

H.R. 3200 America's Affordable Health Choices Act of 2009 (July 14, 2009)

Implications for Improving Access, Affordability and Quality of Health Care for America's Racial/Ethnic Minorities

Table 1. Expanding Access to Affordable Health Coverage

	Summary ¹	Implications for Racial/Ethnic Minorities
Insurance Market Reforms	<ul style="list-style-type: none"> • Guaranteed availability and renewability of coverage. • Prohibit exclusions based on pre-existing conditions. • Prohibit insurance rating variation by health status. Allow variation for participating plans only by family size, geography and age (limited to 2:1 ratio). • Create a National Health Insurance Exchange through which individuals and employers can compare and purchase health insurance. Provide culturally and linguistically tailored outreach through toll-free hotlines, websites, and community-based sites. • Plans participating in the Exchange must meet essential benefit requirements; including no cost-sharing for preventive services, dental and vision services for youths under age 21, prescription drugs, and mental health and substance abuse services. • Place caps on health insurance premiums for out-of-pocket spending for those purchasing coverage through the exchange. • Create a new public plan that meets the same requirements as and competes with private plans in the Exchange. Benefits will range from basic, enhanced, premium to premium plus. Provider payments will be at Medicare rates, with 5% bonuses for providers participating in both Medicare and the public plan and for providers who do not traditionally participate in Medicare (e.g., pediatricians). Provider participation will be voluntary, but Medicare providers will be presumed to be participating unless they opt-out. • Develop innovative payment methods that encourage patient-centered medical care and care coordination. 	<ul style="list-style-type: none"> • Removing barriers to insurance coverage based on illness or health status should improve access to affordable insurance coverage for minorities, who have disproportionately higher rates of morbidity. Nearly half of all black adults suffer from a chronic condition or disability.² • Prohibiting cost-sharing for preventive services would help low-income and minority individuals, particularly the large proportions of Hispanics (54%), Asians (52%) and Blacks (44%) who often delay or forgo routine and preventive care, largely due to cost.³ • Outreach efforts that are culturally and linguistically appropriate have great potential to increase enrollment among racial/ethnic minorities and those with limited English proficiency and enable them to make informed decisions about the coverage they purchase. Resources and training for community based organizations to provide information and application assistance could significantly facilitate participation among historically disenfranchised and minority populations. • Medical debt is a leading cause of personal bankruptcy that disproportionately affects low income and minority families. For example, Blacks are more likely than whites (44% vs. 33%) to be unable to pay their medical bills, be contacted by a collection agency, and have outstanding medical debt.⁴ Caps on spending will help to limit the financial risks and potential exposure to medical debt for minority and poor families. • Creation of a new public plan would offer an affordable health coverage option for many uninsured or underinsured low-income and minority adults. Generally, public plans have lower premiums and out-of-pocket expenses than private plans.⁵ In 2008, for example, administrative costs for Medicare were 1.4%, whereas for Medicare Advantage plans (which are administered privately) costs were 9%.⁶ However, monitoring the impact of provider payments at Medicare rates, which are lower than private insurers (e.g., in 2008, Medicare payments were generally 20% lower)⁷, will be important to assure equality in quality of health care, given that lower-income and minority populations may be disproportionately more likely to be enrolled in a public plan.

