

## Medicare Improvements for Patients and Providers Act of 2008: Addressing Racial and Ethnic Health Disparities

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The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) became law on July 15, 2008, when Congress overrode President Bush's veto. MIPPA contains several provisions affecting the Medicare program, including suspended payment cuts to health care providers, new accountability measures for Medicare Advantage programs, and increased access to preventive and mental health services. Also included were new policies to reduce racial and ethnic health disparities within the Medicare population. (See the box on page 4 for a general description of the Medicare program.)

Medicare provides health care coverage to individuals over 65 and to people with disabilities, offering them the same standard benefits. Numerous Medicare studies have shown that communities of color continue to experience differences in access, treatment, and quality of care. Even after accounting for differences in age, education, and income for enrollees within the same Medicare plans, racial and ethnic minorities tend to have disproportionately higher rates of disease and poorer health outcomes than their white counterparts.<sup>1</sup> As the Medicare population continues to grow and becomes more diverse, it's important to understand why these disparities persist and to find the appropriate remedies for them.

As the country's single largest purchaser of health care, Medicare has tremendous potential to help reduce racial and ethnic health disparities. Since its inception, Medicare has served as a model for other health care systems within the U.S., both public and private. Taking the lead in the field and ensuring that all beneficiaries experience the same access to care and treatment will surely set the stage for other health plans to do so, as well.

In order to tackle health disparities within the Medicare program, MIPPA has laid out three key areas for further study and monitoring:

- ◆ Improved Data Collection for Measuring and Evaluating Health Disparities
- ◆ Outreach to the Previously Uninsured
- ◆ Compliance with Cultural Competency Standards

## Improved Data Collection for Measuring and Evaluating Health Disparities

Since Medicare is a federal entitlement program for seniors that has no income requirements or coverage limits based on health status, it's an ideal program for identifying and documenting disparities. Collecting and analyzing this rich source of data will create a more accurate picture of the differences in health and health care experienced by racial and ethnic minorities; pinpointing these differences and the people affected by them will make health disparities a real issue to policy makers, funders, and the public. Reports and other documents that analyze the health status and health service patterns of communities of color will give advocates and researchers facts they can use to accurately inform policy makers about the scope of the problem and to offer recommendations for the most appropriate interventions.

Medicare health disparities-related data are currently collected from several sources. The primary source, the Social Security Administration's beneficiary enrollment files, contains race and ethnicity information on all Medicare beneficiaries. To measure disparities, these data are analyzed, together with information gathered from claims data and surveys. Claims data allow the Medicare program to determine which beneficiaries use services, while surveys help to document other health indicators, such as beneficiary access to care, satisfaction with care, and usual sources of care. The three main surveys used to collect health disparities-related information are the CAHPS (Consumer Assessment of Healthcare Providers and Systems) Survey, the Medicare Health Outcomes Survey, and the Medicare Current Beneficiary Survey.<sup>2</sup>

MIPPA requires the Secretary of the Department of Health and Human Services (HHS) to evaluate the best methods for data collection and to submit those findings to Congress for implementation. Data collection and evaluation will have to be ongoing, accurate, and timely and will need to include ways to measure disparities in health care and performance in the Medicare program on the basis of race, ethnicity, and gender.

In order to meet this requirement, the HHS division that administers Medicare, the Centers for Medicare and Medicaid Services (CMS), is in the process of reviewing specific health disparities indicators for health plans and providers and deciding which of them should be measured. This process will be designed over the next 18 months and then implemented within 24 months. After four years, the agency will evaluate data collection methods with respect to their effectiveness and how they can be improved. Although it's not clear how CMS will proceed, advocates and experts recommend that traditional fee-for-service Medicare plans be compared to Medicare managed care plans, and that a comparison amongst Medicare managed care programs take place, as well. A Medicare provider comparison is also recommended.

## Outreach to the Previously Uninsured

In 2007, 24 percent of the uninsured were between the ages of 45 and 64.<sup>3</sup> Research has shown that *uninsured* near-elderly adults (those between the ages of 50 and 65) receive fewer basic clinical services, are more likely to experience health declines, and die at younger ages compared to *insured* adults within the same age range.<sup>4</sup> Since communities of color are more likely to be uninsured and to experience language and cultural barriers to enrollment in public programs, it is important for the Medicare program to identify effective outreach methods for these populations.

