

Senate Finance Committee *America's Health Future Act (September 22, 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 the rescinding of health coverage and exclusions based on pre-existing conditions. • Prohibit insurance rating variation by health status. Allow for variation by tobacco use, age, family size, and geography (limited to a ratio of no more than 7.5:1 for all factors combined). • Prohibit cost-sharing for preventive services and lifetime limits on coverage. • Create state-based exchanges where individuals can compare and purchase insurance and require all state-licensed insurers to participate. • Plans participating in exchanges must provide essential benefits, including, coverage for: preventive and primary care; hospitalization; pediatric dental and vision care; surgical care; prescription drugs; mental health and substance abuse services. • Provide \$6 billion to develop a Consumer Operated and Oriented Plan (CO-OP) program to finance start-up costs for non-profit, member-operated health insurance companies. These CO-OPs must have a strong consumer focus and use profits to lower premiums, improve services or the quality of care delivered to its members. CO-OPs will be held to the same standards as plans participating in exchanges. • Require health insurance plans to report information on non-medical care related spending in a standardized format. • Limit out-of-pocket costs on a sliding scale for those 400% below the federal poverty level (FPL). • Restrict undocumented immigrants from purchasing coverage through exchanges, but allow undocumented parents to purchase coverage for their lawfully present children. Require information on name, social security number, and date of birth to verify citizenship of those purchasing insurance through exchanges. • Create a “high-risk pool” to provide immediate assistance for individuals who have been denied coverage for pre-existing conditions until insurance market reforms go into effect in 2013. 	<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 African American adults suffer from a chronic condition or disability.² • Prohibiting cost-sharing for preventive services should help low-income and minority individuals, particularly the large proportions of Hispanics (54%), Asians (52%) and African Americans (44%) who often delay or forgo routine and preventive care due to cost.³ • Medical debt is a leading cause of personal bankruptcy that disproportionately affects low-income and minority families. For example, African Americans 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. • Provisions within this bill would extend insurance through state exchanges to an estimated 3 million lawfully present children of undocumented immigrant parents.⁵ However, precluding nearly 9 million undocumented adults and children, many of whom lack health insurance,⁶ from federally supported programs may perpetuate state disparities in coverage of this population. States will continue to have the option of using state-only dollars to extend coverage to this group. • While the creation of CO-OPs offers a strategy to compete with private insurers, they are likely to face many challenges as new entities without an enrollee base and may not be a viable option for minorities looking for affordable choices and coverage unless they can: establish a regional or national presence with bargaining power; prevent adverse selection by spreading risk broadly, which could be accomplished through an individual mandate; and offer health plans with minimum cost-sharing.⁷ • Requiring proof of U.S. citizenship has the potential to deter many eligible U.S. citizens from obtaining coverage through state exchanges. Recent evidence suggests that a federal policy requiring documentation of U.S. citizenship for Medicaid eligibility, aimed at preventing undocumented immigrants from obtaining coverage, overwhelmingly affected eligible U.S. citizens, mostly African Americans and whites.⁸ • With higher rates of morbidity, minorities are at greater risk of being

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denied coverage for pre-existing conditions.⁹ Establishing a “high-risk pool” in the interim may assist individuals in this group to obtain insurance coverage. The experience of state high risk pools, however, is that they are typically underfunded and impose onerous eligibility restrictions, such as waiting periods, coverage exclusions and high cost-sharing that limit their effectiveness.¹⁰

Individual Role

- Require all U.S. citizens and legal residents to obtain health insurance coverage which meets minimal standards. The mandate would be enforced by a tax in the amount of \$750 per individual (\$1,500 per family) for those between 100% and 300% FPL and \$950 per individual (\$1,900 per family) for those above 300% FPL. Individuals/families below 100% FPL, those with religious objections, and Native Americans will be exempt from the penalty tax.