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Individual Role	<ul style="list-style-type: none">• Require all individuals to have health insurance that meets minimal standards. Mandate would be enforced by a penalty of 2.5% modified adjusted gross income, not exceeding the average cost of the basic plan offered in the Exchange. Exceptions include dependents, those with religious objections, and those who can demonstrate financial hardship.• Individuals can keep their existing coverage, but insurance purchased outside the Exchange that does not meet minimal benefit standards would not be in compliance with the individual mandate unless the plan is "grandfathered" in.	<ul style="list-style-type: none">• An individual mandate would establish a "culture of insurance" that will likely require education and outreach not only to the vulnerable populations defined within the current bill, but also to racial/ethnic/linguistic minorities and particularly those who may have limited experience with insurance coverage.• An individual mandate may increase demand for primary and specialty care among previously uninsured individuals, which would increase demand for culturally and linguistically competent providers.• Safety-net providers that have historically served minorities could face negative financial implications resulting from a wider choice of providers accepting newly insured patients. At the same time, they may benefit from an increase in reimbursements from insured patients.
Employer Role	<ul style="list-style-type: none">• "Pay or play" mandate for employers.• Employers must offer coverage to full-time employees and contribute to the premium cost (72.5% individual, 65% family) of the Basic plan being offered in the Exchange or pay up to 8% of their payroll into the Exchange Trust Fund based on a sliding-scale corresponding with annual payroll. Part-time employees will receive benefits proportional to number of hours worked.• Exclude any employer contribution which corresponds with a reduction in employee compensation from being treated as an employer contribution.• Exceptions for employers with payrolls not exceeding \$250,000 would be available, along with sliding-scale credits for small businesses with average wages between \$20,000 and \$40,000 that want to provide coverage.	<ul style="list-style-type: none">• An employer mandate, with federal assistance to small businesses, could expand coverage for many employed low-income and minority individuals and their families. However, the "play or pay" provision could increase business costs and produce unintentional consequences, such as layoffs, that would negatively impact low-income and minority employees.
State Role	<ul style="list-style-type: none">• Require a Memorandum of Understanding between the Exchange and individual states to coordinate enrollment of residents in participating health plans and Medicaid programs.• Option of providing additional coverage under Medicaid for family planning, freestanding birth clinics, and low-income HIV-infected individuals.• Option of creating state-based Health Insurance Exchanges.	<ul style="list-style-type: none">• Enrollment coordination should work to minimize duplication in enrollment.• Optional Medicaid coverage is especially important for minorities given disproportionately higher rates of unintended pregnancies and HIV/AIDS.⁸ Blacks are ten times as likely, and Hispanics almost three times as likely as whites to have HIV/AIDS.⁹• Allowing the creation of state-based Exchanges could add complexity in administration and oversight especially if many states opt for development. Cost control will be critical to program efficacy and reach. This has arisen as a concern in the Massachusetts Connector program.¹⁰
Federal Government Role	<ul style="list-style-type: none">• Expand Medicaid to individuals with incomes up to 133% FPL and provide states with 100% matching funds to cover expansions.• Increase Medicaid payments to practitioners providing primary care to	<ul style="list-style-type: none">• Expansion of Medicaid eligibility to 133% FPL would extend coverage to approximately one-quarter of the nation's minorities who are living at or below that threshold.³ Increasing payment rates for services

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80% of Medicare rates in 2010, 90% in 2011, and 100% in 2012.

- Allow individuals enrolled in Children's Health Insurance Program (CHIP) to obtain coverage through the Exchange when CHIP expires in 2013.
- Prohibit undocumented immigrants from receiving insurance benefits funded with federal dollars.
- Ensure that all Americans have health insurance by conducting audits of employers and health plans to identify non-compliance with individual and employer mandates.
- Establish a Health Benefits Advisory Council comprised of medical experts, including individuals knowledgeable about racial/ethnic disparities.
- Eliminate the Medicare Part D "donut hole"—or coverage gap between the initial coverage limit and the catastrophic coverage threshold—within 15 years.
- Create temporary reinsurance program to reimburse participating employer-based plans for 80% of costs to provide health benefits for retirees ages 55-64 and their families.
- Require HHS to submit a report to Congress on the adequacy of Medicare Advantage risk-adjustment systems for low-income and dual eligible individuals as well as those with chronic and co-morbid conditions.

provided to this population could increase access to primary care services.

