

Cultural Competency as It Intersects With Racial/Ethnic, Linguistic, and Class Disparities in Managed Healthcare Organizations

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Culture in and of itself is not the most central variable in the patient-provider encounter. The effect of culture is most pronounced when it intersects with low education, low literacy skills, limited proficiency in English, culture-specific values regarding the authority of the physician, and poor assertiveness skills. These dimensions require attention in Medicaid managed care settings. However, the promise of better-coordinated and higher quality care for low-income and working-poor racial/ethnic populations—at a lower cost to government—has yet to be fully realized. This paper identifies strategies to reduce disparities in access to healthcare that call for partnerships across government agencies and between federal and state governments, provider institutions, and community organizations. Lessons learned from successful precedents must drive the development of new programs in Medicaid managed care organizations (MCOs) to reduce disparities. Collection of population-based data and analyses by race, ethnicity, education level, and patient's primary language are critical steps for MCOs to better understand their patients' healthcare status and improve their care. Research and experience have shown that by acknowledging the unique healthcare conditions of low-income racial and ethnic minority populations and by recruiting and hiring primary care providers who have a commitment to treat underserved populations, costs are reduced and patients are more satisfied with the quality of care.

(Am J Manag Care. 2004;10:SP37-SP44)

Minority populations—Hispanics, African Americans, Asian Americans, and other people of color—currently comprise 28% of the population of the United States, and this figure is projected to increase to 40% by 2030.¹ Racial and ethnic minorities, especially those with low incomes and limited English proficiency (LEP), experience multiple barriers to healthcare, encounter lower access to and availability of healthcare, and experience less favorable health outcomes.²⁻⁹ Multiple barriers to healthcare access exist—such as language, economics, geography, and cultural familiarity—even when minorities are insured at the same level as nonminorities.^{10,11} The emerging awareness in the United States over the past 3 decades of what is termed “disparity” has presented innumerable challenges, partly because of the lack of scholarship that examines the intersections of socioeconomic, racial, and ethnic statuses. Questions remain regarding how to improve access and quality of care for economically disadvantaged and culturally distinct groups.

This paper examines the definitions of cultural competence within the context of access to care and identifies Medicaid managed care experiences in select states to describe the experiences of underrepresented low-income racial/ethnic minorities within managed care systems. Building on extant empirical literature, we propose strategies to enhance competent and high-quality care for racial and ethnic groups in managed care systems. A computerized literature search was conducted for the years 1999-2003 using the following keywords: Medicaid managed care, disparities; access to services; health services accessibility; access to primary and preventive care, co-payments; cost sharing; low-income, minority, Latino/Hispanic, African American/Black; quality of care, and Medicaid managed care policy. The databases searched included MEDLINE, Social Science Citation Index, and Science Citation Index. In addition, government and Kaiser and Commonwealth Foundation reports were reviewed. A version of this paper was presented at the Conference on Diversity and Communication in Health Care: Addressing Race/Ethnicity, Language, and Social Class in Health Care Disparities convened in February 2000 by the Office of Minority Health of the US Department of Health and Human Services in Washington, DC.

Cultural Competence: Past and Emerging Definitions

In the past, cultural competence has been called cultural sensitivity, cultural responsiveness, or cultural appropriateness; the name “cultural competence” is

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Prepared for the Conference on Diversity and Communication in Health Care: Addressing Race/Ethnicity, Language, and Social Class in Health Care Disparities; Washington DC; February 17-18, 2000. This study was sponsored by the Office of Minority Health, US Department of Health and Human Services.

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recent.¹² Cultural competence is defined as a “set of congruent behaviors, attitudes, and policies that come together in a system, agency or profession that enables that system, agency or profession to work effectively in cross-cultural situations.”^{2,13} Cultural competence, as originally conceived, emerged as an issue because of public health efforts to make healthcare services more responsive to underserved populations in both rural and urban areas. As the number of patients of diverse racial, ethnic, cultural, and linguistic backgrounds increased in the United States, the need to produce culturally competent providers who incorporate patients’ world view into management decisions also grew.

