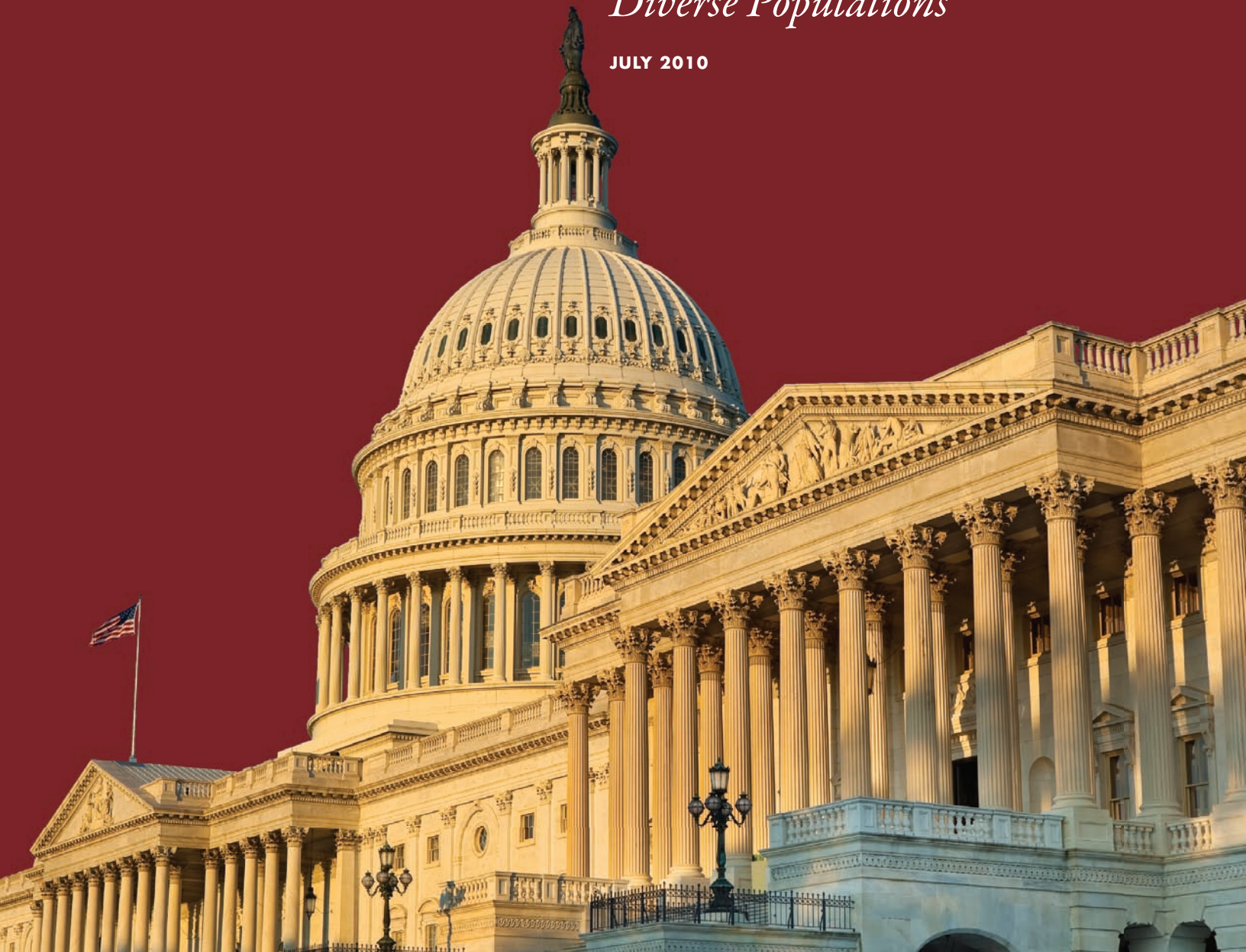




**PATIENT PROTECTION
AND AFFORDABLE CARE
ACT OF 2010:**

*Advancing Health Equity for
Racially and Ethnically
Diverse Populations*

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I. INTRODUCTION

Racial/ethnic disparities in health and health care in the United States are persistent and well documented. Communities of color fare far worse than their white counterparts across a range of health indicators: life expectancy, infant mortality, prevalence of chronic diseases, self-rated health status, insurance coverage, and many others.¹ As the nation's population continues to become increasingly diverse—people of color are projected to comprise 54% of the U.S. population by 2050 and more than half of U.S. children by 2023²—these disparities are likely to grow if left unaddressed. Recent health care reform legislation, while not a panacea for eliminating health disparities, offers an important first step and an unprecedented opportunity to improve health equity in the United States.

Reforming the nation's health care system was President Obama's top domestic priority when he was sworn into office in January 2009. The road to reform was complex and unofficially started in summer of 2009 when House and Senate committees began to draft legislation. On November 7, 2009, the House of Representatives passed its health care reform proposal, The Affordable Health Choices Act of 2009 (H.R. 3962). On December 24, 2009, the Senate passed its own proposal for health care reform, The Patient Protection and Affordable Care Act (H.R. 3590)^{*}, which was a merged version of the Senate Finance Committee's America's Health Future Act (S.1796) and the Senate Committee on Health, Education, Labor, and Pensions' Affordable Health Choices Act (S. 1697).[†] Efforts to reconcile differences between the Senate and House bills were stymied by the death of Senator Edward Kennedy (D-MA), a lifelong proponent of health care reform and critical force in securing a proposal's passage in the Senate.

Faced with limited options and expecting that a compromise bill could not get Senate support, the House passed the Senate's proposal and The Patient Protection and Affordable Care Act (ACA) was signed into law by President Obama on March 23, 2010 (Pub. L. No. 111-148).[‡] On March 30, 2010, the ACA was amended by The Health Care and Education Reconciliation Act of 2010 (H.R. 4872). According to

Congressional Budget Office (CBO) estimates, the ACA, as reconciled by H.R. 4872, will reduce the deficit by \$143 billion over the next decade and decrease the number of non-elderly uninsured by 32 million, leaving 23 million uninsured—approximately one-third of whom would be undocumented immigrants.³

This report provides a comprehensive review of general and specific ACA provisions with the potential to significantly improve health and health care for millions of diverse populations and their communities. The narrative that follows identifies these provisions, discusses why they are important, and considers challenges that may lie ahead in implementing them. We have organized this presentation in three major sections. The next section discusses provisions that explicitly address health disparities, such as those concerning data collection by race/ethnicity, workforce diversity, cultural competence, health disparities research, health disparities initiatives in prevention, and health equity in health insurance reform, and discusses their implications for racially and ethnically diverse communities. Section III describes general provisions, including health insurance reforms, access to care, quality improvement, cost containment, public health and social determinants of health, all of which are likely to have major implications for diverse communities.

An accompanying appendix identifies these provisions, provides a timetable and, where identified in the legislation, the federal agencies responsible for implementation, as well as allocations as of June 30, 2010. Section IV discusses issues that will be critical in realizing the full potential of health care reform and highlights questions and directions for the future, particularly in context of important priorities for reducing racial/ethnic health disparities that were left unaddressed.

* The United States Constitution requires that all revenue-related bills originate in the House. Thus, since the Senate's proposed health care reform legislation contained revenue provisions, the ACA was attached to a bill that originated in the House (H.R. 3590).

† This report represents the final document in a series. Analyses of the potential implications of all major health care reform proposals for racially/ethnically diverse communities are available online at <http://www.jointcenter.org/hpi/pages/2009-publications>.

‡ The Full text of the bill can be found online at <http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf>

II. HEALTH AND HEALTH CARE PROVISIONS SPECIFIC TO RACE, ETHNICITY AND LANGUAGE

The ACA includes numerous provisions that are explicitly intended to reduce health disparities and improve the health of racially and ethnically diverse populations. These include provisions originating not only from the Senate bill, but also those embedded in the House bill that became law through reconciliation. The scope, detail, and focus of these provisions are wide-ranging and span across at least six domains.

A. Data Collection and Reporting by Race, Ethnicity and Language

The ability to identify disparities and monitor efforts to reduce them has been limited due to a lack of specificity, uniformity and quality in data collection and reporting procedures.⁴ As expressed by the Institute of Medicine (IOM)⁵, consistent methods for collecting and reporting health data by race, ethnicity, and language are essential to informing evidence-based disparity reduction initiatives, such as those which address variations in quality of care or facilitate the provision of culturally and linguistically appropriate services. Reliable patient data by race/ethnicity are also necessary to ensure nondiscrimination in the provision of health care and in provider adherence to civil rights laws.⁶ In addition to strengthening existing efforts to collect data across the Office of Management and Budget (OMB) categories of race/ethnicity, improved data collection and reporting systems are necessary to obtain information on the health status and health care needs of immigrant populations and the approximately 100 ethnic groups with populations over 100,000 living in the U.S.⁷

The ACA contains several provisions aimed at improving data collection and reporting procedures, each having the explicit intention of tracking and reducing health disparities (Table 1). The section entitled “Understanding Health Disparities: Data Collection and Analysis,” amends the *Public Health Services Act* to address this issue. No later than 2013, all federally-funded health programs and population surveys, such as the U.S. Census Bureau’s American Community Survey, will be required to collect and report data on race, ethnicity, primary language, and other demographic characteristics identified as appropriate by the Secretary of Health and Human Services (HHS) for reducing health disparities. While the use of oversampling is authorized to produce statistically reliable estimates, OMB categories of race/ethnicity will be the minimum standard unless otherwise expanded by the Secretary or designee. In addition to collecting and reporting such data, the Secretary is

authorized to lead efforts to analyze data and monitor trends in health disparities and disseminate findings to federal health and human service agencies as well as the public. This provision also strengthens data collection and reporting mechanisms in the federal-state Medicaid program and Children’s Health Insurance Program (CHIP).

Table 1. Data Collection & Reporting by Race, Ethnicity and Language	Section No.
Require that population surveys collect and report data on race, ethnicity and primary language	4302
Collect/report disparities data in Medicaid and CHIP	4302
Monitor health disparities trends in federally-funded programs	4302

Improvements in data collection and reporting by race, ethnicity, and language in the ACA have the potential to enhance the evidence-base for new health equity improvement initiatives for diverse communities, while, at the same time, raising awareness about the persistence of health disparities and the urgency for action among policymakers and the public. However, there are several potential barriers that could hinder implementation efforts and the usefulness of data collection and reporting procedures.

An overarching issue is *how* such data are collected. A health care organization’s adherence to race/ethnicity reporting mandates does not necessarily entail uniformity or accuracy in how it *collects* such data.⁸ There is a general consensus that self-reported race/ethnicity data are considerably more accurate than observational reporting of race/ethnicity by health care staff.^{9,10} A body of empirical evidence supports this claim, finding that health care staff often misclassify the race/ethnicity of people of color, particularly Hispanics/Latinos.^{11,12} At the same time, however, self-reporting race/ethnicity has its limitations, especially when broad OMB categories for race/ethnicity are provided.¹³ For example, people of Middle Eastern or Arab descent are often categorized as “Caucasian” or “white,” a classification with which they may not self-identify.¹⁴ The broad categories of “Hispanic/Latino” and “Asian American/Pacific Islander” also homogenize distinct ethnic groups with disparate cultures, languages, and customs.¹⁵ Other challenges to self-reporting may include patient perceptions of intrusion and provider concerns about undermining the quality of nascent patient-provider relationships.⁸

Improvements to collecting data on patient race/ethnicity can benefit from guidance from HHS on how to collect these data to ensure uniformity of reporting as well as to preserve the quality of patient-provider relationships. Additionally, under

the authority granted in the ACA, the Secretary of HHS should require that data be collected on racial/ethnic groups beyond existing OMB standards. Finally, certain health care organizations may not have sufficient financial and staffing resources to effectively collect and report patient racial/ethnic data.¹⁶ Thus, the full realization of this objective may require support to health care organizations from federal as well as private, non-profit and philanthropic sources. The multi-payer advanced medical home demonstration projects that will be implemented through ACA may be one vehicle to promote standardized reporting among public and private payers (See Section III, p. 8).