- Because many states with the lowest income thresholds for Medicaid eligibility have large proportions of low income minorities, expanding Medicaid eligibility at the federal level would expand its availability to many of the nation's lowest income minorities. A federal expansion of Medicaid would reduce the wide disparities in state uninsurance rates.
- Ensuring continuity of coverage for children insured through CHIP should sustain the progress made by CHIP in reducing racial and ethnic disparities in coverage among children.¹¹
- Excluding 12 million undocumented immigrants, many of whom lack health insurance,¹² from federally supported programs may perpetuate state disparities in coverage of this vulnerable population. States will continue to have the option of using state-only dollars to extend coverage to this population.
- A Benefits Advisory Council, as proposed, offers an infrastructure to help ensure that services particular to the needs of racially and ethnically diverse communities (e.g., language interpretation) are made available.
- Elimination of the Medicare donut hole would improve continuity of care and adherence to prescription drug regimens for the estimated 25% of Medicare beneficiaries taking prescription medication and being pushed into the coverage gap.¹³
- A temporary reinsurance program could help to ensure continuity of coverage for minority retirees and their families.
- Minorities comprise 58% of uninsured adults below 200% FPL and an even larger proportion of uninsured at 400% FPL.¹⁴ Credits toward the cost of coverage should lessen the financial burden on low income minority families under an individual mandate whether previously or newly insured.
- Over 90% of minority-owned firms have fewer than 25 employees, the majority of which have less than 10.¹⁵ Federal credits to small employers could assist minority-owned businesses expand coverage for themselves and their employees. The narrow requirements for qualifying for the tax credits may limit participation due to ineligibility and a lack of information and understanding about them. Implementation of the employer pay or play mandate may increase interest and participation compared to existing and previous experiences with insurance plans.

Federal Credits and Subsidies to Individuals

- Provide "affordability credits" for premiums and cost-sharing on a sliding-scale to individuals and families with incomes between 133% to 400% FPL to purchase insurance through the Exchange, limiting out-of-pocket spending on premiums to between 1.5% and 11% of annual income.
- Individuals eligible for Medicaid, with the exception of some childless adults, will be enrolled in Medicaid and prohibited from applying affordability credits to purchase insurance through the Exchange.

Federal Credits and Subsidies to Employers

- Provide tax credits to employers with fewer than 25 employees and average wages below \$40,000. Employers with fewer than 10 employees and average wages below \$20,000 are eligible for the maximum credit of 50% of employer premium costs.

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Financing

- Finance the public plan through premiums.
- Apply a sliding-scale income tax to individuals with adjusted gross incomes above \$280,000 and families above \$350,000. Families with incomes between \$350,000 and \$1 million would be assessed a tax up to 1.5% of their income, with possible reductions if health care reform achieves projected savings. Individuals and families with incomes exceeding \$1 million will be assessed a tax up to 5.4% of annual income.
- Gradually reduce overpayments to private Medicare Advantage plans to rates equivalent to standard Medicare rates over 10 years.
- PhRMA has voluntarily agreed to provide name-brand drugs at half-cost for Medicare beneficiaries in the donut hole.
- Produce savings by reducing fraud, waste, and abuse through various provisions including revisions to Medicare and Medicaid payment mechanisms, increasing penalties for false claims submissions, and streamlining administrative procedures. See also **Reducing Fraud, Waste and Abuse** in Table 3.
- A self-sustaining public plan would require premiums that are high enough to cover medical and administrative costs. The individual mandate will bring uninsured healthy individuals into the public plan to help spread risk, but sustainability may likely depend on reducing unnecessary, ineffective, duplicate and futile care.
- As approximately 88% of households earning over \$250,000 a year are white,¹⁶ taxing this higher income population would work to offset costs and assure solvency while benefiting all low income populations, including the disproportionate number of minorities.
- Reducing payments to Medicare Advantage plans may limit access to supplemental benefits for low-income minorities who receive services through Medicare Advantage plans that they would otherwise not be able to afford.¹⁷

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Table 2. Expanding Access to Health and Medical Care

