers of Excellence in Culturally Competent Care.<sup>15</sup> Kaiser Permanente also has seeks to develop innovative modes and ensure linguistically and culturally appropriate care through its National Linguistic and Cultural Programs (NLCP). NLCP serves as Kaiser Permanente's central resource for member plans on addressing language access for diverse populations. Kaiser has three key initiatives related to its efforts to build, sustain, and evaluate projects to enhance its linguistic competence: it is assessing the impact of trained interpreters on health care use, outcomes and satisfaction, it is building national coalition on quality translation in health care, and it is developing a tool to assess the language proficiency of providers and efforts to target resources to proficient providers to improve their language skills. The Center faces many of the challenges that CMS faces in developing and implementing initiatives to address diverse racial and ethnic groups around the country, and encountering resistance from providers and institutions who may discount the need for efforts to address cultural and linguistic competence.<sup>16</sup>

Kaiser Permanente is not entirely alone in its efforts. A recent survey suggests that health plans have become more engaged in collecting data on racial and ethnic disparities and reducing disparities in care. A 2003 AHIP survey of member plans revealed that half of responding companies, representing 88 million enrollees, including Medicare beneficiaries, collect racial and ethnic identifying data. Most plans began collecting this information in 2002 or 2003, and according to AHIP, the companies use racial and ethnic identifying data to buttress quality improvement efforts designed to reduce disparities in care (AHIP 2004). Seeking to build on these efforts, AHRQ and the Robert Wood Johnson Foundation are funding an initiative, the

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<sup>15</sup> There are currently seven centers, located in Colorado, California, Ohio and the mid-Atlantic states; the centers focus on culturally competent care for Latinos (two centers), African Americans (two centers), persons with disabilities, women, and the Armenian population.

<sup>16</sup> Conversation with Gayle Tang, Director of the National Center for Cultural and Linguistic Competence at Kaiser Permanente.

National Health Plan Learning Collaborative to Reduce Disparities and Improve Quality, which is designed to help reduce disparities in health care for people with diabetes and other conditions. This collaborative brings together nine of the nation's largest health insurance plans to test ways to improve the collection and analysis of data on race and ethnicity, match those data to existing quality measures in the Health Plan Employer Data and Information Set, develop quality improvement interventions that close the gaps in care and produce results that can be replicated by other health insurers and providers serving Medicare, Medicaid and commercial populations (AHRQ 2004). As managed care plans gain experience with initiatives to provide linguistically and culturally competent care and narrow clinical disparities, their experience may help inform CMS initiatives in fee-for-service Medicare.

#### What can be learned from Medicaid?

Medicaid is rarely presented as a model for how to narrow racial disparities in medical care. Medicaid's design—means-tested, state administered within a federal structure with “many options, and few absolutes,” entrenched low payments, and low provider participation—fails to narrow racial disparities in use of care for insured populations (Rosenbaum 2003). At the same time, however, Medicaid agencies have always had to grapple with a very diverse population. Nationally, about half of all Medicaid beneficiaries are members of racial and ethnic minorities (CMS 2000b, p. 24), compared to about 15 percent of the Medicare population. Medicaid agencies have more experience reaching and enrolling vulnerable minority populations and assuring access to care for those beneficiaries. The plans and providers who care for the Medicaid population, though separated from the mainstream, may have extensive experience and more practical and successful approaches to meeting the cultural, social, and linguistic needs of their patients.

A clear lesson from Medicaid is that simplified application and streamlined enrollment practices can help assure high rates of participation and continuous coverage in voluntary insurance programs. Out-stationed eligibility workers can facilitate enrollment of eligible individuals. States have also recognized the need to translate applications and offer interpreter services to better reach non-English speaking populations, though only a few states draw down federal funds for interpreter services. The Medicaid experience also demonstrates that efforts

should be made to avoid fragmenting programs. States that structured their SCHIP as a stand-alone program, rather than as a Medicaid expansion, exacerbated racial disparities (Rosenbaum 2003). These lessons may prove to be tremendously important to CMS as it implements the voluntary prescription drug benefits and low-income subsidy programs in 2006.