B. Workforce Diversity

The 2004 IOM Report, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, underscored the importance of increasing racial/ethnic diversity in the health professions to reduce health disparities.¹⁷ Concordance between patient-practitioner race/ethnicity has long been recognized as a strategy for improving the quality of care.¹⁸ Furthermore, racially and ethnically diverse practitioners are more likely to practice in medically underserved areas and treat patients of color who are uninsured or underinsured.¹⁹ Diversity among health researchers is also critical to pursuing a research agenda on the elimination of racial/ethnic health disparities.²⁰

Despite the efforts of the federal government and private foundations to improve workforce diversity, persisting disparities exist between the racial/ethnic composition of health care workforce and the U.S. population.²¹ For example, while Hispanics comprise approximately 12 percent of the U.S. population, they account for less than four percent of all physicians. African Americans comprise a relatively similar proportion of the nation's population but only five percent of physicians.²² In the absence of focused strategies to increase diversity in the health professions, disparities between the racial/ethnic composition of the health professions workforce and general population are likely to continue as the nation becomes increasingly diverse.

For nearly 50 years, Titles VII and VIII of the *Public Health Services Act* have been successful in increasing racial/ethnic diversity in the health care workforce, improving cultural competence, and encouraging health care providers to practice in medically underserved areas.^{23,24,25} Through reauthorization and expansion of Title VII programs, the ACA has potential to improve diversity in fields such as primary care, long-term care, and dentistry, with appropriations available as early as 2010. Title VII is also amended to authorize \$25 million in grants and assistance to mental and behavioral health professionals—

giving preference to historically black colleges and universities (HBCUs) and institutions with a strong track record of serving diverse populations. Increases in Title VII scholarships and loan forgiveness opportunities are made available through the section entitled, "Health Care Professionals Training for Diversity." Title VIII of the *Public Health Services Act* is also amended to increase opportunities to improve diversity among the nursing professions.

Effective in 2010, the ACA also provides \$85 million in support for programs to train low income individuals as home care aides and in other health professions. At least three of such grants will be administered to Tribal entities. Grants are also made available to recruit and train community health workers, with an emphasis on providing education and outreach in racially/ethnically diverse communities, as well as to support Area Health Education Centers (AHECs) that target underserved populations. While the use of community health workers represents a promising strategy to provide culturally and linguistically appropriate services (CLAS) and information²⁶, the impact of such grants will be linked to appropriations—amounts which currently remain unspecified. The ACA also calls for monitoring diversity in the health care workforce, but does not specify a strategy for doing so (Table 2).

Table 2. Workforce Diversity	Section No.
Collect and publicly report data on workforce diversity	5001
Increase diversity among Primary Care Providers	5301
Increase diversity among long-term care providers	5302
Increase diversity among dentists	5303
Increase diversity among mental health providers	5306
Health professions training for diversity	5402
Increase diversity in nursing professions	5309
Investment in HBCUs and minority-serving institutions	2104
Community-based training for AHECs targeting underserved pops.	5403
Grants for Community Health Workers, providing CLAS	5313
Grants to train providers on pain care, including CLAS	4305
Support for low income health profession/home care aid training	5507

While provisions in the ACA represent promise for increasing racial/ethnic diversity in the health care workforce, formidable challenges surround implementation. Title VII and Title VIII programs address many of the financial barriers that deter people of color from pursuing costly degrees in the health professions. These programs do not, however, directly address the institutional climate of colleges and universities that have a legacy of being historically white.²⁷ Provisions in the ACA also do not address vast inequities in the quality of K through 12 education. In order to adequately prepare culturally diverse individuals for success in higher-education health professions programs, disparities in learning opportunities, particularly in the sciences, need to be addressed at the pre-college level.²⁸ Lastly, there remain staunch opponents of affirmative action policies. While the ACA secures appropriations for workforce diversity initiatives through 2014, support for these programs is likely to come under attack. The continuity of these programs will require a strong commitment from Congressional leaders, as well as an abundance of data that demonstrate their benefits.

C. Cultural Competence Education and Organizational Support

Persons of color are more likely to report experiencing poorer quality and patient-provider interactions than whites, a disparity which is particularly pronounced among individuals whose primary language is other than English.²⁹ Cultural competence training and education for health professionals has gained credibility as a strategy for improving the quality of care delivered to culturally and linguistically diverse patients.^{30,31} In addition to improving the quality of patient-provider interactions in clinical settings, integrating the principles of cultural competence at the organizational level can assist in deinstitutionalizing racism and guiding culturally competent program development and evaluation. The impact of broad efforts to improve access to insurance coverage and high quality medical care for low income populations—the cornerstone of health care reform legislation—will be lessened if these efforts are not grounded in cultural competence (Table 3).

Table 3. Cultural Competence (CC) Education and Organizational Support	Section No.
Develop & evaluate model CC curricula	5307
Disseminate CC curricula through online clearinghouse	5307
CC training for primary care providers	5301
CC training for home care aides	5507
Curricula for CC in working with individuals with disabilities	5307
Loan repayment preference for experience in CC	5203
Transfer federal OMH to Office of the Secretary	10334
Create individual OMHs within federal HHS agencies	10334

The health care reform law allocates five years of support to aid the development and dissemination of model cultural competence training and education curricula. Under this section, a diverse group of stakeholders—including representatives from health professional societies, experts in health disparities and cultural competence, and community-based organizations—will be consulted by the Secretary to evaluate existing, and develop new, cultural competence curricula. The materials will be disseminated via a Web-based clearinghouse. Support is also provided for cultural competence training for primary care providers and home care aides. The ACA also provides support for loan repayment options, giving preference to individuals with experience in cultural competence training.

Additionally, the ACA promotes organizational cultural competence at the federal level. Since being established in 1986, the HHS Office of Minority Health (OMH) has advised the Secretary and Office of Public Health and Science (OPHS) on policies and programs to reduce and eliminate racial/ethnic disparities in health and health care. A provision in the ACA promotes OMH from OPHS to the Office of the Secretary of HHS. As a result, the Deputy Assistant Secretary for Minority Health will report directly to the Secretary and have enhanced authority to carry out initiatives to improve the health of diverse populations. Individual OMH divisions within key federal HHS agencies—such as the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), the Food and Drug Administration (FDA) and others—are also established. While the responsibility and authority of these agency-based OMH divisions remain

undefined, they represent promise for integrating disparity reduction priorities into the federal health agenda.

The ACA makes significant strides toward improving cultural competence at individual provider and institutional levels; however, questions remain regarding the extent to which these initiatives will be embraced. At the individual-level, time-strapped practitioners may be reluctant to participate in cultural competence training or to use Web-based education materials unless they are provided with financial incentives or continuing education credits. There is also a paucity of rigorous research on the impact of cultural competence strategies on health outcomes and reducing racial/ethnic disparities.³² At the organization-level, OMH divisions within HHS agencies will need to be provided with sufficient authority and resources to have a significant impact. Additionally, given that the major drivers of health disparities originate beyond the health care sector (e.g., employment, education, criminal justice), cross-agency collaboration between OMH divisions and departments outside of HHS would enhance efforts to reduce disparities.³³

D. Health Disparities Research

Since the establishment of the Office of Research on Minority Health within the National Institutes of Health (NIH) in 1990, the federal government has steadily increased resources to investigate the causes of health disparities and develop strategies to reduce them. In 2003, NIH funding for minority health research exceeded \$2.13 billion, accounting for approximately 12 percent of the total NIH budget.³⁴ While research alone will not reduce persistent health disparities, the ACA sustains, and enhances, developing an evidence base to inform disparity reduction initiatives (Table 4).

Table 4. Health Disparities Research	Section No.
PCORI to examine health disparities through CER	6301
Increase funding to Centers of Excellence	5401
Promote NCMHHD to Institute status	10334
Support collaborative research on topics including cultural competence	5307
Support for disparities research in post-partum depression	2952
Support for disparities research in pain treatment/management	4305

For example, the ACA promotes the National Center on

Minority Health and Health Disparities to *Institute* status—granting it the authority to plan, coordinate, and evaluate all disparity-related research within NIH. Increases in funding to Centers of Excellence are also made available to support health disparities research. Furthermore, the ACA also creates a Patient-Centered Outcomes Research Institute (PCORI) to carry out comparative effectiveness research (CER) and to examine differences in health care service outcomes among persons of color. By focusing on racial/ethnic differences in procedural outcomes, CER has the potential to reduce health disparities at the national level, especially among patients of color who suffer a disproportionately high burden of chronic disease.³⁵ The success of CER initiatives is likely linked to sustainable funding. However, appropriations and a timeline for this provision are not specified in the legislation. Therefore, there is uncertainty as to whether funds will be sufficient for identifying associations between treatments and outcomes as well as differences by race/ethnicity. Finally, special attention to diverse populations on pain treatment/management and postpartum depression—a condition that disproportionately affects African American and Hispanic women—and support for collaborative research on cultural competence are also provided.³⁶

At least three challenges exist to maximizing the efficacy of health disparities research: coordinating research efforts, translating research into policy and practice, and ensuring racial/ethnic diversity in clinical trials. Challenges surrounding coordination were made evident in the IOM report, *Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished Business*. This report examined the NIH response to a 2000 Congressional mandate to implement a Strategic Plan for health disparities research and found that, despite planning efforts, coordination challenges were numerous and many gaps in disparities research remained—such as those addressing social and behavioral determinants of health and their interaction with biological processes.³⁷

Various factors determine the extent to which evidence-based recommendations and practices are adopted in a health care setting, including the organizational culture, resource constraints, and patient willingness to embrace change.³⁸ These challenges should be taken into consideration when devising strategies to translate health disparities research into practice and policy.

Lastly, people of color have historically been under-represented in clinical trials.^{39, 40} If the PCORI is to be successful in achieving its goals, tailored strategies are needed to *recruit* and *retain* racial/ethnic subpopulations in clinical trials to develop an evidence base for practices and outcomes among diverse patients.⁴¹

E. Health Disparities Initiatives in Prevention

Beyond the social and moral imperative to reduce racial/ethnic health disparities, the economic burden of disparities is immense. Researchers estimate that, between 2003 and 2006, the cost of racial/ethnic disparities in direct medical costs and lost productivity in the U.S. exceeded \$1.24 trillion.⁴² Through innovative health education and preventive programs, health care reform legislation offers the opportunity to stem disparities in premature death, disability, and acute and chronic disease (Table 5).

Table 5. Health Disparities Initiatives Prevention	Section No.
National oral health campaign, with emphasis on disparities	4102
Standardized drug labeling on risks & benefits	3507
Maternal & child home visiting programs for at-risk communities	2951
Culturally appropriate patient-decision aids	3506
Culturally appropriate personal responsibility education	2953
Support for preventive programs for AI/ANs	10221

In addition to preventive efforts that seek to reduce disparities through interventions at federal and community levels (see Section III, Subsection E on *Social Determinants of Health*), the ACA contains numerous prevention and education initiatives that emphasize personal responsibility and individual health behavior. For example, support is provided for pregnancy and sexually transmitted infection prevention education programs targeting racially/ethnically diverse adolescents. This is particularly important given that women of color generally have higher rates of unintended pregnancy⁴³ and that African Americans are ten times as likely, and Hispanics almost three times as likely, as whites to have HIV/AIDS.⁴⁴ Additionally, the law supports home visitation programs for maternal and child care. 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.⁴⁵ These programs are likely to serve as a valuable resource for low income women of color who are first-time mothers, and often have limited social support networks.