	Summary	Implications for Racial/Ethnic Minorities
Expanding Availability of Care	<ul style="list-style-type: none"> • Establish a grant program to support school-based health clinics. • Expand coverage for services performed at freestanding birth centers. • Include public health clinics as acceptable sites for services provided under the Vaccines for Children Program. • Expand primary care access by increasing Medicare and Medicaid payments, providing bonuses to physicians serving in underserved areas, and incentives for primary care providers in graduate medical education programs. • Expand Medicare's telehealth services to freestanding dialysis centers. • Expand the National Health Service Corps (NHSC) by an amount sufficient to eliminate 40% of the estimated shortfall in primary care providers. • Plans participating in the Exchange must contract with "essential" community providers as determined by the Commissioner of the Exchange. • See also Community Strategies below. 	<ul style="list-style-type: none"> • Utilizing schools may help expand access to preventive and routine care for low-income and minority youth who often face barriers to accessing health care beyond lack of health insurance (e.g., reliable transportation, time, distance, child care and limited English proficiency).¹⁸ • Freestanding birth centers offer a family centered alternative to a traditional hospital birth and can provide a culturally appropriate setting for childbirth.¹⁹ Expanding Medicaid coverage for these services would extend this choice, for example, to the approximately 5 million African American women on Medicaid who comprise an estimated 7% of the U.S. population.²⁰ • Historically low reimbursement rates for Medicaid and other public programs have limited the availability of providers willing to serve low income and ethnically/racially diverse communities and families that depend on public insurance for access to medical care. Increased payment and other incentives to increase provider participation in Medicaid and Medicare could help to reduce racial/ethnic disparities in access and quality (e.g., 80% of whites versus 65% of Hispanics have a usual source of primary care).²¹ • Racial/ethnic minorities, and African Americans in particular, are less likely than whites to receive dialysis for reasons including barriers to access.²² The expansion of telehealth sites offers an opportunity to extend access to dialysis for minority Medicare beneficiaries living in medically underserved and rural areas. • The expansion of NHSC will also expand access to services for underserved urban and rural communities. • Engaging "essential" providers will take advantage of their experience with minority and low income populations, and has potential to integrate them into plans participating in the Exchange.
Public Health and Prevention	<ul style="list-style-type: none"> • Establish a Public Health Investment Fund to support a National Prevention and Wellness Strategy to establish national priorities, including those specific to reducing health disparities, and implement evidence-based and community-based prevention and wellness activities. • Require the Office of Minority Health (OMH) to be consulted in establishing priorities and implementation strategies. • Expand the roles of the U.S. Preventive Services Task Force (USPSTF) and the Task Force on Community and Preventive Services (TFCPS) to 	<ul style="list-style-type: none"> • Established in 1986 by the US Department of Health and Human Services, OMH advises the Secretary and Office of Public Health and Science on policies and programs to reduce and eliminate racial/ethnic disparities in health and health care. Consulting OMH will be central to integrating priorities pertaining to minorities in public health programs and reducing longstanding disparities in health and health care. The Investment Fund elevates the importance of addressing disparities in the context of health reform. Similarly, AHRQ's role recognizes the need to heighten national response to disparities in use of evidence-based

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undertake rigorous, systematic reviews of evidence-based strategies and encourage the prioritization of health disparities in identifying and disseminating strategies.

- Award grants to state, local, and tribal health departments to support public health infrastructure.
- Support public health and preventive training programs to strengthen the public health workforce.
- See also **Community Strategies** below.