The release of the national standards for culturally and linguistically appropriate services in 2001 drew attention to the need for culturally and linguistically competent healthcare services for diverse populations and attracted the attention of policymakers, medical schools, public health systems, and healthcare providers.^{12,14} The Institute of Medicine’s report *Unequal Treatment* concluded that ethnic and racial gaps in care beyond access-related factors were attributable to a range of patient-level factors (patient preference, treatment refusal, clinical appropriateness of care), provider-level factors (bias, stereotyping, uncertainty), and system-level factors (lack of interpreters, geography, managed care system).¹⁵

Health disparities are associated with factors such as patients’ perceived discrimination¹⁶ and mistrust of the healthcare system,¹⁷ poor or ineffective communication between patient and physician,¹⁸ and healthcare providers’ lack of cultural competence and sensitivity.^{19,20} Other contributing factors to healthcare disparities are social factors such as socioeconomic status and racism, and systemic factors such as access to care and communication barriers.²¹⁻²³ To ensure quality healthcare and access for minority populations, care must be congruent with patients’ cultural, linguistic, and literacy needs. A recent study of a large staff-model HMO found that interpreter services can increase delivery of healthcare to non-English-speaking patients by facilitating patient-physician understanding, which affects patient adherence and accuracy of diagnosis and treatment, while fostering trust and increased satisfaction with care.²⁴ Quality healthcare is culturally competent and patient centered.²⁵ Culturally competent care can improve the continuity of a patient’s care and health outcomes by increasing the understanding between patients and providers.^{18,26,27}

When healthcare providers and organizations understand and effectively respond to the diverse cultural and linguistic needs of patients, the benefits of a true patient-clinician relationship are more fully real-

ized.²⁸ Several attributes of culturally competent care are useful in examining its meaning within managed care settings:

- When culture-specific health beliefs and health behaviors, gender, race, ethnicity, age, and low socioeconomic status are part of a shared dialog between provider and patient, both communication and delivery of care are more effective.²⁹
- Providers who are aware of and address potential communication difficulties, and who provide linguistically appropriate and literacy-appropriate information in the patient’s native language, interact more effectively with patients.³⁰
- Culturally competent providers consider the patient’s needs and preferences within the context of his or her cultural beliefs and practices, and understand the importance of these factors in the treatment plan.²⁵

Culture in and of itself is not the most central variable in the patient-provider encounter. The effect of culture is most pronounced when it intersects with low education, low literacy skills, LEP, culture-specific values regarding the authority of the physician, and poor assertiveness skills. It is precisely this intersection that has been poorly understood or ignored. Yet these dimensions require attention in Medicaid managed care settings.

Expanding the definition of cultural competency has implications for underrepresented minority groups. The ability to take into account individual and institutional factors, the known health consequences of poverty, and barriers to healthcare access could lead to new mechanisms and interventions to address health disparities. Healthcare access, health outcomes, and patient satisfaction could be improved, and long-term costs for managed care organizations (MCOs) could be reduced.

Emergence of Managed Care as a Policy Solution to Improve Access and Reduce Costs for Medicaid Programs

The trend toward managed care began in the late 1980s, when the cost of healthcare services escalated at an alarming rate, as evidenced by Medicaid costs, which were increasing by an average of 30% annually during that period.³¹ Simultaneously, the number of uninsured in the population continued to increase and presented a challenge to those concerned with providing access to healthcare services for the poor and working poor. As a result, commitments to legislate major changes in healthcare that would address the issues of cost and access to healthcare services became part of the national health agenda. Yet the failure of the healthcare reform plan and all competing proposals introduced

during the 103rd Congress suggests that the primary focus of this national debate was predominantly to control the cost of healthcare and to support managed care as a viable solution.³² Managed care advocates promoted the notion that a well-run managed care system could provide quality healthcare while at the same time reducing costs.^{33,34}