The ACA also authorizes a five-year national oral health education campaign, with an emphasis on racial/ethnic disparities. African American children are nearly twice as likely to report having fair to poor oral health as whites, while Hispanic children are nearly four times more likely.⁴⁶ The ACA also mandates an investigation of drug labeling standards to improve patient decision making, a process that will be conducted in concert with health literacy, health equity and cultural competence experts. Standardizing and tailoring drug labeling would help meet the needs of the nearly 87 million U.S. adults with low-literacy⁴⁷ and the 24 million with limited English proficiency (LEP)⁴⁸ by assisting these groups in better identifying dosage information, risks and benefits of drugs, and ultimately reducing medication errors. Additionally, support for culturally appropriate decision aids will assist this population in making informed medical decisions.

The ACA also establishes the *Indian Health Care Improvement Reauthorization and Extension Act of 2009* (S. 1790) as law. The Act contains a multitude of distinct provisions which address the health and health care needs of American Indians and Alaska Natives (AI/AN).⁴⁹ Examples of such preventive programs include those targeting substance abuse, diabetes, and suicide—all health-related problems that are disproportionately prevalent among the AI/AN population.⁵⁰

F. Addressing Disparities in Health Insurance Reforms

Vast disparities in uninsured rates have long existed between whites and other racial/ethnic groups. For example, African Americans are nearly twice as likely to be uninsured than whites, while Hispanics are more than three times as likely to be uninsured.⁵¹ While health insurance market reforms and expansions in Medicaid hold promise to substantially reduce disparities in insurance status, targeted efforts are necessary to ensure that culturally and linguistically isolated communities are enrolled and take full advantage of benefits for which they are eligible. Failure to successfully enroll these populations is likely to put additional strain on already stressed safety net clinics and Disproportionate Share Hospitals (DSHs) (see Section III, Subsection A on *Health Insurance Reforms* and Section III, Subsection D on *Cost Containment*).

For fiscal years 2010 to 2013, the ACA provides \$14 million in support for outreach efforts targeting low income populations. While details of such efforts are not specified, community-based organizations, community health workers and *promotores* should be central to any outreach efforts as they are well positioned to provide enrollment assistance to diverse low income populations.⁵² It is also required that outreach and

enrollment activities for new national and state health insurance exchanges (see Section III, Subsection A on *Health Insurance Reforms*) be culturally and linguistically appropriate. The ACA also explicitly puts forth a mandate for nondiscrimination in federal health programs and exchanges. The legislation also requires insurers to provide enrollees with a claims appeal process and summary of benefits that are culturally and linguistically appropriate. While these provisions acknowledge the distinct needs of diverse populations in health insurance market reforms, their success is likely to hinge upon the extent to which they are monitored and enforced (Table 6).

Table 6. Addressing Disparities in Insurance Coverage	Section No.
Remove cost-sharing for AI/ANs at or below 300% FPL	2901
Enrollment outreach targeting low income populations	3306
CLAS/information through exchanges	1311
Nondiscrimination in federal health programs and exchanges	1557
Require plans to provide information in "plain language"	1303
Incentive payments for reducing health/healthcare disparities	1303
Summary of coverage that is culturally/linguistically appropriate	1001
Claims appeal process that is culturally/linguistically appropriate	1001

Finally, the ACA removes all cost-sharing requirements for AI/AN individuals at or below 300 percent of the federal poverty level (FPL). While AI/ANs have long been entitled to medical care through the Indian Health Service, the program's limited resources has often restricted access to care. Removing cost-sharing requirements should improve access to health insurance and health care for the approximately 1.1 million AI/ANs that are at or below 300 percent FPL.⁵³

III. GENERAL PROVISIONS WITH SIGNIFICANT IMPLICATIONS FOR RACIALLY AND ETHNICALLY DIVERSE POPULATIONS

The new health care reform law includes a number of general provisions—concerning health insurance reform, improved access to health care, quality improvement, cost containment, public health initiatives and social determinants of health—which are likely to benefit low income and racially and ethnically diverse communities. These provisions and their implications for diverse populations are summarized in this section.

A. Health Insurance Reforms to Expand Coverage and Affordability

Individuals from racially or ethnically diverse backgrounds comprise about one-third of the nation’s population; however, they make up over half of the 47 million uninsured.⁵⁴ In 2005, nearly two-thirds of Hispanic adults (15 million) and one-third of African American adults (6 million) were uninsured compared to 20 percent of white adults.⁵⁵ The new law contains a range of provisions for expanding health insurance coverage (Table 7). The CBO estimates that by 2019 these reforms would reduce the number of uninsured by 32 million.⁵⁶

Table 7. Health Insurance Reforms	Section No.
Individual requirement to have coverage	1501
Expand Medicaid income eligibility to 133% FPL	2001
Employer requirement to offer coverage	1513
Increase federal matching rates for Medicaid	2005
Small business (<25 employees) tax credits	1421
Multi-state plan option	10104
Temporary high risk pools	1101
Consumer Operated and Oriented Plans (CO-OPs)	1322
State-based American Health Benefit Exchanges	1311

Among important provisions for low income communities of color is the expansion of income eligibility for Medicaid to 133 percent of FPL in 2014. It is estimated that Medicaid expansions will extend coverage to nearly one-quarter of the nation’s poorest individuals and, importantly, to those living in states with the most restrictive income eligibility requirements. For example, Texas, Alabama and other Southern states have set their income eligibility for Medicaid well below 20 percent of FPL to qualify.⁵⁷ These are also states with large numbers of racially and ethnically diverse residents and among states with the highest adult uninsured rates.⁵⁸ This policy is an important step toward eliminating geographic disparities in health insurance coverage by setting a federal minimum standard for Medicaid eligibility.

Other concrete actions that are likely to have a large and positive impact on people of color include employer-based health insurance reforms. Whereas 71 percent of working-age whites had health insurance through their workplace in 2005, only one-third of working-age Hispanics and half of working-age African Americans had employer-sponsored coverage.⁵⁹ The ACA requires employers with 50 or more employees to offer coverage to employees or pay a penalty for any full-time employee who receives a premium tax credit for purchasing their own coverage through exchanges. Large employers with 200 or more employees are mandated to automatically enroll employees into their health insurance plans. Small employers with 25 or fewer employees and average annual wages of less than \$50,000 will be provided a tax credit, implemented in two stages, with the first phase (2010-2013) providing a credit of up to 35 percent of the employer’s contribution toward employee health insurance and the second phase (2014 and following years) providing a credit of up to 50 percent. This policy has the potential to expand coverage for a sizeable low income population of color, especially given that over 90 percent of minority-owned firms have fewer than 25 employees and diverse populations are more likely to be employed by a small firm that does not offer health coverage.⁶⁰ Data on non-elderly workers in small firms indicate that approximately 57 percent of Hispanics, 40 percent of African Americans, 40 percent of AI/ ANs, and 36 percent of Asians are uninsured, compared to 24 percent of whites.⁶¹

Within one year of enactment of the ACA, funding will be available to create state-based American Health Benefit Exchanges to enable individuals to compare and purchase qualified coverage. Each exchange is required to offer at least two multi-state plans separately from the Federal Employees Health Benefit Program and to ensure affordability of coverage through premium credits and sliding-scale cost-sharing

subsidies for individuals with incomes at or below 400 percent FPL. Given that nearly 50 percent of the 16 million uninsured adults with incomes between 150 percent FPL and 399 percent FPL belong to communities of color, this policy is expected to have a large impact on racially and ethnically diverse populations.⁶²

In addition, the new health care reform law authorizes \$6 billion to establish Consumer Operated and Oriented Plans (CO-OPs) by July 1, 2013, to foster the creation of a non-profit, member-operated health insurance plan in each state and the District of Columbia. While their creation offers a strategy to compete with private insurers, CO-OPs may face significant start up challenges. Additionally, CO-OPs may not be a viable option for low income, diverse individuals looking for affordable choices and coverage unless they can: establish substantial presence with bargaining power, prevent adverse selection by spreading risk broadly, and offer health coverage with minimum cost-sharing.⁶³

Finally, effective 90 days after enactment until January 1, 2014, the ACA provides immediate assistance to individuals with pre-existing conditions, who have been uninsured for at least six months, by creating state-sponsored high-risk insurance pools and providing subsidized premiums. Removing barriers to insurance coverage based on illness or health status should improve access to affordable insurance coverage for low income, racial/ethnic populations, who have disproportionately higher rates of morbidity. For example, nearly half of all African American adults suffer from a chronic condition or disability.⁶⁴

Collectively, these reforms hold the promise of expanding access to health insurance for millions of individuals and families. However, CBO and the Joint Committee on Taxation (JCT) estimate that by 2019, there will remain nearly 23 million uninsured. An estimated one-third will be undocumented immigrants⁶⁵ and a large portion will be poor and people from diverse racial and ethnic heritage. The success of the ACA's health insurance reform requires that uninsured individuals generally—including people of color and racially/ethnically diverse residents—comply with the individual mandate. As the experiences with health care reform in Massachusetts showed, success hinges upon effective outreach, promotion, education, and decision-support that is culturally and linguistically appropriate.⁶⁶ An understanding of coverage and benefits, including what they entail, how they can be used, and for what services, will also be important for participation among uninsured and low income communities of color. In focus groups conducted in the wake of health care reform in Massachusetts, the uninsured “made it very clear that they not only want information in writing, they want to talk to a person

who is able to help them through the complex decision-making and enrollment processes.”⁶⁷ As 2014 approaches, an adequate number of community outreach workers will be necessary, as will the involvement of community-based organizations, representatives and stakeholders in achieving well-informed and empowered communities of color who can participate and benefit from health insurance reforms. See *Addressing Disparities in Health Insurance Reforms* in Section II, Subsection F, for further details.

B. Actions to Improve Access to Health Care

Access to timely and needed health and medical care is a major challenge for racially and ethnically diverse communities. Even after adjusting for age, insurance and income, communities of color are less likely than their white counterparts to have a usual source of care. More than half of Hispanic adults report not having a regular doctor even when insured—a rate that is 2.5 times greater than the proportion of whites. Furthermore, compared to whites (77 percent), Hispanics and African Americans are less likely to receive care in a private doctor's office (44 and 62 percent, respectively) and more likely to seek care in community health centers (CHCs) or emergency departments. Recent data show that nearly two-thirds of CHC patients are non-white.⁶⁸

With the enactment of the ACA, the health care system, and the safety net in particular, is likely to face even greater demand for its services. Embedded in the reform legislation are important actions for improving health care access that would benefit low income, racially and ethnically diverse patients (Table 8). For example, the ACA expands funding for CHCs by \$11 billion over five years starting fiscal year 2011—a doubling of current funding—with \$9.5 billion for expanding their operational capacity for medical, oral, and behavioral health services, and \$1.5 billion for providing capital support to build new sites and/or expand and improve existing facilities.⁶⁹ Given that CHCs predominately serve low income and diverse patients, this provision is especially important for ensuring these populations have access to basic primary, dental, and mental health care as well as support programs such as language translation, transportation, and case management.⁷⁰

Table 8. Actions to Improve Access to Health Care	Section No.
Support for community health centers	10503
Nurse-managed health centers	5208
Community health teams	3502
Redistribute Graduate Medical Education slots	5503
Extends authorization of National Health Services Corps	5207
Teaching community health centers	5508
Innovative models in Medicare/Medicaid	3021
School-based health centers	4101
Pilot projects for emergency & trauma care	3504

As CHCs expand their scope and reach, patients will need better access to a continuum of care, including specialty and tertiary services. This is especially important for people of color, who have higher rates of mortality, many cancers, and conditions such as asthma, diabetes, heart failure, and stroke.⁷¹ A recent Commonwealth Fund report said that while CHCs are able to provide primary care, they have difficulty connecting their patients to diagnostic testing and specialty care, even when patients are insured.⁷² Specifically, 79 percent of surveyed CHCs reported difficulty in obtaining specialist access for Medicaid patients and 60 percent reported difficulty for Medicare patients. As Medicaid eligibility and coverage expand under health care reform, access barriers for patients who rely on community health centers as their medical home could worsen without efforts to improve specialty care linkages. Funding for CHCs should be structured to encourage and incentivize health centers, specialists and hospitals to provide a seamless continuum of coordinated patient care.