- An individual mandate would establish a “culture of insurance” that will likely require education and outreach to racial/ethnic minorities, individuals with limited English proficiency (LEP) and other underserved populations, particularly those who may have limited experience with insurance coverage. However, subsidies for some low to moderate income individuals and families may be necessary (see *Federal Credits and Subsidies to Individuals* section), as will careful monitoring of the impact of these requirements on minority and other households.
- 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.
- Assuming that significantly increased coverage will enfranchise millions, 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

- Require employers with more than 200 employees to provide coverage.
- Assess businesses with more than 50 employees a fee for each employee that is not offered coverage but who receives a federal tax credit to purchase insurance through an exchange.
- No requirement for businesses with less than 50 employees to provide coverage.

- A mandate for large employers has the potential to expand coverage for many employed low-income and minority individuals and their families. However, the play or pay-like provision for businesses with 50 or more employees could increase business costs, which may be passed down to employees in the form of suppressed wages or wage increases or potentially job cuts, which could negatively impact low-income and minority employees.

State Role

- Establish state health insurance exchanges meeting federal standards and require state insurance commissioners to oversee individual and small group market regulation changes. Develop a standardized format to present insurance options that are available through the exchange and a web-based portal to allow consumers and small businesses to compare plans and calculate eligibility for tax credits. Exchanges must offer call centers with multilingual assistance for consumers.
- Establish an Ombudsman Office to act as an advocate for those with private coverage in individual and small group markets.

- Establishing state exchanges could add complexity in administration and oversight for states, but would offer flexibility within federal standards, which would improve inter-state coordination. However, viability will require broad inclusion of plans, employers and individuals to assure risk is spread and small business owners and others have insurance options with affordable plans. To that end, cost control will be critical to program efficiency and reach, a concern that has arisen in the Massachusetts Connector program.¹¹
- An Ombudsman Office could help immigrants and individuals with LEP navigate the private insurance market if multilingual services are provided.

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Federal Government Role

- Expand Medicaid to all non-elderly adults up to 133% FPL and extend Medicaid eligibility to childless adults.
- Allow adults with incomes 100% to 133% FPL the option of enrolling in Medicaid or acquiring coverage through the exchange with federal subsidies.
- Provide states with additional support to defray the costs of extending Medicaid to newly eligible residents. High need states, including those with low-enrollment rates or high unemployment rates, would receive full federal funds to cover newly eligible individuals for the first five years.
- Extend the Children's Health Insurance Program (CHIP) to children 250% FPL.

Federal Credits and Subsidies to Individuals

- Provide "Health Care Affordability Tax Credits" on a sliding-scale to individuals and families with incomes between 100% and 400% FPL to purchase insurance through exchanges, limiting out-of-pocket spending on premiums for the second most basic plan to between 2% and 12% of adjusted gross income for those within this FPL threshold.
- Individuals who are offered coverage by their employer would be ineligible for credits, unless the employer-sponsored coverage fails to have an actuarial value equivalent to the most basic plan being offered through an exchange or an out-of-pocket premium that exceeds 10% of income.
- Provide cost-sharing subsidies to individuals and families with incomes between 100% and 200% FPL.
- Lawfully-present immigrants below 400% FPL would be eligible for tax credits.
- Undocumented immigrants would be ineligible for tax credits.
- Prohibit cost-sharing (e.g., premiums and co-payments) for state exchange plans and public programs for American Indians and Alaska Natives (AIANs) at or below 300% FPL.

Federal Credits and Subsidies to Employers

- Provide tax credits to small businesses with 25 or fewer employees for whom average wages are below \$40,000, and that contribute to at least 50% of the total premium cost. Employers with 10 or fewer employees and average wages below \$20,000 would be eligible for the maximum credit of 35% of employer premium costs, rising to 50% in 2013 and later years. Credits will not be provided for more than 2 consecutive years.
- Create temporary reinsurance program to reimburse employers providing health coverage to retirees ages 55 to 65.