As is true in Medicare, access to Medicaid substantially narrows, but does not eliminate, racial and ethnic disparities in medical care for previously uninsured populations. Among children gaining eligibility for Medicaid, health care utilization rates increased more for black children and than for whites and Medicaid eligibility had a larger impact on the mortality rate for black children. Medicaid's broad benefits and nominal cost sharing substantially reduce disparities in access to care for poor and low-income minorities. However, black children gaining Medicaid coverage were more likely than newly insured white children to experience increases in the use of hospital clinics and emergency rooms rather than doctors' offices (Currie and Gruber 1996). Other research finds that Medicaid coverage (relative to no insurance or private insurance) increases the probability of routine checkups for both black and white children, but increases the number of visit for illness only for white children (Currie and Thomas 1995).

Racial disparities in the services received by minority and white beneficiaries in Medicaid have been identified in a number of clinical areas including the treatment of asthma (Lieu et al. 2004; Shields, Comstock, and Weiss 2004), access to routine and specialized prenatal care services (Gavin et al. 2004), access to epidural anesthesia during labor and delivery (Rust et al. 2004), the diagnosis and treatment of mental health conditions in children including depression and autism (Mandell et al. 2003; Richardson et al. 2003), the use of prescription drugs, including lipid-lower agents for patients diagnosed with cardiovascular disease (Schore, Brown, and Lavin 2003; Litaker and Koroukian 2004), the use of health care providers (e.g. the number and duration of hospitalizations for children, and use of emergency rooms and clinics as opposed to care in physician offices) (Currie and Gruber 1996; Currie and Thomas 1995), and in consumer assessments of Medicaid health plans (Weech-Maldonado et al. 2004).

Despite evidence of persistent disparities, it is also likely the individual providers, health clinics and health-center affiliated plans that have traditionally served this population have developed policies and practices that enable them to bring "high-quality, culturally competent health care to the communities they serve" (Zambrana et al. 2004, p. SP42). Medicaid providers

are more likely to “a sense of mission” to learn to care for those from vastly different racial, ethnic and socioeconomic backgrounds (Watson 2001, pp. 56-57).

Practices that predominantly serve a Medicaid population may be more likely to adopt interventions shown to be effective in narrowing disparities. One study of the care provided by Medicaid managed care plans revealed that patient satisfaction with care was higher, and outcomes of care were better among those receiving care in plans and health care settings with higher cultural competence ratings. Care for children with asthma in Medicaid plans also improved with access and continuity, practice-site policies such as case management, support for self-management, and use of written asthma management plans (Lieu et al. 2004). Other studies of urban primary care practices show that can narrow disparities in childhood immunization rates through reminder/recall interventions (Szilagyi et al. 2002).

Not all Medicaid plans are as familiar with the unique needs of the populations they serve, however. Consequently, in their role as purchasers, Medicaid agencies have included standards for cultural competence, access to providers, and language access. “State Medicaid programs are far ahead of the federal government in the case of managed care organizations; their contracts with managed care organizations typically contain extensive access requirements related not only to networks but to hours, locations of services, cultural competency and translation services, and other steps designed to remove barriers that disproportionately could affect minority enrollment and utilization” (Rosenbaum 2003, p. 691). Medicaid requirements are more specific than Medicare and private accreditation requirements. For example, Medicaid regulations are unique in their requirement that state’s quality strategies include procedures to identify the race, ethnicity and primary language of each enrollee at the time of enrollment and provide this information to the managed care organization. States must also make oral interpretation services available free of charge to each enrollee and potential enrollee (GAO 2004). As is true throughout Medicaid, however, states do different things. Certain states, Wisconsin among them, have comprehensive standards related to cultural competence and access.<sup>17</sup>

There is only limited research on the impact of these contracting requirements on plan performance and patient outcomes. Researchers who have examined the impact of cultural

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<sup>17</sup> Conversation with Sara Rosenbaum.

competence requirements in California suggest that plans have responded in a significant way to contract requirements, updating their policies and practices to meet the state's requirements (Brach et al. 2004; Coye and Alvarez 1999).