Support for the Health Care Safety Net

- Draw from the Public Health Investment Fund to increase funding for community health centers (CHCs): \$1 billion FY 2010; \$1.5 billion 2011; \$2.5 billion FY 2012; \$3 billion FY2013; and \$4 billion FY2014.
- Establish a new grant program to support the development and operation of primary care residency programs in CHCs and other community-based health settings.
- Reduce Medicaid Disproportionate Share Hospital (DSH) payments to States by a total of \$10 billion. Amount of reduction for each state will be based on uninsurance rate and amount of uncompensated care provided by hospitals.
- Reduce Medicare DSH payments to an empirically justified level to yield \$10 billion in savings.
- Require a report on the continued role for Medicare and Medicaid DSH payments including the appropriate targeting of Medicare and Medicaid DSH payments to hospitals and the distribution of Medicaid DSH among the states.

Community Strategies

- Establish community-based prevention and wellness strategies as a national priority and provide grants to support related research and efforts, including those that target health disparities, both broadly and specifically for subpopulations of racial, ethnic and other groups.
- Support Health Empowerment Zones consisting of cooperative partnerships between health departments and local communities to implement prevention and wellness strategies to address health disparities. Require that at least 50% of such funds go to planning and implementing strategies to measurably reduce health disparities.
- See also **Care Coordination and Disease Management** in Table 4.

Regional Strategies

- Not Specified

treatment.

- Broad investments in public health infrastructure, workforce, and evidence-based prevention programs would foster an integrated public health approach to reducing health disparities that could yield positive results by addressing disparities within behavioral, social, economic, and environmental contexts.²³
- Targeted efforts to strengthen the public health workforce may help reduce the current shortage of public health professionals, particularly in many underserved and minority communities.^{24,25}
- CHCs are a major provider of primary care to low-income minority patients.²⁶ Their expansion in underserved communities could help improve access to primary and preventive care. However, safety-net support will need to extend beyond CHCs to improve access to specialty and tertiary care services to poor and minority patients. Federal guidance to CHCs and other safety net providers is needed to facilitate implementation of health care reforms, given the role of these providers in serving poor and minority populations.
- Medicare and Medicaid DSH payments are significant and critical sources of support especially for safety net hospitals in caring for low income patients. Medicaid alone allocated over \$11 billion to these facilities in 2009.²⁷ Given that they are likely to be seen as a way to pay for health care reform, and given the argument that expanding health insurance should reduce the need for DSH support, assessing their importance, distribution and scope under health reform will be critical. This assessment will help determine the future role and composition of the safety net and related access issues central to minorities who are disproportionately depending on them-as well as the role they may play in caring for undocumented immigrants or others not insured.
- Providing grants to support community-based efforts targeting broad minority populations as well as subgroups has the potential to foster trust, understanding, and adherence to healthy behaviors and preventive health practices among these vulnerable groups.
- Support for Health Empowerment Zones and targeting disparities reduction offer the opportunity to expand engagement of minority communities in improving their health and well being as well as significantly expanding the potential to address transportation, nutrition, environment and other priorities frequently not seen as central to medical care, but essential for improving health.²⁸
- Not specified, however, given frequent concentration of services especially in urban areas, regionalizing expensive or limited care (e.g., tertiary) could work to significantly expand access for the nation's

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growing poor and racially/ethnically diverse populations in sprawling cities, suburbs and exurbs, and in historically underserved rural areas with limited health care resources and capacity.