The ACA also provides support for expanding primary care by: increasing funding for the National Health Services Corps by \$1.5 billion over five years (FY 2011-2015); providing \$43 million in 2011 in grants to provide training to graduate medical residents in preventive medicine specialties; and increasing Medicaid payments for primary care services provided by primary care physicians (family medicine, general internal medicine or pediatric medicine) to 100 percent of the Medicare payment rates for 2013 and 2014. These initiatives are especially important given that an estimated 56 million Americans, a large majority of whom are people of color, are

considered “medically disenfranchised”—or having inadequate access to a primary care physician regardless of insurance status.⁷³ These initiatives are also important for addressing the looming shortage of primary care providers and historically low provider participation in Medicaid that has contributed to gaps in care in low income and medically underserved communities.

Furthermore, the ACA expands access to care by supporting health promotion, prevention and education activities that take advantage of community assets and resources and go beyond traditional medical settings and practices. Specifically, the law appropriates \$50 million for each fiscal year between 2010 through 2014 to support school-based health centers; provides support for nurse-managed health clinics; provides grants to create Community Health Teams to support medical homes for patients; and creates a medical home option for Medicaid enrollees with chronic conditions. The ACA also eliminates cost-sharing for a wide range of preventive services under qualified health plans. Together, these initiatives are important for helping poor and racially/ethnically diverse residents, particularly the large proportions of Hispanics (54 percent), Asians (52 percent) and African Americans (44 percent) who often delay or forgo routine and preventive care.^{74,75} The use of Community Health Teams to support primary care providers in establishing patient-centered medical homes are also important steps for fostering trust, understanding, and adherence to healthy behaviors and preventive health practices as well as for addressing issues around coordination and continuity of care among low income, racially and ethnically diverse communities.⁷⁶

Given the frequent concentration of services in urban areas, the new law also provides funding for demonstration projects that evaluate innovative models for emergency care systems, such as the regionalization of emergency and trauma care—an initiative which could significantly expand access to care for the nation’s growing poor and diverse communities in sprawling cities, suburbs and exurbs, as well as in historically underserved rural areas with limited resources and capacity.

C. Quality Improvement

It is well documented that the care received by racially and ethnically diverse patients often falls short on quality-related dimensions, including safety, timeliness, effectiveness, efficiency, patient-centeredness and equity.⁷⁷ Embedded in the health care reform law are a number of provisions intended to improve quality of care, including a national strategy and support for health care providers in the delivery of evidence-based medicine and services (Table 9).

Table 9. Quality Improvement	Section No.
National Strategy for Quality Improvement	3011
Quality improvement technical assistance	3501
Interagency Group on Healthcare Quality	3012
Develop, improve & evaluate quality measures	3013
Link Medicare payments to quality outcomes	3001
Pediatric Accountable Care Organizations	2706

The ACA authorizes the HHS Secretary to create a National Strategy for Quality Improvement in Healthcare by fiscal year 2011 through a transparent collaborative process that will improve the delivery of health care services, patient outcomes and population health overall. Through the Center for Quality Improvement and Patient Safety of AHRQ, the new law authorizes \$20 million for fiscal years 2010 through 2014, in grants for technical assistance to eligible health care providers for improving quality of care. In addition, AHRQ along with the Centers for Medicare and Medicaid Services (CMS), are called upon to advise and assist the HHS Secretary in awarding grants and contracts to develop, improve, update and expand quality measures where they do not exist (including those addressing health equity and health disparities). A total of \$75 million is authorized for this purpose for each fiscal year between 2010 and 2014.

As described in more detail in Section II, Subsection D on *Health Disparities Research*, the law also creates a Patient-Centered Outcomes Research Institute, a non-profit corporation, to identify research priorities and conduct research that compares the clinical effectiveness of medical interventions and programs for diseases, disorders and health conditions. Furthermore, the ACA includes support for national Medicare and Medicaid pilot/demonstration programs to develop and evaluate bundled payments for health services provided for an episode of care. Aligning payment with quality rather than quantity of care in public programs to reduce hospital readmissions and health care-acquired conditions could potentially reduce racial/ethnic disparities in preventable hospitalizations and health care outcomes. Blacks are two to four times more likely than whites to be hospitalized for a potentially preventable condition.⁷⁸

Finally, the new law authorizes the creation of a new office within CMS to improve care coordination for dual eligibles, effective March 1, 2010. This action could potentially improve continuity and quality of care for approximately 1.2 million low income elderly African Americans who are dual beneficiaries of Medicare and Medicaid.⁷⁹

D. Cost Containment

As recent data show, disparities in health and health care impose a significant burden on individuals and communities, and account for considerable costs to society as a whole.⁸⁰ In addition to health insurance market reforms, improving efficiency and reducing fraud in the health care system are essential to curbing the growth of health care and prescription drug costs and making health care more affordable. While such improvements would benefit individuals across-the-board, the implications would be particularly profound for low income, racially and ethnically diverse patients who are more likely than whites to be unable to pay medical bills, be contacted by a collection agency or have outstanding medical debt.⁸¹ As such, the health care reform law includes a number of provisions to contain costs (Table 10).

Table 10. Cost Containment	Section No.
Interoperable systems of enrollment	1561
Reduce Medicaid DSH Payments	1203
Reduce Medicare DSH Payments	2551
Demonstration projects for HIT	6114
Strengthening Medicaid drug rebate programs	2501
Enhancing public program fraud screening	6401

First, the ACA considerably reduces Medicare and Medicaid Disproportionate Share Hospital (DSH) payments. Between 2014 and 2020, Medicaid DSH allotments will shrink by \$18.1 billion and in 2014 Medicare DSH payments will be reduced initially by 75 percent. Medicare and Medicaid DSH payments are significant sources of financial support for safety net hospitals that disproportionately care for low income and uninsured patients. Medicaid alone allocated over \$11 billion to these facilities in 2009.⁸² While it is argued that expanding health insurance should reduce the need for DSH support, parallel reforms in Massachusetts resulted in

straining the health care safety net as low income people, both uninsured and newly insured, were increasingly relying on safety net institutions for care.⁸³ It will, therefore, be important to examine the distribution and scope of DSH payments, both preceding and following implementation, especially in localities which currently have and are likely to continue to have large uninsured and undocumented immigrant populations. This assessment will help determine the current role of DSH payments in caring for vulnerable communities, as well as inform the future role and composition of the safety net and related access issues central to racially and ethnically diverse communities.

Secondly, the new law supports actions to strengthen Medicaid drug rebate programs, effective upon enactment. While many states voluntarily provide prescription drug coverage through Medicaid, a federal mandate will ensure a minimum level playing field for access to this benefit, and could potentially improve compliance with physician-recommended prescription drug regimens among low income populations. However, ensuring equity in communities of color will require monitoring and comparing the distribution and utilization of Medicaid prescription drugs by small geographic areas.⁸⁴

Finally, among other provisions, the new law simplifies health insurance administration by authorizing the development of national standards for interoperable systems of enrollment; provides grants to state and local governments for demonstration projects for implementing information technology for enrollment; and sets policies to reduce fraudulent claims and waste in public programs (estimated to account for three to ten percent of total health care spending) through enhanced provider screening and oversight.⁸⁵

E. Public Health Initiatives

Racially and ethnically diverse communities have higher rates of morbidity and mortality as compared to their white counterparts across a broad range of disease conditions. Improving the health status of these populations will require explicit support for public health programs and policies designed to improve health care knowledge, prevention, and adherence to treatment, as well as to overcome barriers in the areas of culture, language and health literacy.

One year following enactment, the ACA mandates the creation of a National Prevention, Health Promotion and Public Health Council to coordinate and promote health-related policies across multiple sectors and agencies at the federal level—including health, agriculture, education, labor, and transportation (Table 11). The new law also creates a Prevention

and Public Health Fund, which will be appropriated \$7 billion in funding for fiscal years 2010 through 2015 and \$2 billion for each fiscal year thereafter, to support prevention, wellness, and other public health activities. Furthermore, the law explicitly acknowledges the need for the CBO to develop new methodologies for scoring prevention and wellness. Neither appropriations nor deadlines, however, are specified within this Section.

Table 11. Public Health Initiatives	Section No.
National Prevention & Public Health Council	4001
Prevention & Public Health Fund	4002
Childhood obesity demonstration projects	4306
National diabetes prevention program	10501
New methods for scoring prevention/wellness programs	4401
Education campaign for breast cancer	10413

In addition, the ACA authorizes \$25 million (FY 2010-2014) in funding for demonstration projects to develop a comprehensive and systematic model for reducing childhood obesity. Nearly one in four African American children (ages 6-17) is overweight, compared with one in seven white children.⁸⁶ Rates for African American teenage girls are especially alarming, with 40 percent being overweight or at risk for overweight.⁸⁷ Recognizing these disparities, new models and programs will need to be culturally and linguistically appropriate and include measurable objectives for evaluating not only the success in curbing obesity rates, but also assessing any unintended psychosocial consequences.⁸⁸

Acting through the CDC, the legislation also includes support (\$9 billion for each year between 2010 and 2014) for a national campaign to increase knowledge about breast health. Given that African American women have the highest rates of breast cancer mortality,⁸⁹ this is an especially important objective for improving knowledge, screening behavior and adherence to treatment among this population. Finally, through the CDC, the ACA mandates the creation of a National Diabetes Prevention Program to support community-based prevention initiatives. This initiative also holds significant importance for African Americans, whose prevalence of diabetes is 65 percent higher than whites, and for whom obesity rates are 50 percent higher.⁹⁰ However, neither appropriations nor a timeline are specified for this provision.

F. Social Determinants of Health

Disparities in health and health care are largely a product of social and economic inequalities as well as those related to location (e.g., inner city, areas isolated from needed services). Therefore, efforts to successfully reduce health disparities require an understanding of how policies beyond the traditional domains of health and health care—education, transportation, housing, and employment, for example—impact health. The health care reform law incorporates strategies that utilize a collaborative approach and span multiple sectors of the economy and federal government to improve overall community infrastructures and population health (Table 12).

Table 12. Social Determinants of Health	Section No.
Health Impact Assessments	4003
CPSTF review/recommend interventions in social context	4003
Community Transformation Grants	4201
Non-profit hospital community needs-assessment	9007
Primary Care Extension Program	5405

The new law tasks the Community Preventive Services Task Force (CPSTF) with developing topic areas for new preventive interventions and recommendations that consider social, economic and physical environments of communities.⁹² The law also authorizes the Task Force to review the health effects of interventions at least once every five years using methodologies that include Health Impact Assessments (HIAs). HIAs can be valuable for evaluating potential adverse health consequences associated with policies and interventions across a range of sectors beyond the health care system. For example, they can monitor the health consequences of environmental risk factors, such as air pollution, heat exposure, and proximity to toxic wastes, as well as inform policies that reduce exposure to environmental risk factors for asthma and other chronic diseases.⁹³ Racially and ethnically diverse communities are disproportionately exposed to environmental degradation and hazards, and these disparities remain unchanged since they were first documented 20 years ago.⁹⁴ The efforts of the Task Force, therefore, represent important steps for monitoring and improving the health and related social, economic and environmental conditions that characterize racially and ethnically diverse communities. The new law also encourages primary care physicians to address social determinants of health through community-based efforts.