In an effort to control rising healthcare costs and limit the utilization of services, public purchasers are increasingly relying on managed care models. By the year 2000, almost all states had begun to offer the option of managed care to their Medicaid beneficiaries, with varying degrees of success. Remaining states continue to study plans to transition and restructure state and county systems to managed care.³⁵ Managed care has continued to expand as states experience pressure to contain costs and is increasing in both Medicaid and State Children's Health Insurance Program (SCHIP) programs. The number of Medicaid clients enrolled nationwide in managed care has increased dramatically, with a 3% enrollment in 1983, a 23% enrollment in 1994, and a 58% enrollment as of December 31, 2001.³⁶

Managed care, which is based on the premise that regular use of primary and preventive care can prevent illness and reduce costs, holds great promise for delivering quality and cost-efficient healthcare to low-income families, many of whom face overwhelming barriers to care. But while more Medicaid recipients and low-income children are enrolling in managed care plans, the promise of better coordinated and higher quality care for low-income and working-poor racial/ethnic populations—at a lower cost to government—has yet to be fully realized.³⁷

Medicaid beneficiaries are more likely to have poor health status and therefore incur higher costs for healthcare services.³⁸ Further, a large majority of Medicaid patients lack transportation, live in medically underserved communities, are less likely to have continuous telephone service, and tend to use the emergency room as a regular source of care. In 30% of Aid to Families and Dependent Children households, at least 1 family member reported having a disability.⁵ More than 50% of Medicaid beneficiaries belong to racial/ethnic minorities.³⁹ In general, underrepresented racial/ethnic minority groups are poorer, have more chronic health conditions (eg, asthma, diabetes, heart disease), engage in more high-risk behavior, and have less access to providers. As a result, they are more expensive to care for. However, unfavorable health status is associated with poverty and limited access to quality health services, not with minority status. The performance of managed care systems in providing care for publicly insured populations in different states must be examined as part

of any effort to reduce ethnic and racial disparities in healthcare.

State Experiences With Low-income and Medicaid Recipients: Issues and Challenges

States can move toward managed care either by allowing voluntary enrollment or by instituting a mandatory enrollment program. In some cases, the voluntary option comes first and is used as an experimental enrollment strategy, often followed by a more structured and systematic mandatory model. The rapid expansion of Medicaid managed care was seen by the states as a way to improve the quality of care by encouraging more primary healthcare services and less emergency room utilization. In the second generation of managed care, states are moving to ensure quality of care by incorporating innovative approaches designed to guarantee that both psychosocial needs and medical needs are met.⁴⁰ The states of Oregon and Washington have taken the lead in this regard, as MCOs are mandated to develop a continuum of services that meet the needs of Medicaid populations. Most states, however, are lagging behind and have not developed the capacity to meet the comprehensive needs of low-income and underrepresented racial/ethnic minority populations.⁴¹

Medicaid managed care experience in 5 states (California, Minnesota, New York, Oregon, and Tennessee) consistently shows that Medicaid managed care confronts more challenges than commercial managed care efforts because the Medicaid population of low-income women and children, the disabled, and the elderly have unique needs that require initiatives to be tailored so that they are responsive to these populations.⁴¹ States vary significantly in their requirements for services such as translation, outreach, and transportation. Oregon, for example, has no such requirement; and Minnesota adopted special services only after it was evident that certain supportive services were an essential and necessary part of providing access for the poor.

However, in the long term, the stability of Medicaid managed care programs is uncertain. Private HMOs have dropped out of the Medicaid market when the profit margin has declined.⁴² Although competition for Medicaid business is fierce in most states, the profitability of serving Medicaid clients may diminish if Medicaid officials try to reduce reimbursement rates whenever they conclude that a MCO is making excessive profits. If the federal contribution to Medicaid declines, there will be additional pressure to decrease HMO reimbursement rates. If Medicaid officials introduce program improvements to reduce adverse selec-

tion, the profitability of Medicaid clients will diminish even further.