- 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.¹² Because many states with large proportions of low-income minorities have among the lowest income thresholds for Medicaid eligibility, a federal expansion would make large portions of the nation's poorest and uninsured minorities eligible for Medicaid.
- A federal expansion of Medicaid would reduce the wide disparities in state uninsurance rates.
- Expanding CHIP coverage should continue the progress made by CHIP in reducing racial/ethnic disparities in coverage among children.¹³

- Minorities comprise 58% of uninsured adults below 100% FPL and an even larger proportion of uninsured at 400% FPL. 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.
- Premium credits and cost-sharing subsidies will help to limit the financial risks and potential exposure to medical debt for minority and poor families who were previously uninsured or underinsured.
- While AIANs are entitled to medical care through the Indian Health Service, the program's limited resources restrict access to care among this population. Removing cost-sharing requirements would improve access to health insurance and health care for the approximately 1.1 million AIANs that are at or below 300% FPL.¹⁴
- An estimated 12 million undocumented immigrants, many of whom lack health insurance, would be ineligible for tax credits and banned from purchasing insurance through exchanges, therefore severely limiting their coverage options.¹⁵

- Over 90% of minority-owned firms have fewer than 25 employees, the majority of which have less than 10 workers.¹⁶ Federal credits to small employers could assist minority-owned businesses expand coverage for themselves and their employees but the two year limit may undercut longer term health insurance financing for these businesses. Moreover, the narrow requirements for qualifying for tax credits may limit participation due to ineligibility and a lack of information and understanding about criteria for participation.
- The temporary reinsurance program could help to ensure continuity of coverage for minority retirees before becoming eligible for Medicare.

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Financing

- The bill is estimated to cost \$774 billion over 10 years according to the Congressional Budget Office (CBO).
- Require industries within the health care sector to pay fees: pharmaceutical manufacturing (\$2.3 billion), medical device manufacturing (\$4 billion), health insurance providers (\$6.7 billion), and clinical laboratories (\$750 million). The amount of the fee for individual businesses in each sector would be proportional to its market share.
- Restructure payments to Medicare Advantage plans through a competitive bidding process as opposed to statutorily set rates.
- The CBO estimated that the proposed legislation would reduce the number of non-elderly uninsured by 29 million by 2019, leaving approximately 25 million non-elderly residents uninsured, one-third of whom would be undocumented immigrants. The proposal would expand Medicaid benefits to an estimated 11 million low-income individuals.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">• Improve access to emergency psychiatric care through a demonstration project allowing select states to receive Medicaid reimbursement for services provided in freestanding psychiatric hospitals.• Provide grants to small businesses with less than 100 employees to implement evidence-based workplace wellness programs. Permit employers to offer rewards to employees who complete wellness programs.• Create a Workforce Advisory Committee comprised of external stakeholders to develop a National Workforce Strategy to recruit, educate and retain health care professionals, with an explicit focus on the needs of minorities and other medically underserved populations.• Redistribute unused Graduate Medical Education (GME) slots to primary care and general surgery positions and to hospitals in states with health profession shortages.• Require states to conduct a needs assessment to identify communities at risk for poor maternal and child health outcomes to target Maternal and Child Health (MCH) block grant funding.	<ul style="list-style-type: none">• Racial/ethnic disparities in access to and quality of mental health care, including emergency psychiatric care, are well documented.¹⁸ Long-term funding is needed, however, to improve access to inpatient and outpatient mental health services that could help prevent the need for emergency psychiatric care. Minority communities at relatively higher-risk for particular mental health conditions (e.g., suicide in AIANs) would be best served through a more coordinated system of community-based mental health services rather than expanded emergency psychiatric care.¹⁹• Promoting healthy behaviors and evidence-based wellness programs in non-medical settings such as workplaces may help expand access to preventive services for low-income and minority populations, who often face access barriers beyond lack of health insurance (e.g., reliable transportation, time, distance, and child care).²⁰• Establishing a National Workforce Strategy will be important for ensuring an adequate supply of health care professionals, particularly in areas with severe health profession shortages as well as in communities with special needs (e.g., racially and ethnically diverse areas).• Each state that receives Title V MCH block grant funding is required to complete a needs assessment, but the rigor and comprehensiveness varies among states.²¹ As part of these assessments, states should be encouraged, if not required, to collect community data on MCH by race, ethnicity, and primary language so that funds are made available to expand culturally and linguistically as well as health care-appropriate services in identified high need racially and ethnically diverse communities.
Public Health and Prevention	<ul style="list-style-type: none">• Provide Medicare beneficiaries with the option of receiving a comprehensive health risk assessment (HRA) to identify chronic diseases, modifiable risk factors, urgent health needs and develop a personalized wellness plan. The HRA could be conducted through a telephonic or web-based program or with a health professional.• Remove cost-sharing requirements for selected preventive services and provide incentives for Medicare beneficiaries to successfully complete healthy lifestyle programs targeting risk factors such as: high blood pressure and cholesterol; tobacco use; obesity; and diabetes.• Develop criteria for evidence-based healthy lifestyle programs that are tailored to the needs of Medicaid eligible beneficiaries. Allow	<ul style="list-style-type: none">• Offering HRAs through Medicare has the potential to assist an estimated 22% of minority beneficiaries²² in developing care management plans that are tailored to their specific health care needs, preferences and personal beliefs. The utility of this program could be further enhanced for minority populations and those with LEP or low health literacy if it includes language assistance in the form of interpreters or bi-lingual telephone staff, translated information, and a web-based interface that is easy to navigate with simple language and pictograms.• Minorities are more likely to forgo care due to cost.²³ Therefore, removing cost-sharing for selected preventive services in Medicare has