Finally, the ACA, acting through the CDC, will award competitive Community Transformation Grants (CTGs) to encourage development of community infrastructures and programs that support healthy lifestyles in neighborhoods, schools, worksites, and restaurants, and to help communities prioritize strategies for reducing racial/ethnic disparities.

Community-centric efforts that look beyond the health care sector to improve community health have great potential to reduce longstanding social inequalities that adversely impact the health of racial/ethnic sub-populations. However, several provisions embedded in the law that address these important issues (e.g., HIAs, CTGs), largely lack specificity, particularly around funding and whether sufficient dollars will be made available for meaningful impact in the community.

IV. LEVERAGING THE POTENTIAL OF HEALTH CARE REFORM TO REDUCE DISPARITIES

Health care reform, as envisioned within the scope and sweep of the ACA, offers the greatest opportunity in at least a generation to improve health equity and reduce disparities. From reducing financial barriers to access and improving quality to its many race, ethnicity and language-specific provisions, the new law directly targets longstanding, entrenched problems that have frustrated progress in improving patient outcomes and population health. If implementation achieves the intended objectives, this law will have a profound impact on reducing racial/ethnic health disparities for decades to come.

At the same time, the ACA is not a “disparities panacea.” Many priorities for improving health and health care for racially and ethnically diverse populations and communities remain unaddressed, unclear or not fully realized. Nonetheless, as presented in the following narrative, the ACA offers a platform to improve the delivery of health care at the community and provider levels for diverse populations. The community discussion in particular highlights the need to create incentives and initiatives that integrate health services and treatment with housing, transportation and other programs. The intended goal is developing evidence-based, community-focused strategies to eliminate the causes and perpetuation of disparities in illness and disease.

A. Advancing the Health of Communities

The goals of improved access, financial affordability and greater quality of care that lead to improved health for residents lie at the heart of health care reform and the law’s provisions reflect these priorities. Toward these goals, specific language in the ACA supports Community Transformation Grants that target neighborhood-level concerns. Other initiatives include community needs and health impact assessments that will assist or direct public health and health care institutions to measure and report the community benefit of their services to the populations and neighborhoods they serve. Nonetheless, addressing the legacy of segregation and entrenched community barriers will require greater attention to social determinants and other issues of “place” that perpetuate disparities, and which cannot be eliminated by the health care sector alone. Two areas of concentration could further the vision and goals of health care reform.

Leveraging support for community-based strategies and engagement in reducing disparities. Progress toward eliminating racial/ethnic health disparities will require communities to be active and involved in setting overall objectives, specific goals and strategies for achieving them. Examples of this recognition at the federal level are evident, for example, in a Center for Medicare and Medicaid Services initiative that requires the involvement of community health workers in Medicare diabetes disease management for diverse populations. Health care provider organizations have also acknowledged that achieving health and public health goals will, in large part, depend on active community engagement throughout planning, implementation and review.⁹⁵ Community-based participatory research has also gained prominence among investigators. And yet, while there is greater acknowledgement of the critical role of community engagement in addressing health disparities, active participation of affected populations in the planning and assessment of community-based initiatives is often missing.

Health reform provides a platform for individuals, providers and researchers to learn from and inform diverse communities to ensure that “policy fits the context” where people live and work. Such collaboration can begin to address a litany of neighborhood and health care barriers such as community distrust and skepticism about attention to community needs, while educating health care professionals about community health priorities, and empowering individuals to become active participants in designing what works best for their settings. Embedding community engagement requirements into health-related initiatives will help assure that the “context” remains front and center.

Promoting integrated strategies across health and social services to improve the health of diverse communities. Poverty, inadequate transportation, unsafe neighborhoods, food insecurity, segregation and other circumstances of “place” take such significant tolls on individual and community health and well being that their effects often impede, if not negate, efforts to improve the health of racially and ethnically diverse communities.⁹⁶ In fact, in many communities, failure of state and local governments and the private sector to address and resolve a broad range of social problems—housing, homelessness, violence, domestic abuse and other conditions and circumstances—has left many community hospitals, their emergency rooms and clinics to deal with the consequences: disease, disability and death.⁹⁷ Working to reduce other social disparities that greatly influence short-, intermediate- and long term-health will require direct, concerted research, policy and programs that seek to alter significantly the negative influence of social determinants on diverse communities.

The ACA's provisions for Community Transformation Grants and other related initiatives offer opportunities to test or bring to scale innovative community-based strategies that coordinate social and health services to fit individual and family circumstances—if adequately funded. Community accountability for these federally-sponsored initiatives should include setting goals for reducing health disparities, developing measures to assess progress, and rewarding success and improvement.

B. Health Care Organization-based Initiatives

As health equity, including reducing disparities, is an important objective of the new law, organizations will face new opportunities and challenges in implementing related provisions. Safety net providers may be especially well positioned to take advantage of new incentives given their mission, location and history. But other healthcare organizations may be much less familiar with effectively addressing the needs of racially and ethnically diverse patients. Moreover, certain health care system or service programs and policies may create or perpetuate what has been called, “institutionalized racism in health care”.⁹⁸ As stated by the IOM, “...it is important...to examine...the health care system, broadly defined, to determine whether there are policies and practices in place that have the effect of discriminating against communities of color.”⁹⁹ Further, the best efforts of health care professionals will be limited if not negated without knowledgeable and formal commitment from their practice settings. Analysis and research have similarly reinforced this priority, acknowledging the differences of communicating between racial/ethnic cultures and the culture of medicine.¹⁰⁰

This section identifies two specific organization-based initiatives intended to assure effective implementation of health care reform's vision for diverse patients and populations. In discussing related roles and responsibilities, a final recommendation in this section discusses the importance of preserving one specific sector with considerable experience in caring for large numbers of immigrants and other diverse and underserved populations—safety net organizations.

Developing and testing model programs that link specific organizational efforts to reducing disparities and improving quality of care. Many research, program and policy experts as well as community representatives contend that reducing disparities requires significant involvement and support of health care organizations.¹⁰¹ In essence, individual practitioners or single divisions within a health care setting can go only so far in addressing language needs, improving cultural competence

and reducing disparities. For sustainable success to occur, these organizations must commit to supporting practitioners through more comprehensive and active engagement in caring for diverse patients—a conclusion implied in the spectrum of related priorities identified in the ACA. And yet, beyond a few studies and positive evidence around addressing the needs of patients with limited English proficiency, little information exists that validates these assumptions. Similarly, there is little guidance available that providers can use to adapt and apply to their unique settings.

Within the new health care reform law, research and demonstration projects aim to undertake and document initiatives to improve quality of care and outcomes for racially and ethnically diverse patients (e.g., high performance health systems that integrate race, culture and language into services and structure, and demonstrate improved care processes and outcomes for these patients). Rigorous testing, measurement and assessments of structure, process and patient outcomes should accompany these efforts. Strategies may focus on building programs around specific disease conditions and diverse patient populations and investment in organization infrastructure and service, program and management functions.

Documenting and linking non-profit community needs assessment/benefit requirements to health care reform incentives to address disparities. As noted, the ACA introduces numerous incentives and/or requirements for health centers, clinics and hospitals with the explicit goal of reducing disparities. Some efforts are designed to support monitoring patterns in disparities, while others, such as improving workforce diversity and cultural competence education, are intended to increase the cultural mix of practitioners and create more informed and skilled health care professionals. Still other efforts are designed to make navigation of access to insurance and services more culturally and linguistically appropriate.

Taking actions to reduce disparities through improving cultural competence has gained visibility and importance in recent years. Safety net facilities—public and certain non-profit hospitals and community health centers, in particular—have implemented important training, education and service programs to improve care for diverse communities and patients. However, it is far from certain whether health care organizations generally, to date, have undertaken many or, in some cases, any of these or related actions. Moreover, their current capacity, drive for increasing market share, or financial constraints or concerns may lead them to not see cultural competence, language assistance specifically, nor disparities more broadly, as priorities.

Health care reform introduces or strengthens “levers” such as community benefit and certain race- and culture-oriented incentives that, if effectively used, can work to bring organizations to recognize the need for elevating the importance of what it takes to improve the health of racially and ethnically diverse patients. However, it may well be necessary to significantly reach beyond demonstrations and funding opportunities to require provider organizations to show evidence of working to reduce identified disparities in the communities they serve through training, education, community outreach, service, language assistance and other programs.

Preserving and transitioning the health care safety net.

For decades, public and non-profit hospitals, community health centers and free or reduced fee clinics have played a core and central role in caring for uninsured, Medicaid and racially and ethnically diverse populations in the U.S. Many have served vital roles in providing underserved populations with life-saving services such as trauma and emergency care, specialty services such as burn and neonatal intensive care, and emergency response as well as primary care. However, while the ACA provides substantial resources to support and expand community health centers, the role of and assistance related to other safety net sectors who serve a critical role in caring for diverse patients and communities is more open if not uncertain for different reasons. Safety net hospitals greatly dependent on Medicaid and Medicare DSH payments are scheduled for significant reductions to finance the health care reform legislation. Many philanthropic and other organizations that support free or reduced fee clinics may be questioning the need for continued support for such services with the financial enfranchising of so many historically uninsured individuals.¹⁰² These sectors will remain critical to maintaining a viable and essential safety net, particularly as health care reform, for the most part, excludes an estimated 12 million undocumented immigrants. Others such as lawful residents and immigrants may not participate based on choice, distrust or other reasons. Additionally, there is an extended transition period during which many will remain uninsured. Finally, the extensive experience of hospitals and clinics in caring for diverse communities and populations may well be lost.

Preserving a strong safety net of hospitals, community health centers and clinics will need to be at the core of future health care priorities. This will likely require direct support to safety net hospitals, particularly in regions with large uninsured and undocumented immigrants, to continue their services for underserved patients. These providers may also require help in adapting health information systems and other critical

components of their infrastructure as they work to balance their continued safety net and essential community provider functions with a more mainstream and integrated role in health care. Finally, philanthropic and other organizations supporting safety net clinics may need guidance that reinforces both their important role and the most beneficial application of their resources, including new ideas for leveraging their safety net role—e.g., new safety net partnerships and collaborations—in the era of health reform.¹⁰³

C. Individual-level Initiatives

Research and experience documenting the incidence and prevalence of disparities-related conditions, as well as their consequences for racially and ethnically diverse patients, provided a substantial evidence base for many of the initiatives included within the ACA. However, knowledge gaps remain as to why disparities in outcomes remain. This section identifies two research and service priorities that build on the intent and objectives of health care reform.

Developing effective care/disease management and self management interventions and protocols for diverse patients. Even before health care reform, considerable efforts were underway to develop a strong evidence base for care management and self management of chronic disease. A key goal is to improve patient understanding and adherence to treatment, and promote greater individual and family involvement with care. New programs included in the ACA need to address how and to what extent inattention to race, culture, language and literacy concerns may create impediments to care management and self management. Adoption of clinically valid interventions based in cultural competence should contribute significantly to improving outcomes, reducing medical errors due to misunderstanding and resistance, and decreasing unnecessary costs—all central goals of health care reform. Performance reporting and pay-for-performance or other incentives may be appropriate tools to encourage practitioners to adopt culturally competent, evidence based practices.