Enrollment and Outreach

Addressing disparities in the recruitment and enrollment of Medicaid beneficiaries into managed care plans is critically important for the health of low-income and racial and ethnic populations. In the early wave of recruiting Medicaid clients, many MCOs engaged in recruitment and enrollment tactics that did not protect the rights, options, and choices of the client population. Both Oregon and Minnesota do not allow any direct marketing by health plans, because direct marketing by plans has been associated with abuse of rights in Medicaid managed care. Initially, the New York marketing was conducted from door to door, a practice that has since been suspended.

There is evidence that some MCOs have engaged in discriminatory practices, including refusing to provide services to entire geographic areas and populations.^{37,43} The Office of Civil Rights of the US Department of Health and Human Services has been called on to investigate Medicaid managed care enrollment and marketing practices.⁴⁴ Some MCOs also have been found to engage in additional “skimming” or “creaming” practices such as locating their membership office on the second floor (without access to elevators), or training their enrollment counselors to visually assess whether the enrollee would need a lot of services in order to enroll only the healthiest members.^{6,44} States have found that if managed care structures are to benefit all enrollees, the states must establish marketing guidelines and prohibit these discriminatory practices. Populations with low education, low literacy, and/or LEP are particularly vulnerable in the transition to managed care. Notices informing enrollees of their rights often go unread because they are not understood or have not been translated into the appropriate languages of the population. States implementing mandatory enrollment in Medicaid managed care have found that these groups are least likely to respond to enrollment notices and are more likely to be automatically enrolled by the state.⁴⁵

Safety-net Providers

The transition from a fee-for-service system to a managed care system poses a major challenge, with significant implications for the future viability of safety-net providers that deliver healthcare to the poor and near poor.⁴⁶ Given the high proportion of uninsured persons in the US population (particularly the Latino population), safety-net providers that serve this community are doubly challenged in the managed care environ-

ment. Despite the fact that there is no competition among providers to serve uninsured patients, the transition of Medicaid recipients (another patient population traditionally served by safety-net providers) into managed care plans has produced competition for Medicaid enrollees that has implications for safety-net providers.⁴⁷ The ability of community-based organizations, public hospitals, and public clinics, the traditional safety net for the poor and medically indigent, to compete in the Medicaid managed care environment and to negotiate contracts and appropriate payment rates is uncertain.

In California, state Medicaid officials have developed a managed care model (the 2-plan model) designed to protect safety-net providers. In contrast, New York State Medicaid officials have neither designed nor implemented a safety-net protection plan. Instead, the state tasked its 57 counties to design and implement their own initiatives to protect the provider safety net.⁴³ Lipson and Naierman argue that this decentralized approach does not provide for clear universal guidelines or clear lines of accountability that would ensure the systematic strengthening and protecting of the safety-net infrastructure.⁴⁸ The potential lack of long-term MCO commitment to the Medicaid population increases the need to preserve a strong medical safety net to serve the poor and medically indigent.⁴⁹

Safety-net providers have historically been able to cross-subsidize care for the uninsured using Medicaid payments, but as Medicaid dollars decrease while uninsured patients increase, providers are forced to turn to grant money to subsidize their operations. Thus, few to no resources remain for public health programs and health education efforts. But in some communities, the result is even worse: public hospitals, federally qualified health centers, and health clinics are shutting their doors or drastically reducing their services.⁶ The challenge is not only to contain costs and provide quality healthcare, but more importantly, to secure the future viability of safety-net providers delivering healthcare services to the poor and uninsured. Furthermore, strengthening safety-net providers under managed care may be the *only* way of ensuring that the poor and uninsured populations continue to be served.