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Table 3. Cost Containment

	Summary	Implications for Racial/Ethnic Minorities
Containing Drug Costs	<ul style="list-style-type: none"> • Require reporting on financial relationships between manufacturers and distributors of drugs, devices and other medical supplies. • Extend prescription drug rebate to enrollees of Medicaid managed care plans and increase Medicaid drug rebate percentage. 	<ul style="list-style-type: none"> • Public reporting of financial relationships could help contain costs and make drugs more affordable for everyone. • Extending the prescription drug rebate for Medicaid will help many low-income and minority individuals enrolled in the program afford needed medication. In 2001, about 1 in 5 black adults and 1 in 6 Hispanic adults did not purchase needed prescription medication due to cost.²⁹
Reducing Fraud, Waste and Abuse	<ul style="list-style-type: none"> • Deny Medicaid reimbursement for health care-acquired conditions. • Modify Medicare provider payments to incentivize physician practice in “efficient” areas and reduce payments to hospitals and post-acute providers with excess readmissions. Incorporate incentive payments for quality in Medicare Advantage plan. • Establish pilot programs to test the effectiveness of bundled payments for acute, post-acute and other providers. Establish compliance programs for Medicare and Medicaid providers and suppliers as well as develop evaluations of integrity programs. • Allow provider screening for public programs in areas identified as being at elevated risk of fraud. 	<ul style="list-style-type: none"> • Aligning payment with quality rather than quantity of care in public programs to reduce hospital readmissions and health care-acquired conditions could potentially reduce racial/ethnic disparities in preventable hospitalizations and health care outcomes. Blacks are two to four times more likely than whites to be hospitalized for a potentially preventable admission.³⁰ • Reducing fraud, abuse and waste needs to extend beyond public programs to the private health care market to reduce errors, contain costs and improve quality across the board.
Information Technology	<ul style="list-style-type: none"> • Promote the use of IT by issuing electronic insurance cards and supporting the development of infrastructure for electronic medical records. • Standardize claim forms and increase use of electronic administrative and clinical data. • Utilize IT to make health care quality data widely available to the public. 	<ul style="list-style-type: none"> • The use of IT for standardizing medical records, claims and health care quality data has potential for reducing preventable errors and administrative inefficiencies. IT can also be especially useful for standardizing the collection and monitoring of racial/ethnic disparities data in health care. However, the expansion of IT use in health care will require expanded training to ensure that health care providers possess sufficient knowledge and skills to utilize IT tools appropriately.

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Table 4. Quality Improvement

	Summary	Implications for Racial/Ethnic Minorities
Data Collection and Public Reporting	<ul style="list-style-type: none"> Establish a Center for Quality Improvement within AHRQ to identify existing and develop new best-practices, develop quality improvement activities, measure patient outcomes, and conduct research on behavioral and environmental factors necessary to improve quality. Establish a multi-stakeholder group to provide input on quality measures. Require hospitals and ambulatory surgical centers to report data on healthcare-associated infections (HAIs) by demographic information to the CDC. Require plans participating in the Exchange to report data and meet the network adequacy standards. Increase the transparency of skilled nursing facilities by establishing reporting requirements on nursing hours per resident day, staff training, and relationship between nurse staffing and quality of care to be posted on a Medicare Nursing Home website. See also <i>Collecting Data on Disparities in Quality of Care</i> in Table 5. 	<ul style="list-style-type: none"> The Center for Quality Improvement's effectiveness in reducing disparities in quality of care will be enhanced if it examines differences in outcomes and patient satisfaction among minorities. Minorities, including Asian Americans and Hispanics, are disproportionately more likely to die from complications in hospital care.³¹ Requiring the monitoring of HAIs, particularly by race/ethnicity and other demographic indicators, will be important for reducing medical errors, improving health care quality and eliminating disparities. Providing extensive publicly available data on skilled nursing facilities could increase competition and gradually ameliorate disparities in the quality of nursing home care. African Americans utilize nursing homes at a higher rate than whites, but persisting disparities in quality of nursing home care exist.³² The benefits of a website to compare information may be limited for low-income minorities who are less likely than whites to use the internet to seek out health information.³³
Care Coordination and Disease Management	<ul style="list-style-type: none"> Implement community-centered Medical Home Pilot Project staffed by community health workers, physician assistants and others to help individuals manage chronic diseases and their medications. The project will be evaluated for success in providing quality of services and reducing health disparities. Establish Community Care Networks (CCNs) that provide primary, acute, and long-term care services to assist individuals with serious chronic conditions and their families through incentives to providers to improve transitions and care continuity through patient-centered medical home model. Designate Medicare Advantage programs as fully integrated dual eligible plans and create an office within the CMS to improve access and continuity of care for dual-eligibles of Medicaid and Medicare. 	<ul style="list-style-type: none"> Acknowledges critical link to community for providing coordinated care and disease management within a community context and represents potential to address long-standing lack of coordination and continuity of care for minorities.³⁴ CCNs have potential to improve access and service coordination in low-income minority communities by utilizing a community-based approach that features community decision making, accountability, and public-private partnerships.³⁵ Establishing an authoritative body to oversee dual-eligibles could improve the continuity and quality of care for approximately 1.2 million low-income/elderly African Americans who are dual beneficiaries, by coordinating the services of state and federal programs.³⁶
Promoting Evidence-Based Practices	<ul style="list-style-type: none"> Establish a Comparative Effectiveness Research (CER) Commission to support and disseminate research on the effectiveness of health care services while considering potential differences among racial/ethnic minorities and other sub-populations. Membership of the Commission to include an individual with expertise on health disparities. Establish national priorities and measurements for quality improvement (QI), including those explicitly addressing health disparities associated with race, ethnicity, place of residence, and language. 	<ul style="list-style-type: none"> As identified in a report recently provided to the President and Congress by DHHS, CER that focuses on racial/ethnic differences in procedural outcomes has potential to reduce health disparities at the national level, especially among minority populations who suffer a disproportionately high burden of chronic disease.³⁷ The success of CER initiatives is likely to be linked to sustainable funding.³⁸ It is uncertain whether current provisions in the bill will be sufficient for identifying associations between treatments and outcomes