Mitigating the effects of overweight/obesity and negative environmental factors that may impede progress on reducing disparities. A historic lack of access to timely health care has contributed to deep-rooted disparities in health status and outcomes. Health care reform will likely have a significant and positive impact on reducing these barriers. However, higher rates of overweight and obesity among racially/ethnically diverse populations¹⁰⁴, and the socio-economic and environmental conditions that contribute to these rates, have

the potential to significantly impede progress in closing the health disparities gap, particularly for consequences of this condition, for example chronic diseases such as diabetes. At the same time such conditions may be acting as a counterweight to progress in reducing disparities on other fronts.

Individuals and families with limited resources, many of whom are disproportionately from racially and ethnically diverse communities, will struggle to reduce their health risks from being overweight or obese without greater practitioner/health care organization comprehension of their culture and the challenges they face. Moreover, as community-based initiatives are implemented under the ACA, as described earlier, their potential effectiveness may be limited without including efforts to expand access to affordable, nutritious food, safe places to exercise in disadvantaged neighborhoods, provide culturally and linguistically appropriate consumer education, and positive reinforcement from local public health and medical providers. Strategically linking many of health care reform's goals with actions to address this urgent priority among diverse residents may be necessary to show true progress in reducing disparities.

V. CONCLUSION

The ACA and its provisions to improve access, affordability and quality of care—in supporting comprehensive action to improve health and health services for racially and ethnically diverse patients and communities—lays a strong foundation for eliminating the legacy of health disparities. In looking forward, this new law has the potential to seed, promote and guide diversity initiatives in this country for decades to come. Realizing its vision will do much to promote the longstanding promise of equality and equity for all.

NOTES & REFERENCES

- 1 Smedley, B, Stith, A., Nelson, A. (eds). (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine Washington, DC, 2001.
- 2 US Census Bureau. (August 14, 2008). An older and more diverse nation by midcentury. Retrieved June 16, 2010, from <http://www.census.gov/newsroom/releases/archives/population/cb08-123.html>.
- 3 Congressional Budget Office. (2010). Cost estimates for health care legislation. H.R. 4872, Reconciliation Act of 2010 (Final Health Care Legislation). Retrieved June 16, 2010, from <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.
- 4 Smedley, B. (June 23, 2009). Addressing racial and ethnic health inequities: Tri-Committee discussion draft for health care. House Energy and Commerce Committee, Health Subcommittee. Retrieved June 16, 2010, from http://energycommerce.house.gov/Press_111/20090623/testimony_smedley.pdf.
- 5 Ulmer, C., McFadden, B., & Nerenz, D.R. (2009). Race, ethnicity, and language data: Standardization for health care quality improvement. Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement, Institute of Medicine. Retrieved June 16, 2010, from http://www.nap.edu/catalog.php?record_id=12696.
- 6 Perot, R.T. & Youdelman, M. (2001). Racial, ethnic, and primary language data collection in the health care system: An assessment of federal policies and practices. New York: The Commonwealth Fund. Retrieved June 16, 2010, from <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2001/Sep/Racial--Ethnic--and-Primary-Language-Data-Collection-in-the-Health-Care-System--An-Assessment-of-Fed.aspx>.
- 7 Brittingham, A. & de la Cruz, G.P. (2004). Ancestry: 2000. US Census Bureau. Retrieved June 16, 2010, from <http://www.census.gov/prod/2004pubs/c2kbr-35.pdf>.
- 8 Perot, R. & Youdelman, M. (2001).
- 9 Ibid.
- 10 Hasnain-Wynia, R., Pierce, D. & Pittman, M.A. (2004). The Commonwealth Fund. Who, when, and how: The current state of race, ethnicity, and primary language data collection in hospitals. Retrieved June 16, 2010, from <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2004/May/Who--When--and-How--The-Current-State-of-Race--Ethnicity--and-Primary-Language-Data-Collection-in-Ho.aspx>.
- 11 Smith, T.W. (1997). Measuring race by observation and self-identification. National Opinion Research Center. University of Chicago. GSS Methodological Report, No. 89. Retrieved June 16, 2010, from <http://cloud9.norc.uchicago.edu/dlib/m-89.htm>.
- 12 Moscou, S., Anderson, M.R., Kaplan, J.B., et al. (2003). Validity of racial/ethnic classifications in medical records data: An exploratory study. *American Journal of Public Health*, 93(7): 1084–1066.
- 13 Billheimer, L.T. & Sisk, J.E. (2008). Collecting adequate data on racial and ethnic disparities in health: The challenges continue. *Health Affairs*, 27(2): 383-391.
- 14 Lopez, A. (2002). Middle Eastern populations in California: Estimates from the Census 2000 Supplementary Survey. Center for Comparative Studies in Race and Ethnicity, Stanford University. Retrieved June 21, 2010, from http://ccsre.stanford.edu/reports/report_10.pdf.
- 15 Flores, L. & Moon, D. (2002). Rethinking race, revealing dilemmas: Imagining a new racial subject in race traitor. *Western Journal of Communication*, 66(2): 181–207.
- 16 Perot, R. & Youdelman, M. (2001).
- 17 Smedley, B.D., Butler, A.S. & Bristow, L.R. (2004). In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce. Washington, DC: Institute of Medicine.
- 18 Cohen, J.J., Gabriel, B.A., & Terrell, C. (2002). The case for diversity in the health care workforce. *Health Affairs*, 21(5): 90-102.
- 19 Kington, R., Tisnado, D. & Carlisle, D.M. Increasing racial and ethnic diversity among physicians: An intervention to address health disparities? in, Smedley, B.D., et al. (2001). *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions*. Washington, DC: National Academy Press.

- 20 Cohen, J.J., Gabriel, B.A., & Terrell, C. (2002).
- 21 Ibid.
- 22 Smedley, B.D., Butler, A.S. & Bristow, L.R. (2004).
- 23 American Public Health Association. (2009). Public Health Services Act Title VII and Title VIII: Why are these programs so important? Retrieved June 21, 2010, from <http://www.apha.org/NR/rdonlyres/13E647B5-E51B-4A47-91A8-652EE973A2DB/0/TitleVIIandTitleVIII.pdf>.
- 24 Green, A.R., et al. (2008). Providing culturally competent care: Residents in HRSA Title VII funded residency programs feel better prepared. *Academic Medicine*, 83(11): 1071-1079.
- 25 Rittenhouse, D.R., et al. (2008). Impact of Title VII training programs on community health center staffing and National Health Service Corps participation. *Annals of Family Medicine*, 6(5): 397-405.
- 26 Witmer, A., Seifer, S.D., Finocchio, L., et al. (1995). Community health workers: integral members of the health care work force. *American Journal of Public Health*, 85(8 Pt 1): 1055-1058.
- 27 Smedley, B.D., Butler, A.S. & Bristow, L.R. (2004).
- 28 Terrell, C. & Beaudreau, J. (2003).
- 29 Mead, H., et al. (2008). Racial and ethnic disparities in US health care: A chartbook. New York: The Commonwealth Fund.
- 30 Beach, M.C., Saha, S., & Cooper, L.A. (2006). The relationship of cultural competence and patient-centeredness in health care quality. New York: The Commonwealth Fund. Retrieved June 21, 2010, from http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Oct/The%20Role%20and%20Relationship%20of%20Cultural%20Competence%20and%20Patient%20Centeredness%20in%20Health%20Care%20Quality/Beach_rolerelationshipcultcompatient%20cent_960%20pdf.pdf.
- 31 Office of Minority Health. (2002). National standards for culturally and linguistically appropriate services in health care. Washington, DC: US Department of Health and Human Services.
- 32 Brach, C. & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57(1): 181-217.
- 33 Rashid J.R., Spengler, R.F., Wagner, R.M., et al. (2009). Eliminating health disparities through transdisciplinary research, cross-agency collaboration, and public participation. *American Journal of Public Health*, 99(11):1955-1961.
- 34 Thompson, G.E., Mitchell, F. & Williams, M.B. (2006). Examining the Health Disparities Research Plan of the National Institutes of Health. Washington, DC: Institute of Medicine.
- 35 Federal Coordinating Council for Comparative Effectiveness Research. (June 30, 2009). Report to the President and the Congress. Retrieved July 6, 2009, from <http://www.hhs.gov/recovery/programs/cer/cerannualrpt.pdf>.
- 36 Howell, E., et al. (2003). Racial differences in reported postpartum depression. *AcademyHealth Meeting Abstract*, 20(236). Retrieved June 21, 2010, from <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102275218.html>.
- 37 Thompson, G.E., Mitchell, F. & Williams, M.B. (2006). Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished Business. Washington, DC: Institute of Medicine.
- 38 Davis, D.A. & Taylor-Vaisey, A. (1997). Translating guidelines into practice. A systematic review of theoretic concepts, practical experience and research evidence in the adoption of clinical practice guidelines. *Canadian Medical Association Journal*, 157(4): 408-416.
- 39 King, T.E. (2002). Racial disparities in clinical trials. *New England Journal of Medicine*, 346(18):1400-1402.
- 40 Murthy, V.H., Krumholz, H.M. & Gross, C.P. (2004). Participation in cancer clinical trials: race-, sex-, and age-based disparities. *Journal of the American Medical Association*, 291(22):2720-2726.
- 41 Baylor College of Medicine. (2010). Eliminating Disparities in Clinical Trials. Retrieved June 21, 2010, from <http://www.bcm.edu/edict/home.html>.
- 42 LaVeist, T.A., Gaskin, D.J. & Richard, P. (2009). The economic burden of health inequalities in the United States. Washington, DC: The Joint Center for Political and Economic Studies. Retrieved June 21, 2010, from http://www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf.

- 43 Finer, L. & Henshaw, S. (2006). Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspectives on Sexual and Reproductive Health*, 38(2): 90–96.
- 44 Centers for Disease Control and Prevention. (2008). HIV/AIDS surveillance report: Cases of HIV infection and AIDS in the United States and dependent areas, by race/ethnicity, 2007. Retrieved June 21, 2010, from <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/default.htm>.
- 45 American Academy of Pediatrics, Council on Child and Adolescent Health. (1998). The role of home-visitation programs in improving health outcomes for children and families. Retrieved June 28, 2010, from <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;101/3/486.pdf>.
- 46 Dietrich, T., et al. (2008). Racial and ethnic disparities in children's oral health: the National Survey of Children's Health. *Journal of the American Dental Association*, 139(11): 1507-1517.
- 47 Vernon, J.A., et al. (2007). Low health literacy: Implications for national health policy. Retrieved June 21, 2010, from http://www.npsf.org/askme3/pdfs/Case_Report_10_07.pdf.
- 48 US Census Bureau. (2007). Population 5-years or older who speak English "less than very well."
- 49 US Congress. S. 1790: Indian Health Care Improvement Reauthorization and Extension Act of 2009. Dorgan, B. Retrieved June 21, 2010, from <http://www.govtrack.us/congress/bill.xpd?bill=s111-1790>.
- 50 Office of the General Counsel, US Commission on Civil Rights. (2004). Native American health care disparities briefing. Retrieved June 21, 2010, from <http://www.law.umaryland.edu/marshall/usccr/documents/nativeamericanhealthcaredis.pdf>.
- 51 Centers for Disease Control and Prevention. (2008). Behavioral Risk Factors Surveillance Systems. Adults aged 18-64 who have any kind of health care coverage. Retrieved June 21, 2010, from <http://apps.nccd.cdc.gov/BRFSS/race.asp?cat=HC&yr=2008&qkey=880&state=UB>.
- 52 Kaiser Family Foundation. (2010). Optimizing Medicaid enrollment: Perspectives on strengthening Medicaid's reach under health care reform. Retrieved June 21, 2010, from <http://www.kff.org/healthreform/upload/8068.pdf>.
- 53 James, C., Schwartz, K., & Berndt, J. (2009). A profile of American Indians and Alaska Natives and their health coverage. Kaiser Family Foundation. Retrieved June 21, 2010, from <http://www.kff.org/minorityhealth/upload/7977.pdf>.
- 54 Smedley, B.D. (2008). Moving beyond access: Achieving equity in state health care reform. *Health Affairs*, 27(2): 447-455.
- 55 Doty, M.M. & Holmgren, A.L. (2006). Health Care Disconnect: Gaps in Coverage and Care for Minority Adults: Findings from the Commonwealth Fund Biennial Health Insurance Survey. New York: Commonwealth Fund Issue Brief.
- 56 Kaiser Family Foundation. (2010). Summary of Coverage Provisions in the Patient Protection and Affordable Care Act. Retrieved June 15, 2010 from <http://www.kff.org/healthreform/upload/8023-R.pdf>.
- 57 Kaiser Family Foundation. (2009). Medicaid and state funded coverage income eligibility limits for low-income adults, 2009. State Health Facts. Retrieved November 4, 2009, from <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>.
- 58 Kaiser Family Foundation. (2009). Health insurance coverage of the total population, states (2007-2008), US (2008). State Health Facts. Retrieved November 4, 2009, from <http://www.statehealthfacts.org/comparetable.jsp?typ=2&ind=125&cat=3&sub=39&sortc=6&o=a>.
- 59 Doty, M.M. & Holmgren, A.L. (2006).
- 60 Lowrey, Y. (2007). Minorities in Business: A Demographic Review of Minority Business Ownership. Small Business Administration. Retrieved November 6, 2009, from <http://www.sba.gov/advo/research/rs298tot.pdf>.
- 61 Kaiser Family Foundation. (2009). Health Reform and Communities of Color: How Might it Affect Racial and Ethnic Health Disparities? Facts on Health Reform.
- 62 Ibid.
- 63 Wick, E. (2002). Health insurance purchasing cooperatives. The Commonwealth Fund. Retrieved October 2, 2009, from http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2002/Nov/Health%20Insurance%20Purchasing%20Cooperatives/wicks_coops%20pdf.pdf.