This provision requires the Secretary to establish a demonstration project to research the most effective ways to reach individuals who didn't have health insurance prior to enrolling in Medicare and to determine their greatest health care needs. This study will last for two years, have no fewer than 10 sites, and will include service providers such as state health insurance assistance programs, community health centers, and community health workers. The findings will be submitted to Congress and will include an analysis of the effectiveness of specific activities, such as revising outreach and enrollment materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers, and amending the *Medicare and You* handbook. Also included will be an analysis of beneficiary access to care, use of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes. Demonstration sites have not yet been selected.

## Compliance with Cultural Competency Standards

According to the Census Bureau, 47 million people—18 percent of the U.S. population—speak a language other than English at home.<sup>5</sup> The census has also found that more than 28 percent of all Spanish speakers, 22 percent of Asian and Pacific Islander language speakers, and 13 percent of Indo-European language speakers report that they speak English “not well” or “not at all.”<sup>6</sup>

In order for high-quality health care to be delivered and received, providers and patients have to be able to communicate effectively with one another. Patients with limited English proficiency are more likely to report having overall problems with care and may be at an increased risk for experiencing medical errors.<sup>7</sup>

To ensure that all patients have access to linguistically appropriate care, the U.S. Department of Health and Human Services's Office for Civil Rights (OCR) issued guidance on how recipients of federal funds should provide meaningful language access; HHS's Office of Minority Health (OMH) has developed standards for how this should be done.<sup>8</sup>

Under MIPPA, the Inspector General will report on how well Medicare providers and plans are meeting OCR's guidance and the cultural competency standards set by OMH. The report will provide recommendations for improving the enforcement of these standards and offer suggestions to help providers meet them. It will also detail the savings or costs that health care providers experience when they provide language services for patients.

The HHS Office for Civil Rights (OCR) developed and implemented guidance on improving health care access for individuals with limited English proficiency in response to Executive Order 13166, *Improving Access to Services for Persons with Limited English Proficiency*, issued by President Clinton in August 2000. This executive order reinforced a patient's right to language access, which was originally established in Title VI of the Civil Rights Act of 1964. The OCR guidance recommended best practices; it extends to recipients of federal funds, including the agency itself. Subsequently, the HHS Office of Minority Health developed 14 standards for culturally and linguistically appropriate services (CLAS) in health care for use by policy makers, providers, patients, advocates, purchasers of health care, and accreditation and credentialing agencies.

### What is Medicare?

Medicare is the federal health insurance program that provides health coverage for more than 41 million adults aged 65 and older and for people with permanent disabilities.

### Who is eligible for Medicare coverage?

Individuals aged 65 or older are enrolled in Medicare if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for at least 10 years. Individuals under the age of 65 who have permanent disabilities and qualify for Social Security Disability Insurance (SSDI) are also eligible.

### What benefits are covered?

Medicare currently provides hospital coverage and outpatient medical coverage through Parts A and B; Medicare Part C encourages beneficiaries to enroll in private "Medicare Advantage" plans; and Part D, which was added in 2006, gives Medicare beneficiaries a choice to enroll in a prescription drug plan.

### How diverse is the Medicare population?

Currently, more than one in five elderly Medicare beneficiaries is a member of a racial and ethnic minority group. Although the majority of Medicare beneficiaries are still non-Hispanic whites, in 2007, Medicare provided health insurance coverage to 4.3 million African Americans, 2.9 million Hispanics, 1.2 million Asians, 298,000 American Indians and Alaska Natives, and 49,000 Native Hawaiians and Other Pacific Islanders.<sup>9</sup>

## Action Steps for Advocates

Advocates can play a key role in ensuring that MIPPA provisions are understood and implemented in their communities. Below are several strategies that can be used to educate and engage Medicare beneficiaries, their families, and the health care community.