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states to apply for funds to provide incentives to Medicaid enrollees who successfully complete healthy lifestyle programs.

- Require states to provide Medicaid coverage for smoking cessation services for pregnant women.
- Provide support for postpartum depression services, educational outreach to inform mothers and their families about the condition, and research on causes and effective treatment methods.
- Provide incentives for states to cover, in their Medicaid program, all services recommended by the U.S. Preventive Services Task Force (USPSTF) and all immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).
- Provide select primary care physicians with 10% Medicare fee bonuses for 5 years. The cost of bonuses would be offset by reductions in Medicare reimbursement rates for non-primary care services, except for physicians practicing in designated health professional shortage areas.

the potential to improve access and promote preventive care among minority beneficiaries.

- Studies show that financial incentives are effective for improving healthy behaviors such as smoking cessation and for encouraging preventive care.²⁴ The Medicare and Medicaid incentive programs could potentially improve healthy behaviors among low-income and minority beneficiaries who are disproportionately more likely to be overweight/obese.²⁵ African-American males are also more likely to smoke than other populations.²⁶
- Support for postpartum depression education, services and research are likely to benefit minority women, in particular African American and Hispanic women who are more likely to suffer from this condition than white women.²⁷ However, integral to this effort is the engagement of community health workers and utilization of community sites to ensure information is delivered and received by mothers and families of need.
- USPSTF-recommended services include preventive screenings for cancers (e.g., colorectal and prostate cancer) which disproportionately affect certain racial/ethnic minorities. While covering these services through Medicaid could improve access for low-income minorities, educational and outreach efforts will be required to raise awareness of the benefits of preventive screenings.²⁸

Support for the Health Care Safety Net

- Establish Teaching Health Centers (THCs) as community-based training sites for primary care residency programs to improve access to primary care. THCs may include community health centers (CHCs), rural health clinics, and migrant health centers.
- Reduce disproportionate share hospital (DSH) payments by 50% once the number of uninsured individuals in the state is reduced by 50%, with corresponding payment reductions based on insurance rates. DSH payments would not fall below 35% of the 2012 allotment.

- Establishing THCs in community sites, such as CHCs, will be important for improving access to primary care, particularly in historically underserved communities. However, integral to this effort is the need to expand support for CHCs and other safety net providers, such as public hospitals and charitable clinics, which serve as major providers of primary care to low-income minority patients.²⁹ Support could be financial or in-kind. Examples include: expanding CHC and other safety net sites in provider shortage areas; and improving infrastructure through electronic medical records or electronic regional registries of the availability of bi-lingual staff.
- Medicare and Medicaid DSH payments are significant sources of financial support to safety net hospitals in caring for low-income and uninsured patients. Medicaid alone allocated over \$11 billion to these facilities in 2009.³⁰ 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

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Community Strategies

- Create a Community First Choice Option under Medicaid to provide community-based services to Medicaid enrollees with disabilities. Participating states would be required to collect data on home and community-based services.
- Require non-profit hospitals to conduct a community health needs assessment every three years and implement a strategy to meet community needs. The assessment must include input from broad community interests.
- Provide support to improve access to home and community-based services for Medicaid enrollees in need of long-term care.