There is much still to be learned about the impact of states' managed care contracting requirements on the performance of managed care plans to improve structures and processes of care and, in turn, the impact of those policies and practices on patterns of care for white and minority enrollees. There is also much more to be learned about the characteristics of health care systems that are able to improve quality and reduce disparities.<sup>18</sup> Evidence on both could help inform efforts to develop requirements and initiatives to narrow disparities in Medicare.

## **Conclusions**

Medicare's central commitment to fund a consistent set of health care for all of the elderly has substantially reduced racial and ethnic disparities for those who would otherwise be unable to obtain affordable health care services. However, more can be done to assure that those eligible for Medicare and related programs are enrolled in those program, are able to navigate them effectively, and have access to providers from whom they can receive culturally competent and continuous care, and who will be strong advocates to help them obtain the services they need. The discussion above has summarized the efforts developed by CMS and its partners – SHIPs, QIOs, managed care plans—to intervene to narrow disparities. Though important first steps, these activities have fall short of what is needed to make more substantial progress toward narrowing disparities. In developing future initiatives, it is useful to consider what can be accomplished through broad-based mechanisms designed to improve access and quality for all beneficiaries, and what can and should be done through local initiatives.

As nearly 40 years of history demonstrates, a national program like Medicare can effectively address diverse groups by doing what it does best: it can assure that resources are distributed in a relatively equitable fashion across the nation, it can improve the quality of care for all beneficiaries, it can assure that federal outreach and education is linguistically and

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<sup>18</sup> Future work funded by the Robert Wood Johnson Foundation and the Commonwealth Fund, the Center for Health Care Strategies, Inc. will bring together 12 Medicaid managed care plans to “partner with appropriate stakeholders (consumers, providers, and state purchasers) develop strategies for identifying and addressing disparities to “structure quality improvement activities, develop realistic short- and long-term measures, pilot their interventions, and evaluate the results” (Center for Health Care Strategies 2004).

culturally appropriate and that states and communities have materials and tools they can use to meet local needs. In administering a national program, CMS also has a unique ability to develop and test alternative approaches to narrowing disparities and to disseminate information to providers nationally about what works.

At the same time, research and practical experience demonstrate that many of the obstacles and solutions vary by region and culture, so there probably will never be one model for care that would work in all communities. Local medical and social cultures vary dramatically across the country, as do the populations receiving care. Local understanding of cultures, barriers can be addressed by community groups and institutions with federal financial assistance. The QIO community based efforts provide opportunities for local communities to identify disparities and design interventions that may work for their local circumstances. Ideally, a mid-21<sup>st</sup> century Medicare program will be better able to address the needs of its much more diverse beneficiary population. More vigorous efforts are clearly needed within CMS to improve education and outreach, address providers' cultural competence and physician decision-making, and bring greater focus and attention to equity-based measures of quality.

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Figure 1

### SELECTED QIO PROJECTS, 1999-2002

**The North Carolina QIO focused on narrowing black-white disparities in annual glycosylated hemoglobin A1c (hbA1c) test utilization rates.** The QIO identified several potential sources of the disparity, including lack of knowledge about diabetes, early screening methods, and Medicare benefits, as well as lack of knowledge about the location of community services and transportation assistance. The QIO mailed two brochures to all African Americans with diabetes in the intervention counties of the state. An initial flyer focused on the quality indicators and Medicare coverage information. A second brochure encouraged beneficiaries to make a treatment plan with their doctor. A third brochure was developed that recognized Black History Month and offered a gift to those beneficiaries who returned a coupon signed or stamped by their doctor or medical facility. Provider behavior was also addressed. The QIO sent a letter describing racial disparities for Medicare beneficiaries with diabetes, and included a flowchart physicians could use to track beneficiaries with diabetes. The QIO also held a telephone conference on “best practices for the target population.” At baseline, Medicare data revealed a 10 percentage point disparity, with 70 percent of whites and 60 percent of African Americans receiving the test. At re-measurement, these rates had substantially increased for both populations: 75% of blacks and 83% of whites had received the annual test, representing a narrowing of the disparity from 10 to 8 percentage points (pp. B32-33).