Andrulis argues that the entire tradition of public-sector healthcare is threatened by managed care, as the intensity and growth of the competition might be too powerful for it to withstand.⁵⁰ He raises 2 central issues: (1) Although community healthcare centers might become attractive to MCOs as a way of gaining entry into certain neighborhoods, it still remains unclear whether MCOs would invest adequate funds to deliver effective healthcare services to low-income and work-

ing-poor populations, or whether any autonomous role would remain for community-based organizations under such partnerships. (2) Although in the past a fully vested public sector provided and financed healthcare, the emergence of a “residual public sector” or an entirely “divested public sector” is possible given the current questioning by policymakers and state and local governments regarding what role, if any, the public sector has to play in the new managed care environment.⁵⁰

A review of the nonprofit sector in managed care suggests that to ensure the survivability of the system, innovative models of joint partnership and ownership of managed care enterprises by community providers need to be explored.⁵¹ Although the healthcare reform debate addressed the need to better define expectations for the nonprofit sector as a provider of free services, it did not adequately envision the role of the nonprofit-sector providers as entrepreneurs who would assume an ownership role in the system. Unless the nonprofit sector assumes an ownership role in managed care, services for the poor will be compromised.^{52,53}

Community-based organizations providing safety-net healthcare services require particular attention, because they serve a disproportionate number of uninsured. The ability of community-based organizations to compete in the managed care marketplace and gain entry to Medicaid contracts will solidify their position as safety-net providers serving low-income and racial ethnic groups in their community. However, the majority of community-based organizations work within an organizational environment that has few financial and personnel resources available—which makes them less able to compete and negotiate in their environment.⁵⁴ Community-based organizations that provide healthcare services to the poor and near poor are mandated by their governance not only to provide culturally competent healthcare but also to advocate on behalf of these patients for their rights. The transition to managed care poses additional challenges for these organizations. Organizations adapting to the managed care environment generally lack the technological resources, cash reserves, and sophisticated accounting systems needed to be part of a provider network, despite the fact that they carry the heaviest burden for delivering healthcare services to the poor and underserved.⁵⁴

Managed care organizations can meet their goals of lowered costs and improved access to care by tailoring their services to the needs of the population they serve and by working closely with local community-based providers to increase access, enhance the trust of clients, and utilize existing community resources. Strategies include:

- Provide financial resources to support partnerships between local government, MCOs, and community agencies for outreach and enrollment in publicly funded programs. The involvement of community-based healthcare organizations in improving access to healthcare for low-income, racial/ethnic communities has become increasingly apparent. Many states and counties are beginning to formalize these relationships (particularly in SCHIP programs), and these efforts must be evaluated.⁴⁶
- Improve government purchasing. Public purchasers need training on rate setting to establish payment rates that do not discourage MCOs from serving high-risk populations. The costs of providing culturally and linguistically competent healthcare should be included in capitation rate-setting methodologies.
- Provide federal subsidies to MCOs that serve low-income vulnerable populations to ensure the provision of supplemental services such as transportation, medical supplies, and medications.
- Mandate the inclusion of minority, linguistically competent, and culturally competent providers in managed care networks.
- Conduct radio and television mass media education campaigns to help people understand their rights as MCO enrollees.

Primary Care Capacity in Low-income and Racial/Ethnic Communities

Primary care capacity (ie, having enough primary care practitioners to meet people’s needs for healthcare) is a critical link to improving the health status of low-income, minority, and LEP populations. People who have access to convenient primary care facilities where care is available in their language receive higher quality care and are less likely to experience serious illness; for those with chronic conditions such as asthma, diabetes, and hypertension, many hospitalizations are avoidable.⁵⁵