Regional Strategies

- Not Specified.

play in caring for undocumented immigrants or others not insured.

- A Community First Choice Option would improve access to community-based services for the approximately 8 million disabled individuals under age 65 who are Medicaid beneficiaries. These services would particularly benefit severely disabled children under age 4, half of whom are Medicaid beneficiaries.³¹
- Non-profit hospitals are required to provide a “community benefit” in exchange for being exempt from most taxes. Uncompensated care for indigent members of the community is often cited as a community benefit provided by non-profit hospitals; however, the definition of what constitutes a community benefit remains rather ambiguous.³² A requirement for non-profit hospitals to conduct a community health needs assessment could enable facilities to identify the most pressing needs of racial/ethnic communities and target efforts to make improvements (e.g., culturally competent staff, interpreter services) through their community benefits. However, further specificity may be required (at least in federal regulations) around implementing strategies which are significant in scope and potential effect.
- 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 growing poor and racially and 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"> • Provide brand-name prescription drugs at half-cost for Medicare beneficiaries who enter the Medicare Part D "donut hole" (i.e., coverage gap between the initial coverage limit and the catastrophic coverage threshold). • Require states to offer prescription drug coverage through Medicaid programs. • Strengthen Medicaid rebate program to reduce drug costs to state Medicaid programs. 	<ul style="list-style-type: none"> • Discounts could improve continuity of care and adherence to prescription drug regimens for the estimated 25% of Medicare beneficiaries who take prescription medications and will face the coverage gap.³³ • While states generally provide prescription drug coverage through Medicaid, it is still an optional benefit. A federal mandate ensures a minimum level playing field for access to this coverage under Medicaid. Drug discounts and Medicaid drug rebates should help states better manage their scarce resources. However, disparities in the availability of prescribed medications in communities of color suggest a need for states to monitor and compare the distribution and utilization of Medicaid prescription drugs by small geographic areas.³⁴
Reducing Fraud, Waste and Abuse	<ul style="list-style-type: none"> • Establish a Value-Based Purchasing program in Medicare that provides financial incentives for hospitals to meet quality performance standards. • Establish an Innovation Center within the Centers for Medicare and Medicaid Services (CMS) to evaluate different payment mechanisms to improve patient-centered care and slow the growth of Medicare costs. • Deny Medicaid reimbursement for health care-acquired conditions. • Strengthen screening requirements for Medicare and Medicaid providers to reduce fraud and abuse. 	<ul style="list-style-type: none"> • Aligning payment with quality rather than quantity of care in public programs to increase the efficiency, coordination and safety of care could potentially reduce racial/ethnic disparities in preventable hospitalizations and other adverse health care outcomes. African Americans are two to four times more likely than whites to be hospitalized for a potentially preventable admission.³⁵ • Some state Medicaid programs have already begun denying payment for health care-acquired infections or readmissions. Applying federal rules and standards to both Medicaid programs and Medicare should help incentivize providers to improve the quality and safety of care. • 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"> • Develop a timeline for the refinement and adoption of Health Insurance Portability and Accountability Act (HIPAA) electronic standards to create uniformity and promote electronic reporting and sharing of health information. 	<ul style="list-style-type: none"> • The use of IT for standardizing and reporting on medical records, claims and health care quality data has potential for reducing preventable errors and administrative inefficiencies. IT can be especially useful for standardizing the collection and monitoring of data related to racial/ethnic disparities in health care. However, the expansion of health IT use will require expanded training to ensure that 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 federal interagency workgroup on health care quality to identify reporting and payment measures for federal health programs. • Increase nursing home and skilled nursing facility (SNF) transparency by requiring public reporting information on facility ownership and staffing. 	<ul style="list-style-type: none"> • Developing robust quality measures across public health care programs, including Medicare, Medicaid and CHIP, could help states and federal officials better compare quality by state, and by provider, and make data collection and reporting less onerous for providers. Results of improved reporting, especially by race, ethnicity, and language, could help public purchasers and providers collaborate in identifying racial/ethnic gaps in health care services and quality and in developing quality improvement strategies to address them. • Providing extensive publicly available data on SNFs 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, and disparities in quality of nursing home care persist.³⁶
Care Coordination and Disease Management	<ul style="list-style-type: none"> • Create a medical home option that provides comprehensive care management and coordination for Medicaid enrollees with at least one chronic condition. Provide states with 90% matching funds for the first two years of the program. • Launch a pilot program to provide incentives for Medicare providers to coordinate care, improve patient outcomes, reduce costs, and improve efficiency. • Recognize Certified Diabetes Educators (CDEs) as Medicare providers eligible to provide diabetes outpatient self-management training services. • Encourage the development of accountable care organizations (ACOs) by allowing those which meet quality standards to share in the cost-savings they achieve through Medicare. • Launch demonstration projects in Medicaid and CHIP to allow pediatric ACOs to share in the cost-savings they achieve. • Create an office within CMS to improve access and continuity of care for dual eligibles of Medicaid and Medicare. 	<ul style="list-style-type: none"> • Of the approximately 67 million individuals in the U.S. who receive Medicaid benefits, over half are African American or Hispanic. Furthermore, 46% of Medicaid beneficiaries suffer from at least one chronic condition.³⁷ Expanding access to a medical home option could improve the continuity and quality of care delivered to these populations. • Medicare beneficiaries suffer a disproportionate burden of chronic disease and are more likely to have multiple chronic conditions. Developing and implementing coordinated systems of care is critical to improving quality and reducing costs for this population, which is projected to increase in both size and racial/ethnic diversity.³⁸ In particular, medication management services may increase adherence to medication regimens for the disproportionately high number of minorities living with chronic disease if service providers are culturally and linguistically competent.³⁹ • Both African Americans and Hispanics have diabetes prevalence rates that are more than twice those as whites.⁴⁰ Recognizing CDEs as Medicare providers could improve access to diabetes self-management services to minorities living with the condition, but preventive initiatives should be implemented to address the socioeconomic and environmental factors which often contribute to racial/ethnic disparities in prevalence rates of diabetes.⁴¹ • ACOs could potentially reduce unnecessary health care spending and improve quality of care through service integration and coordination.⁴² Targeting incentives to providers serving Medicaid clients to organize as ACOs could improve the quality of care transitions after hospital