**The Georgia QIO sought to reduce the disparity in mammography utilization rates between African American and Caucasian women in the state.** First, they sought to identify barriers to mammography screening and access to care barriers. The QIO found that lack of available facilities, lack of physician recommendations, “lack of knowledge about the effectiveness of mammography as a preventive tool,” and “African American women’s fear of detecting abnormalities” influenced mammography utilization. They conducted physician, beneficiary, and facility mailings. The physician mailing contained county mammography rates, information on Medicare coverage, office reminder tools, patient education sources and a prompt sheet for responding to patient barriers to mammography. The facility mailings were similar. The patient mailings contained a health planner/calendar with relevant information and phone numbers. The cover of the calendar presented facts and myths about breast cancer screening. The packet also contained information regarding Medicare payment for mammography and a list of mammography facilities. Mammography utilization rates did not increase for either the target or the reference population. At both baseline and re-measurement, about 51 percent of African American women in Medicare had been screened. The rate among whites declined from 67% to 63%, causing the measured black-white gap to narrow, but only because of the decline in utilization among whites (p. B10-11).

**The Colorado QIO sought to reduce the disparity in mammography utilization rates between Medicare-eligible Hispanic and Caucasian women in the state.** The QIO identified barriers to mammography use including “limited knowledge, misconceptions about services, fatalistic views, sense of being punished, access to care, modest ad the needs of putting the family needs ahead of one’s own.” The QIO chose to implement a community-based intervention aimed at patients. Specifically, “given the failure of traditional methods to address

### **Selected QIO Projects, continued**

these barriers,” they launched a church-based outreach effort. The QIO contacted 213 Catholic churches throughout the state and asked them to distribute information to their congregation. “An enhanced intervention” included Promotoras (lay health educators) trained by a local community clinics, women’s health groups, and an influential “opinion leader” who championed the effort. The pre-/post-intervention measurement indicated modest improvements in the mammography service utilization rate for both the target Hispanic and white reference populations. The utilization rate for Hispanic women rose by 8 percentage points from 43% to 51% while the rate for white women rose by 4 percentage points from 57% to 61%, narrowing the disparity in use (pp. B91-92).

**The New York QIO (IPRO) sought to reduce the disparity in pneumococcal vaccination (PPV) rates between African American beneficiaries and non-African American beneficiaries in the state.** The QIO identified barriers including: lack of knowledge about PPV, under use of Part B due to beneficiary cost sharing, low numbers of clinics, a need for physician recommendation. The QIO also identified the need for culturally appropriate messages. IPRO used a previously developed model for physician office interventions, which included the use of contact management software for tracking preventive health services, including PPV. Strategies included reminders for recalling patients, feedback to providers, and standing orders for PPV. The QIO collaborated with hospitals, hospital networks, the New York City Department of Health, and community groups working through individual hospitals. Community-based messages were also developed, including a poster promoting PPV. The QIO found that outpatient department staffs with many African American employees were successful in promoting PPV and that standing orders were also an effective method for improving immunization rates. A substantial disparity in black-non black immunization rates was reduced as the PPV rate for the target population rose by 22 percentage points (from 31% to 53%) and the rate for the reference population rose by 10 percentage points from 53% to 63% (pp. B48-49).

Source: (QSource 2004), Appendix B, Summaries of Each QIO Project.