Underrepresented racial/ethnic communities have long been plagued with a paucity of medical professionals. In New York City, for example, there are 232 physicians in office-based practice per 100 000 residents. In 9 low-income, primarily minority communities, the rate was as low as 21.6 physicians per 100 000. These communities experienced a severe shortage in primary care capacity within a city that has immense physician resources.⁵⁶ Racial/ethnic practitioners are more likely to serve minority and poorer patients, and racial/ethnic health researchers are more likely to be interested in problems relevant to minority and historically underserved populations.⁵⁷ African American physicians are more likely than others to treat patients who are African American and/or on Medicaid; Latino physicians are more likely than others to treat patients who are Latino

and/or uninsured.⁵⁸ Racial/ethnic minority patients also are more likely to feel that their physicians involved them in decisions about their care when the patient and the physician are of the same sex and race.⁵⁹

Over the past several years, the number of African Americans and Latinos admitted to medical school has declined. Although racial and ethnic minority groups represented 19.4% of the US population in the 1990 US Census, they represented only 10.9% of the 1997 medical school matriculants. The shift away from a national acceptance of affirmative action is having a negative effect on the ability to recruit and retain minority students and faculty in the health professions. After Proposition 209 in California and the Hopwood decision in Texas, Louisiana, and Mississippi, applications of minorities to medical schools in these states declined 17% (2.3 times more than the national average), accepted applications of minorities declined 27% (7 times more than the national average), and minority matriculants declined 26% (6 times more than the national average).⁶⁰

At the federal level, repeatedly documented strategies have been recommended to increase the number of underrepresented minorities in the health professions through investments in pipeline programs, mentoring programs, and incentive programs for both providers and MCOs, and more scholarship funds targeting low-income, underrepresented racial and ethnic groups.^{57,58} Although federal efforts are required to increase African American and Latino representation in medicine and the health professions, MCOs can enhance the number of primary care physicians and health professionals by recruiting professionals who have a commitment to practicing in underserved areas, by creating opportunities for internships and residencies in MCOs, and by providing financial incentives to underrepresented minority primary care physicians to work in underserved communities. In addition, federal and state governments can strengthen the efforts of MCOs through the following strategies:

- Increase the reimbursement rate for MCOs that serve Medicaid and SCHIP individuals, and provide incentives such as tax credits to encourage MCOs to recruit the participation of more providers in underserved areas.
- Create financial incentives for MCOs to reimburse primary care providers who practice in neighborhoods with a primary care shortage at an above-average rate.
- Strengthen existing efforts and create new opportunities through the Health Resources and Services Administration to support primary care improvement, especially in MCOs that are located in minority communities (eg, National Health Service Corps, Bureau of Health Professions).

Culturally Competent Practices

There is no universal understanding among providers and researchers of what culturally competent care is, how to measure or evaluate appropriate care, or how to define successful programs. There are several reasons for this: no established standards define competent care; the costs of providing appropriate care (eg, interpreter services) often are not reimbursed; many public officials, healthcare facilities, and providers are unaware of their obligations or unwilling to provide linguistic and culturally appropriate healthcare to their patients⁶¹; and institutional practices often tend to disregard the healthcare needs of those who are unable to pay, have public insurance, or are unable to negotiate the system due to low education and literacy skills, and/or access constraints. In addition, cultural competence involves a dynamic interplay among socioeconomic status, race, ethnicity, and language—an interplay that definitions and interpretations of the term do not always acknowledge.

Local clinics, health centers, and individual providers have provided leadership in bringing high-quality, culturally competent healthcare to the communities they serve. Yet many publicly financed programs continue to be uninformed about the unique characteristics of the populations they serve. This information gap is associated with provision of less effective services, particularly for those who have a low income and LEP. (See the article by Carter-Pokras et al in this issue for a complete discussion of LEP.⁶²) Several studies have shown that language is important when a person does not have health insurance, has limited education, and has a low income.^{7,22} In those instances, qualified medical interpreters—who are aware not only of language appropriateness but also of literacy and culture-specific health beliefs and behaviors—are crucial in bridging the language and culture chasm between patient and physician to effectively communicate health issues.²⁴