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	<ul style="list-style-type: none">• Provide regional grants for quality improvement that encourage cooperative initiatives to identify best practices, improve patient safety and quality care.	<p>as well as differences by race/ethnicity over time.</p> <ul style="list-style-type: none">• Current provisions do not specify preference in awarding regional quality improvement grants to health care providers serving in low-income or underserved areas.
Civil Rights Enforcement and Legal Action	<ul style="list-style-type: none">• Develop standardized form for nursing home complaints.• Enact “whistleblower” protection that prohibits employers from retaliating against nursing home employees who submit complaints regarding quality of care or unlawful behavior.	<ul style="list-style-type: none">• Provisions that increase nursing home transparency and standardize/encourage the reporting of grievances would deter nursing homes from discriminating against high-risk minority residents with multiple chronic conditions and promote compliance with Title VI of the 1964 Civil Rights Act.³⁹• Also see <i>Data Collection and Public Reporting</i> above

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Table 5. Infrastructure Support for Reducing Racial/Ethnic Disparities

	Summary	Implications for Racial/Ethnic Minorities
Collecting Data on Disparities in Quality of Care	<ul style="list-style-type: none"> • Establish a Bureau of Health Information to develop standards to identify, collect, and publish key health data, including information on race, ethnicity, and primary language. Identify, in consultation with OMH, indicators and data sources to reduce health disparities. • Direct a new Assistant Secretary for Health Information to set standards for data collection on broad population and subpopulation categories and to facilitate and coordinate analyses of health disparities within HHS and in collaboration with other departments. • See also <i>Data Collection and Public Reporting</i> in Table 4. 	<ul style="list-style-type: none"> • Current federal and state data collection efforts on health disparities are largely inconsistent⁴⁰; therefore, a Bureau and new Assistant Secretary position focused explicitly on establishing standards for collecting data by race, ethnicity, primary language and other population subgroups will be critical for assessing and reducing inequalities in health and health care. OMH would play an important role in this process. For example, key principles and priorities outlined by OMH in their <i>National Standards for Culturally and Linguistically Appropriate Services</i>⁴¹ could serve as a foundation for indicators and standards that are developed to reduce disparities. • Constraining data collection to broad OMB Standards of race and ethnicity limits the ability to track persistent health disparities among racial/ethnic subgroups.²³ Greater refinement in these categories will be required.
Cultural Competence and Language Assistance	<ul style="list-style-type: none"> • Support research to examine the extent to which Medicare services providers offer language access services and subsequently develop Medicare payment systems for language services, such as on-site interpreters, to reduce health disparities. Have IOM conduct a review of the impact of language access services on Limited English Proficiency (LEP) populations. • Support cultural/linguistic competency training for health care professionals as well as research on culturally/linguistically competent health care. • Require plans participating in the Exchange to provide culturally/linguistically appropriate communications and health services. 	<ul style="list-style-type: none"> • Increasing access to interpreter services for Medicare beneficiaries would improve quality, continuity of care, and adherence with treatment recommendations for the estimated 14% of the 65+ population who speak a language other than English at home, more than a third of whom are LEP.