- 64 Mead et al. (2008). Racial and ethnic disparities in U.S. health care: A chartbook. New York: The Commonwealth Fund.
- 65 Mertens, M. (March 24, 2010). Health Care for All Leaves 23 Million Uninsured. NPR. Retrieved June 29, 2010 from http://www.npr.org/blogs/health/2010/03/health_care_for_all_minus_23_m.html.
- 66 Raymond A. (2007). The 2006 Massachusetts Health Care Reform Law: Progress and Challenges After One Year Implementation. Retrieved June 10, 2010 from <http://masshealthpolicyforum.brandeis.edu/publications/pdfs/31-May07/MassHealthCareReformProgress%20Report.pdf>.
- 67 Ibid.
- 68 National Association of Community Health Centers. (2007). Access Denied: A Look into America's Medically Disenfranchised. Last retrieved June 4, 2010 from http://www.graham-center.org/PreBuilt/Access_Denied.pdf.
- 69 National Association of Community Health Centers (2010). Community health centers and health reform: Summary of key health center provisions. Retrieved June 1, 2010 from <http://www.nachc.com/client/Summary%20of%20Final%20Health%20Reform%20Package.pdf>.
- 70 Andrulis DP, Smith DB, Siddiqui NJ, and Duchon L. (2008). Health Care Proposals of the 2008 Democratic and Republican Presidential Nominees: Implications for Improving Access, Affordability and Quality for America's Minorities. Joint Center for Political and Economic Studies.
- 71 Ibid.
- 72 Doty MM, et al. (2010). Enhancing the Capacity of Community Health Centers to Achieve High Performance: Findings from the 2009 Commonwealth Fund National Survey of Federally Qualified Health Centers. Commonwealth Fund. Retrieved June 16, 2010 from http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/May/1392_Doty_enhancing_capacity_community_hlt_ctr_2009_FQHC_survey_v4.pdf.
- 73 Ibid.
- 74 Mead et al., Racial and Ethnic Disparities in U.S. Health Care.
- 75 Lurie, N. & Dubowitz, T. (2008). Health disparities and access to health. *Journal of the American Medical Association*, 297: 1118-1121.
- 76 Doescher M.P. et al. (2001). Racial/Ethnic Inequities in Continuity and Site of Care: Location, Location, Location. *Acad Health Serv Res Health Policy Meet*; 18:7.
- 77 Smedley, B., Smith, A., & Nelson, A. (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: Institute of Medicine.
- 78 Commonwealth Fund (2006). Why Not the Best? Results from a National Scorecard on US Health System Performance. New York: Commonwealth Fund.
- 79 Conrad, D.A., et al. (2003). Community care networks: Linking vision to outcomes for community health improvement. *Medical Care Research and Review*, 60(4):95-129.
- 80 Angeles J and Somers SA. (August 2007). From Policy to Action: Addressing Racial and Ethnic Disparities at the Ground Level. Issue Brief. Center for Health Care Strategies. Retried June 14, 2010 from http://www.chcs.org/usr_doc/From_Policy_to_Action.pdf.
- 81 Doty, M.M. & Holmgren, A.L. (2006).
- 82 National Health Policy Forum. (June 15, 2009). The basics: Medicaid disproportionate share hospital (DSH) payments. Retrieved July 9, 2009, from http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf.
- 83 National Association of Public Hospitals and Health Systems. (April 2009). Massachusetts Health Reform: Lessons Learned about the Critical Role of Safety Net Health Systems. Issue Brief. Retrieved June 21, 2010, from <http://www.naph.org/Publications/MA-Health-Reform-Issue-Brief.aspx>.
- 84 Morrison, R., et al. (2000). We don't carry that—failure of pharmacies in predominantly nonwhite neighborhoods to stock opioid analgesics. *New England Journal of Medicine*, 343: 442-445.
- 85 Morris, L. (2009). Combating fraud in health care: An essential component of any cost containment strategy. *Health Affairs*, 28(5): 1351-1356.
- 86 Children's Defense Fund. (2009). Disparities in Children's Health and Health Coverage. Retrieved on June 21, 2010 from <http://www.childrensdefense.org/child-research-data-publications/data/childrens-health-disparities-factsheet.pdf>.
- 87 Ibid.

- 88 Krukowski R.A., West, D.S., Perez A.P., Bursac Z., Phillips M.M., and Raczynski J.M. (2009). Overweight children, weight-based teasing and academic performance. *International Journal of Pediatric Obesity*, 4(4): 274-280.
- 89 National Center for Health Statistics (NCHS). (2007). *Health, United States, 2007*. Hyattsville, MD: NCHS.
- 90 Centers for Disease Control and Prevention. (2009). *U.S. Obesity Trends*. Retrieved June 21, 2010 from <http://www.cdc.gov/obesity/data/trends.html>.
- 92 Patient Protection and Affordable Health Care Act of 2010, Public Law No: 111-148, Pg 425.
- 93 Dannenberg, A.L., Bhatia, R., Cole, B.L., Heaton, S.K., Feldman, J.D., & Rutt, C.D. (2008). Use of Health Impact Assessment in the U.S. 27 Case Studies, 1999–2007. *American Journal of Preventative Medicine*, 34(3): 241-256.
- 94 Andrulis D.P., Smith D.B., Siddiqui N.J. and Duchon L. (2008). *Health Care Proposals of the 2008 Democratic and Republican Nominees: Implications for Improving Access, Affordability and Quality for America's Minorities*. Drexel University School of Public Health's Center for Health Equality and Health Management Associates. Supported by the Joint Center for Political and Economic Studies.
- 95 Morgan, M. and Lifshay, J. (2006). *Community engagement in public health*. Contra Costa County Department of Health Services.
- 96 Smedley, B. (2010). *Building stronger communities for better health: moving from science to policy and practice*. IOM Workshop: "Ten years later: how far have we come on reducing disparities?"
- 97 Hurowitz, J. (1993). *A social policy for health*. *New England Journal of Medicine*, 29:130-133.
- 98 Smedley, B, Stith, A., Nelson, A. (eds). (2001). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, D.C.: Institute of Medicine.
- 99 Ibid, p.637.
- 100 Fox, R. (2005). *Cultural competence and the culture of medicine*. *New England Journal of Medicine*, 353:1316-1319; Betancourt, J. (2003). *Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care*. *Public Health Reports*, 118: 293-302.
- 101 Betancourt, 2003. *Defining cultural competence*.
- 102 Gibbs, R.D., & Gibbs P.H. (2010). Comment on "Free Clinics in the United States". *Archives of Internal Medicine*, 170(11):953-954.
- 103 Darnell, J. (2010). *Free clinics in the United States: A nationwide survey*. *Archives of Internal Medicine*, 170: 946-953.
- 104 Trust for America's Health.(2010). *Racial and ethnic disparities in obesity*. Washington, D.C.

**Appendix A.
Implementation Timeline and Appropriations for Health Equity-Specific Provisions in the
Patient Protection and Affordable Care Act of 2010**

	Provision	Sec. No.	2010	2011	2012	2013	2014	2015	Administration	Others Involved
Data	Require population surveys to collect racial/ethnic subgroup data	4302		Such sums as necessary					ONCHIT	OMH, IHS
	Collect/report disparities data in Medicaid and CHIP	4302		Such sums as necessary					HHS Sec.	N/A
	Monitor health disparities trends in federally-funded programs	4302		Such sums as necessary					HHS Sec.	Multiple Organizations ¹
Workforce Diversity	Collect and publicly report data on workforce diversity	5001		Such sums as necessary					NHCWC	BLS
	Loan repayment preference for experience in CC	5203	\$30 mil	\$30 mil	\$30 mil	\$30 mil	\$30 mil		HHS Sec.	N/A
	Increase diversity among PCPs	5301	\$125 mil		Such sums as necessary				HHS Sec.	N/A
	Increase diversity among long term care providers	5302		\$10 mil					HHS Sec.	N/A
	Increase diversity among dentists	5303	\$30 mil		Such sums as necessary				HHS Sec.	N/A
	Increase diversity among mental health providers	5306		\$25 mil					HHS Sec.	N/A
	Health professions training for diversity	5402	\$51 mil		Such sums as necessary				HHS Sec.	N/A
	Increase diversity in nursing professions	5309	\$35,500 per student		Such sums as necessary				HHS Sec.	N/A
	Investment in HBCUs and minority-serving institutions	2104		\$255 mil. for FY 2010-2019					HHS Sec.	N/A
	Community training for AHECs targeting underserved pops.	5403	\$ 130 mil	\$ 130 mil	\$ 130 mil	\$ 130 mil			HHS Sec.	N/A
Cultural Competence Education & Organizational Support	Grants for Community Health Workers, providing CLAS	5313		Such sums as necessary					CDC Dir.	HHS Sec.
	Grants to train providers on pain care, including CLAS	4305		N/A					HHS Sec.	N/A
	Projects for core competences of health professions	5507	\$85 mil	\$85 mil	\$85 mil	\$85 mil	\$85 mil		HHS Sec.	DOL Sec.
	Develop & evaluate model CC curricula	5307		N/A					HHS Sec.	Multiple Orgs. ²
	Disseminate CC curricula through online clearinghouse	5307		N/A					HHS Sec.	Multiple Orgs. ²
	CC training for primary care providers	5301	\$125 mil		Such sums as necessary				HHS Sec.	N/A
	CC training for home care aids	5507	\$5 mil	\$5 mil					HHS Sec.	DOL Sec.
	Curricula for CC in working with individuals with disabilities	5307		Such sums as necessary					HHS Sec.	Multiple Orgs. ²
	Transfer federal OMH to Office of the Secretary	10334			Such sums as necessary				OMH	HHS Sec., OPHS
	Create individual OMHs within federal HHS agencies	10334			Such sums as necessary				Multiple Orgs. ³	HHS Sec.
Health Disparities Research	PCORI to examine health disparities through CER	6301		N/A					PCORI	N/A
	Increase funding to Centers of Excellence	5401	\$50 Mil	\$50 Mil	\$50 Mil	\$50 Mil	\$50 Mil		NCHMD	N/A
	Promote NCMHHD to Institute status	10334		N/A					NCHMD	NIH
	Support collaborative research on topics including CC	5307		Such sums as necessary					HHS Sec.	Multiple Orgs. ²
	Support for disparities research in post-partum depression	2952	\$ 3 mil	Such sums necessary					HHS Sec.	NIMH, Dir.