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Promoting Evidence-Based Practices

- Establish a private, non-profit Patient-Centered Outcomes Research Institute to conduct research on the effectiveness of medical treatments, including variations among racial/ethnic minorities, and disseminate findings to patients, clinicians, and policymakers to inform health care decisions.
- Develop a comprehensive national quality improvement strategy that includes priorities to improve patient-centeredness in health care, reduce health disparities, and enhance the use of health care data to improve transparency and efficiency.
- Support evidence-based childhood home visitation programs to improve maternal and child health, injury prevention, and school readiness in coordination with community resources.

Civil Rights Enforcement and Legal Action

- Not Specified.

discharge, for example, and therefore reduce readmission rates for low-income and minority beneficiaries.

- 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 better coordinating reimbursement policies for services covered separately under Medicaid and Medicare.⁴³
- As identified in a report recently provided to the President and Congress by HHS, comparative effectiveness research (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.⁴⁴
- The success of CER initiatives is likely linked to sustainable funding.⁴⁵ It is uncertain whether current provisions in the Chairman's Mark will be sufficient for identifying associations between treatments and outcomes as well as differences by race/ethnicity over time.
- By providing families with client-centered education, parenting skills, and social support, home visitation programs can serve as an effective and relatively low-cost strategy to improve prenatal and postnatal health outcomes, in addition to a variety of other long-term benefits.⁴⁶ These programs would serve as a valuable resource for low-income minorities who are first-time mothers, and often have limited social support networks.
- Mandatory and standardized reporting procedures on race/ethnicity would allow for civil rights violations to be more readily identified.