Training for health professionals on the provision of culturally appropriate care also lacks systematic and comprehensive standards. Schools of medicine, nursing, and public health offer courses on cultural competency. But the quality and depth of these offerings varies dramatically, from a single lecture per semester to an entire course on cultural differences. To date, no clear guidelines or comprehensive standards exist on how to prepare healthcare providers to become culturally competent. When 118 US and 15 Canadian medical schools were surveyed, few schools (United States: 8%, Canada: 0%) had separate courses addressing cultural issues and only 35% of US schools addressed the cultural, economic, and insurance status issues of the largest minority groups in their particular states.^{63,64} Managed care organizations

can institute continuing education or required training for all healthcare professionals regarding the culture-specific health beliefs and clinical, economic, and language issues experienced by the population they serve.

To institutionalize a set of practices that ensure equal treatment for all, both federal and state legislative policies should mandate a set of strategies that account for socioeconomic status and its associated literacy, language, and cultural dimensions. These policies should be monitored at the provider-institutional level to ensure compliance:

- Mandate standards on culturally and linguistically appropriate services to ensure culturally competent healthcare. Consider making mandatory the standards recently issued by the Office of Minority Health.¹⁴
- Establish minimum standards to compel training institutions to incorporate cultural competency into academic requirements.
- Adjust reimbursement rates to reflect any increased costs associated with implementation of the Office of Minority Health standards for culturally and linguistically appropriate services in healthcare, particularly the provisions of language interpretation sources.

Conclusion

This paper identifies strategies to reduce disparities in access to healthcare that call for partnerships across government agencies and between federal and state governments, provider institutions, and community organizations. In a recent article, Zambrana and Carter-Pokras examine the most promising practices in state reform strategies to increase health insurance coverage for eligible low-income racial and ethnic populations.⁶⁵ Lessons learned from successful precedents must drive the development of new programs in Medicaid MCOs to reduce disparities. Federal initiatives (eg, requests for proposals) can help ensure participation of community agencies in planning, implementing, and monitoring new initiatives; their involvement can be required as a condition for funding. As a result, these strategies also would aim to forge lasting community partnerships.

New investments in programs and initiatives must be accompanied by systems to track the effects of disparity-reducing efforts. Collection of population-based data and analyses by race, ethnicity, education level, and patient's primary language are critical steps for MCOs to better understand their patients' healthcare status and improve their care. Some data do exist; however, in many instances, insurance data, utilization data, outcomes data, and/or satisfaction data are neither collected nor analyzed from an intersectional perspective that

examines differences by demographic characteristics. Managed care organizations, in conjunction with public health agencies, can make better efforts to both capture these data and produce regular reports that show results by demographic and geographic strata. As noted in a recent report on national healthcare disparities, "More complete healthcare data could enhance understanding of why differences on health and healthcare exist and would help to determine the appropriate interventions for specific populations."⁶⁶

Delivery of healthcare to Medicaid managed care groups provides an opportunity to improve access and quality of care for Medicaid-eligible, low-income, underrepresented racial/ethnic minority groups. Research and experience have shown that by acknowledging the unique healthcare conditions of low-income racial and ethnic minority populations and by recruiting and hiring primary care providers who have a commitment to treat underserved populations, costs are reduced and patients are more satisfied with the quality of care. Managed care organizations are important to ensure that the financing, provisioning, and monitoring of healthcare improve so that high-quality services can be provided for historically underrepresented racial and ethnic groups, low-income groups, and non-English-speaking groups.

Acknowledgments

Dr Zambrana acknowledges the research assistance of Clare Jen, doctoral student in the Department of Women's Studies at the University of Maryland, College Park. Ms Molnar acknowledges the assistance of Doreena Wong, National Health Law Program, Inc; Geraldine Sanchez Agilpay, Association of Schools of Public Health; and Patrick C. Hines, Student National Medical Association.

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