- ◆ Help educate those in your community about MIPPA, including local providers, colleagues, and your constituents.
  - ◆ Begin a dialogue with other local health advocates on the most appropriate ways to educate your target audience(s).
  - ◆ Plan events in locations where your target audience may gather, such as a local church, community center, or health clinic. Work with these organizations to inform beneficiaries and their caregivers about recent Medicare changes.
- ◆ Contact the local Social Security Administration office to find out how they plan to implement MIPPA changes and whether or not a demonstration project will take place in your community. If there will be a demonstration project in your area, explore opportunities for collaboration and data sharing.
- ◆ Write your local congressperson to show your support for MIPPA and its health disparities provisions. Include comments on the positive effects these provisions will have on health disparities, and provide examples of other policies that would complement these provisions.
- ◆ Continue to advocate for other policies to eliminate health disparities, such as increasing diversity in the health care workforce, enhancing health care quality and access, and funding health disparities research.
- ◆ Help identify what language needs exist in your community. Encourage trained translators to volunteer their time with local health care facilities or state health insurance assistance program (SHIP) offices; provide local health care facilities with referrals to individuals who are trained translators.
- ◆ Help beneficiaries report on health care facilities that are not complying with cultural competency standards. Develop a process to assist beneficiaries in communicating their concerns to their health care provider, local Social Security Administration office, SHIP office, Office for Civil Rights, and congressperson.
- ◆ Collect stories from beneficiaries. Success stories, as well as those that describe difficulty obtaining health care, can be used by health advocates and the media to demonstrate the need to address health disparities and the benefits that result when it's done well.

## Endnotes

- <sup>1</sup> Amal N. Trivedi, MD, MPH et al., "Relationship Between Quality of Care and Racial Disparities in Medicare Health Plans," *The Journal of the American Medical Association* 296, no.16 (October 25, 2006): 1998-2004.
- <sup>2</sup> Thomas D. Sequist and Eric C. Schneider, "Addressing Racial and Ethnic Disparities in Health Care: Using Federal Data to Support Local Programs to Eliminate Disparities," *Health Services Research* 41:4, Part 1(August 2006): 1451-1468.
- <sup>3</sup> Kaiser Family Foundation, *Kaiser Fast Facts: Characteristics of the Uninsured, 2007* (Washington: Kaiser Family Foundation, October 7, 2008), available online at <http://facts.kff.org/chart.aspx?ch=480>.
- <sup>4</sup> J. Michael McWilliams, MD et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *The New England Journal of Medicine* 357, no. 2 (July 12, 2007): 144, available online at <http://content.nejm.org/cgi/content/full/357/2/143>.
- <sup>5</sup> Hyon B. Shin with Rosalind Bruno, *Language Use and English-Speaking Ability: 2000* (Washington: Census Bureau, October 2003), available online at <http://www.census.gov/prod/2003pubs/c2kbr-29.pdf>.
- <sup>6</sup> U.S. Census Bureau, *Ability to Speak English by Language Spoken at Home: 2000, Table 1a*, October 29, 2004 (revised 2/06), available online at <http://www.census.gov/population/www/cen2000/briefs/phc-t37/tables/tab01a.pdf>.
- <sup>7</sup> Brian Smedley, *Lifeline to Health Equity: Policies for Real Health Care Reform* (Washington: Service Employees International Union and National Conference of Black Mayors, June 2008).
- <sup>8</sup> Grantmakers In Health, *In the Right Words: Addressing Language and Culture in Providing Health Care* (Washington: Grantmakers in Health, August 2003), available online at [www.gih.org/usr\\_doc/In\\_the\\_Right\\_Words\\_Issue\\_Brief.pdf](http://www.gih.org/usr_doc/In_the_Right_Words_Issue_Brief.pdf).
- <sup>9</sup> U.S. Census Bureau, *Current Population Survey, Annual Social and Economic Supplement, 2008*, available online at <http://www.census.gov/hhes/www/hlthins/hlthins.html>.

To stay up-to-date on how MIPPA will be implemented, sign up for our e-newsletter, *Minority Health Connection* at [www.familiesusa.org/issues/minority-health](http://www.familiesusa.org/issues/minority-health)

To view the full text of the *Medicare Improvements for Patients and Providers Act* (MIPPA), PL 110-275, go to [www.govtrack.us/congress/billtext.xpd?bill=h110-6331](http://www.govtrack.us/congress/billtext.xpd?bill=h110-6331).

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