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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"> Require CMS to collect data on primary language for CHIP enrollees and their parents. Require federally-funded population surveys to produce large enough samples of racial/ethnic subgroups to generate statistically significant results to compare health disparities between sub-populations. 	<ul style="list-style-type: none"> As expressed in a report recently released by the Institute of Medicine, current reporting standards are inconsistent and insufficient for comprehensively monitoring racial/ethnic disparities in health.⁴⁷ A definitive set of guidelines for collecting data on race, ethnicity, and language for federal, state, and local authorities will be necessary to fully achieve this goal. Collecting robust data on racial/ethnic sub-groups will provide information on the health status and specific needs of immigrant populations and, over time, the approximately 100 different ethnic groups with populations over 100,000 living in the U.S.⁴⁸
Cultural Competence and Language Assistance	<ul style="list-style-type: none"> Establish a demonstration program to develop core training competencies—including cultural and linguistic competence and sensitivity—for personal and home care aids. 	<ul style="list-style-type: none"> While the proposed demonstration is limited, personal and home care aids are a vital source of long term care for elderly and chronically ill individuals. Enhancing the cultural and linguistic competency of these providers will improve the quality of care delivered to the growing number of elderly minorities in the U.S. To achieve greater depth and reach, core competencies for cultural and linguistic competence in health care should extend to other health professionals, including physicians, nurses, mental health providers and others to improve the quality of care provided to racial/ethnic minorities of all ages.
Health Workforce Diversity	<ul style="list-style-type: none"> Provide grants and supportive services (e.g. childcare) to low-income individuals to train for health care occupations. Require at least three grants to be provided to Tribal entities. 	<ul style="list-style-type: none"> Providing support for training health professionals from diverse backgrounds could help to increase workforce diversity and may improve quality of care in underserved minority communities. Singling out Tribal support is important to assure they participate in these initiatives.
Patient Navigation	<ul style="list-style-type: none"> Provide support for family-to-family health information centers (FHICs) to assist families of children with special health care needs in making informed treatment decisions. 	<ul style="list-style-type: none"> One in five U.S. households with children has a child with a special health care need. Should language assistance be effectively integrated into these programs, support for FHICs could help minority families with low literacy levels and newly arrived immigrants and families with LEP who have children with special needs more easily navigate the health care system and enroll in public programs, especially if FHICs are encouraged to partner with local cultural organizations.⁴⁹

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Table 6. Social Determinants of Health

	Summary	Implications for Racial/Ethnic Minorities
Interagency Collaboration	<ul style="list-style-type: none"> Require HHS to share health disparities data and analyses with other relevant agencies. 	<ul style="list-style-type: none"> Collaboration across federal agencies is important to understanding and addressing the range of social, economic, and infrastructural factors that contribute to health disparities. HHS should actively collaborate with other departments and agencies outside of its purview (e.g., housing, education, transportation) in disseminating health disparities data and developing targeted strategies to reduce the impact of non-medical contributors to poor health outcomes.
Infrastructure Support	<ul style="list-style-type: none"> Not Specified. 	<ul style="list-style-type: none"> A strong public health infrastructure at the national, state and local levels is vital to eliminating racial/ethnic disparities in health care outcomes, which are inseparable from racial/ethnic inequities in housing conditions, exposure to environmental hazards, and access to affordable and high quality food, transportation, education and health services.
Data Collection	<ul style="list-style-type: none"> Not Specified. 	<ul style="list-style-type: none"> Robust data collection on factors beyond race, ethnicity, and language that are likely to influence and shape health and health care decisions—such as social, economic, and environmental conditions—offer the opportunity to identify associations between health outcomes and social determinants and develop targeted programs to advance health equity.⁵⁰

Notes

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