⁴² This population is liable to grow over the next 20 years in the US as elderly, Hispanic and Asian populations are projected to increase. • Enforcing language assistance requirements among prescription drug plans participating in Medicare Part D would enable LEP beneficiaries to more readily compare plans and make informed health care choices.⁴³ These provisions would be in compliance with Title VI of the 1964 Civil Rights Act. • Explicit support for cultural/linguistic competence in medical and health professions education can expand the capacity and improve the quality of health care systems in delivering culturally and linguistically appropriate services to growing minority populations and in reducing disparities. • Incentives to increase the workforce and utilization of trained medical interpreters could improve the quality of care for nation’s 24 million LEP residents.^{44,45} • Resources for monitoring and enforcement mechanisms are needed to ensure that plans participating in the Exchange provide culturally/linguistically appropriate services.

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Health Workforce Diversity

- Reauthorize Centers of Excellence Program and Health Careers Opportunity Program to increase the racial/ethnic diversity of the health care workforce.
- Provide grants to develop the primary care workforce, giving preference to institutions with a record of training individuals from minority background and conduct programs that target vulnerable populations.
- Reauthorize Title VII workforce diversity programs to increase diversity in the nursing workforce.
- Supporting programs and providing incentives for training health professionals from diverse backgrounds, with an emphasis on primary care, could help to increase workforce diversity and may improve quality of care and access to preventive services in underserved minority communities.
- Racial, ethnic, or linguistic minorities are not included in the definition of "vulnerable populations" as it currently appears in the bill.
- Title VII workforce diversity programs could improve the cultural competency of the health care work force and increase the number of health care professionals choosing to practice at CHCs and in underserved areas.^{46,47}

Patient Navigation

- Establish a demonstration program on the use of decision aids and other technologies to help patients improve their understanding of treatment options, including risks and benefits, and make informed decisions about their medical care.
- Decision aids and other patient navigators are important for assisting low-income and minority patients "navigate" through the complex health-care system and understand their medical care options to make timely and informed decisions.⁴⁸ Such aids, however, will be most beneficial if culturally and linguistically tailored to low literacy, LEP and other minority groups.

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Table 6. Social Determinants of Health

	Summary	Implications for Racial/Ethnic Minorities
Interagency Collaboration	<ul style="list-style-type: none">• Collaborate with other federal departments to facilitate and coordinate analyses of health disparities.	<ul style="list-style-type: none">• Collaboration across federal sectors and agencies—e.g., health and human services, education, housing, transportation, environment—is important to understanding and addressing the range of social, economic, and infrastructural factors that contribute to health disparities.
Infrastructure Support	<ul style="list-style-type: none">• Not Specified.• See <i>Public Health and Prevention</i> in Table 2.	<ul style="list-style-type: none">• Strong support for public health initiatives that adopt an ecological perspective and interdisciplinary approach to health disparities are likely to address the social determinants of health.
Data Collection	<ul style="list-style-type: none">• Not Specified.• See <i>Collecting Data on Disparities in Quality of Care</i> in Table 5.	<ul style="list-style-type: none">• Robust data collection on factors beyond race, ethnicity, and language—such as social, economic, and environmental conditions—can allow for association between health outcomes and social determinants to be identified.⁴⁹

Notes

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