Provision		Sec. No.	2010	2011	2012	2013	2014	2015	Administration	Others Involved
Health Disparities Initiatives in Prevention	National oral health campaign, with emphasis on disparities	4102	Planning	Implementation 2012-2017					CDC Dir.	HHS Sec.
	Standardized drug labeling on risks & benefits	3507	N/A						HHS Sec.	FDA Comm.
	Maternal & child home visiting programs for at-risk communities	2951	\$100 mil	\$250 mil	\$350 mil	\$ 400 mil	\$400 mil		HHS Sec.	N/A
	Culturally appropriate patient-decision aids	3506	N/A						HHS Sec.	N/A
	CPSTF review/recommend disparity interventions	4003			Sums such as necessary				CDC Dir.	N/A
	CLAS personal responsibility education	2953	\$75 mil	\$75 mil	\$75 mil	\$75 mil	\$75 mil		HHS Sec.	N/A
	Support for AI/AN preventive programs	10221			N/A				HHS Sec.	I.H.S.
	Community Health Teams to deliver CLAS in primary care	3502			N/A				HHS Sec.	N/A
	Remove cost-sharing for AI/ANs at or below 300% FPL	2901					N/A		N/A	N/A
	Enrollment outreach targeting low income populations	3306			\$ 1.5 mil				CMS	States
Addressing Disparities in Health Insurance Reform	CLAS/information through exchanges	1311							HHS Sec.	Exchange Navigators
	Nondiscrimination in federal health programs/Exchanges	1557			N/A				HHS Sec.	N/A
	Require plans to provide information in "plain language"	1303					N/A		HHS Sec.	DOL Sec.
	Incentive payments for reducing health/healthcare disparities	1303					N/A		HHS Sec.	Insurers
	Summary of coverage that is culturally/linguistically appropriate	1001				N/A			HHS Sec.	NAIC ⁵
	Claims appeal process that is culturally/linguistically appropriate	1001				N/A			HHS Sec.	N/A

1. OMH, NCMHHD, AHRQ, CDC, CMS, HIS, ORH, "other agencies within HHS and other entities as determined appropriate by the Secretary."

2. Health professions societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations and other organizations.

3. CDC, HRSA, SAMHSA, AHRQ, FDA, CMS

4. State and regional organizations representing affected entities, State health offices, community organizations, health centers and other affected entities, and other interested parties.

5. Advocates for patients with limited English proficiency.

**Appendix B.
Implementation Timeline and Appropriations for General Provisions with
Major Implications for Racially and Ethnically Diverse Populations in the
Patient Protection and Affordable Care Act of 2010**

Provision	Sec. No.	2010	2011	2012	2013	2014	2015	Administration	Others Involved	
Health Insurance	Individual requirement to have coverage	1501				N/A		HHS Sec.	N/A	
	Expand Medicaid income eligibility to 133% FPL	2001				N/A		CMS	N/A	
	Employer requirement to offer coverage	1513				N/A		HHS Sec.	N/A	
	Increase federal matching rates for Medicaid	2005			\$6.3 bil			CMSO	HHS Sec.	
	Small business (<25 employees) tax credits	1421		Such sums as necessary				HHS Sec.	Labor Sec.	
	Multi-state plan option	10104				N/A		HHS Sec.	OMP Dir.	
	Temporary high risk pools	1101		\$5 bil.				HHS Sec.	N/A	
	Consumer Operated and Oriented Plans (CO-OPs)	1322				\$6 bil.		HHS Sec.	State Exchanges	
	State-based American Health Benefit Exchanges	1311		Planning				HHS Sec.	State Exchanges	
	Support for community health centers	10503		\$1 bil	\$1.2 bil.	\$1.5 bil	\$2.2 bil	\$3.6 bil	HHS Sec.	NHSC
Access to Care	Nurse-managed health centers	5208	\$50 mil.	Such sums as necessary				HHS Sec.	N/A	
	Community health teams	3502		N/A				HHS Sec.	N/A	
	Redistribute Graduate Medical Education slots	5503			N/A			HHS Sec.	N/A	
	Extends authorization of National Health Services Corps	5207	\$320mil	\$41.4mil	\$53.5mil	\$69.1mil	\$89.3mil	\$1.15bil	HRSA	N/A
	Teaching Health Centers	5508	\$25 mil	\$50 mil	\$50 mil	Sums such as necessary			HHS Sec.	NHSC
	Innovative models in Medicare/Medicaid	3021	\$ 5 mil.		\$10 bil. 2011-2019				GMI	CMS
	School-based health centers	4101	\$50 mil.	\$50 mil.	\$50 mil.				HHS Sec.	N/A
	Pilot projects for emergency & trauma care	3504	\$24 mil.	\$24 mil.	\$24 mil.	\$24 mil.	\$24 mil.		HHS Sec.	ASPR
	National Strategy for Quality Improvement	3011			N/A				HHS Sec.	N/A
	Quality improvement technical assistance	3501	\$20 mil	\$20 mil	\$20 mil	\$20 mil	\$20 mil		CGIPS, AHRQ	N/A
Quality	Interagency Group on Healthcare Quality	3012	N/A					President	Multiple Orgs. ¹	
	Develop, improve & evaluate quality measures	3013	\$75 mil	\$75 mil	\$75 mil	\$75 mil	\$75 mil	HHS Sec.	AHRQ Dir., CMS Admin.	
	Link Medicare payments to quality outcomes	3001					N/A	HHS Sec.	N/A	
	Pediatric Accountable Care Organizations	2706			Sums such as necessary	2012-2016		HHS Sec.	N/A	

Provision		Sec. No.	2010	2011	2012	2013	2014	2015	Administration	Others Involved
Cost	Interoperable systems of enrollment	1561			N/A				HHS Sec.	HIT Committees
	Reduce Medicaid DSH Payments	3133		Reduce by \$18.1 million for 2014 to 2020						State
	Reduce Medicare DSH Payments	2551				Reduce by 75%				
	Demonstration projects for HIT	6114		Such sums as necessary					HHS Sec.	N/A
	Strengthening Medicaid drug rebate programs	2501		N/A					HHS Sec.	FDA
	Enhancing public program fraud screening	6401		N/A					HHS Sec.	HHS I.G.
Public Health	National Prevention & Public Health Council	4001		N/A					President	HHS, S.G., Multiple Orgs. ²
	Prevention & Public Health Fund	4002	\$500 mil.	\$750 mil.	\$1 bil.	\$1.25 bil.	1.5 bil.	\$2. bil.	HHS Sec.	
	Childhood obesity demonstration projects	4306		\$2.5 mil					N/A	N/A
	National diabetes prevention program	10501		Such sums as necessary					HHS Sec.	CDC Dir.
	New methods for scoring prevention/wellness programs	4401		N/A						
	Education campaign for breast cancer	10413	\$9. mil	\$9. mil	\$9. mil	\$9. mil	\$9. mil	\$9. mil	HHS Sec.	CDC Dir.
	Health Impact Assessments	4003		N/A					PSIF	N/A
	CPSTF review/recommend interventions in social context	4003		Sums such as necessary					CDC Dir.	N/A
	Community Transformation Grants	4201		\$100 mil					HHS Sec.	CDC Dir.
	Non-profit hospital community needs-assessment	9007		N/A					HHS Sec. , D.Treas. Sec.	IRS
Social Determinants	Primary Care Extension Program	5405	\$120 mil.	\$120 mil.	\$120 mil.	Sums as necessary			HHS Sec.	AHRQ Dir., CMS Admin.

1. CMS, NIH, CDC, FDA, HRSA, AHRQ, ONCHIT, SAMHSA, ACF, DOC, OMB, USCG, FBP, NHTSA, FTC, SSA, DOL, OPM, DOD DOE/DVA, VHA

2. HHS, USDA, DOE, FTA, DOT, DHS, EPA, ONDCP, DPC, BIA, CNCS

Appendix C. Acronyms

Organizations

ACF	Administration for Children and Families
AHRQ	Agency for Healthcare Research and Quality
BIA	Bureau of Indian Affairs
BLS	Bureau of Labor Statistics
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CMSO	Center for Medicaid and State Operations
CNCS	Corporation for National and Community Service
CPSTF	Community Preventive Service Task Force
CQIPS	Center for Quality Improvement and Patient Safety
D.Treas.	Department of the Treasury
DHHS	Department of Health and Human Services
DHS	Department of Homeland Security
DOC	Department of Commerce
DOD	Department of Defense
DOE	Department of Education
DOL	Department of Labor
DOT	Department of Transportation
DPC	Domestic Policy Council
DVA	Department of Veterans Affairs
EPA	Environmental Protection Agency
FBP	Federal Bureau of Prisons
FDA	Food and Drug Administration
FTA	Federal Transit Administration
FTC	Federal Trade Commission
I.H.S.	Indian Health Service
HRSA	Health Resources and Services Administration
IRS	Internal Revenue Service
NAIC	National Association of Insurance Commissioners
NCMHHD	National Center on Minority Health and Health Disparities
NHCWC	National Health Care Workforce Commission
NHSC	National Health Service Corps
NHTSA	National Highway Traffic Safety Administration
NIH	National Institutes of Health

Organizations (cont.)

NIH	National Institutes of Health
NIMH	National Institute of Mental Health
OMB	Office of Management and Budget
OMH	Office of Minority Health
OMP	Office of Personnel Management
ONCHIT	Office of the National Coordinator for Health Information Technology
ONDCCP	Office of National Drug Control Policy
OPHS	Office of Public Health and Science
OPM	United States Office of Personnel Management
ORH	Office of Rural Health
PCORI	Patient-Centered Outcomes Research Institute
SAMHSA	Substance Abuse and Mental Health Services Administration
SSA	Social Security Administration
USCG	United States Coast Guard
USDA	United States Department of Agriculture
VHA	Veterans Health Administration

Positions

Admin.	Administrator
Comm.	Commissioner
Cord.	Coordinator
Dir.	Director
I.G.	Inspector General
S.G.	Surgeon General
Sec.	Secretary

Other

AHECs	Area Health Education Centers
AI/AN	American Indian Alaska Native
CC	Cultural Competence
CLAS	Culturally and Linguistically Appropriate Services
FPL	Federal Poverty Level
HPSA	Health Professional Shortage Areas
MUP	Medically Underserved Populations
PCPs	Primary Care Physician

ABOUT THE JOINT CENTER AND ITS HEALTH POLICY INSTITUTE

The Joint Center for Political and Economic Studies is one of the nation's pre-eminent research and public policy institutions and the only one of whose work focuses exclusively on issues of particular concern to African Americans and other people of color. For four decades, our research and information programs have informed and influenced public opinion and national policy to benefit not only African Americans, but every American.

The Joint Center's Health Policy Institute (HPI) was launched eight years ago to play a leadership role in reframing debates on health and refocusing attention on health disparities. With a focus on addressing racial disparities in health status, HPI initiates cutting-edge research and analysis, while seeking to expand the participation of African Americans in health-related public policy issues. Through its work, HPI helps generate new policy recommendations while raising awareness of important equity and social justice concerns – particularly in the area of the economic, social, behavioral and environmental determinants of health outcomes

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