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Short Paper #9

The ACA and Health Disparities

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Introduction

This Short Paper examines provisions of the Patient Protection and Affordable Care Act (ACA) that address health disparities for particular communities and identifies areas where further development is needed to address disparities.[1]

Our discussion focuses on some of those provisions addressing data collection, prevention of chronic illnesses, workforce development, and quality improvements. As the paper will note, although these provisions offer a blueprint for improving the health status of underserved people; unfortunately, the ACA does not guarantee that funding will be available to ensure adequate implementation.

Background

The goals to obtain improved life expectancy and overall health have remained out of reach for many communities of color, particularly for low-income communities. Quality of health care is often affected by factors such as an individual's economic status, race, and gender.[2] According to a National Vital Statistics Report, ethnic minority groups continue to have noticeably shorter life expectancies than whites, due to factors such as disproportionate burdens of disease and lack of access to health care.[3]

The ACA recognized the need to eliminate health disparities. In the health care workforce title, the ACA defines a population as a "health disparity population" if there is a

> significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in the population as compared to the

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[1] Patient Protection and Affordable Care Act, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010) [hereinafter ACA].

[2] *See* U.S. Dep't. of Health and Human Serv., Ctrs. for Disease Control and Prevention, Office of Minority Health & Health Disparities, *About Minority Health*, http://www.cdc.gov/omhd/AMH/AMH.htm (last visited June 30, 2011).

[3] U.S. Dep't. of Health and Human Serv., Ctrs. for Disease Control and Prevention, Nat'l Ctr. for Health Statistics, *National Vital Statistics Report, Deaths: Final Data for 2006* (April 2009), http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf (last visited June 30, 2011). *See, e.g.,* Alicia Armstrong, M.D., MHSCR, and Yvonne Maddox, Ph.D., *Health Disparities and Women's Reproductive Health*, 17 ETHNICITY & DISEASE, S-24 (Spring 2007), (noting current evidence of reproductive health disparities in health access and outcomes among poor women of color).

> health status of the general population . . . includ[ing] populations for which there is a significant disparity in the quality, outcomes, cost, or use of health care services or access to or satisfaction with such services as compared to the general population.[4]

Discussion

The ACA provides several initiatives geared towards addressing health disparities for underserved populations through general areas of data collection, prevention, workforce development, and quality improvement strategies. It should be noted that some of the ACA's new grant programs that impact health disparities are authorized but funds have not yet been actually provided. Many of these provisions include statutory language to authorize funding in the amount of "such sums as necessary for FY 2010 – FY 2014" ("such sums as necessary" hereinafter referred to as "SSAN").[5] Funding for new discretionary funding programs must be provided by congressional appropriators, who may decline to fund new activities and programs. Accordingly, although these provisions were included in the ACA, some may not become funded, except if actually included in the appropriations process.

The ACA also amended and authorized new funding for existing discretionary grants through the Public Health Service Act.[6] In addition, other ACA prevention programs have mandatory funding through the ACA's Prevention and Public Health Fund.[7]

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[4] ACA § 5002.

[5] *See, e.g.,* Cong. Research Serv., CRS Report to Congress, *Discretionary Funding in the Patient Protection and Affordable Care Act (PPACA)* (Sept. 2, 2010), http://tinyurl.com/3dtfvpd (last visited June 30, 2011) [hereafter cited as, CRS, *Discretionary Funding in the ACA*]. Although not discussed in this short paper, other new discretionary programs include grants for managing and operating school-based health centers (ACA §4101(b)), an oral health education campaign (ACA § 4102(a)), and a community wellness pilot program (ACA § 4202(a)). *Id.*

[6] *Id.* See, for example, funding for Area Health Education Centers (ACA § 5403(a); the Public Health Workforce Programs (ACA § 10501(m)(2)); and recruitment and retention of underrepresented minorities in the health professions (ACA § 5401)).

[7] U.S. Dep't of Health and Human Serv., *News Release - HHS Announces $750 Million in Prevention*, (Feb. 9, 2011), http://www.hhs.gov/news/press/2011pres/02/20110209b.html (last visited June 30, 2011) (noting that these funded activities are in the areas of clinical prevention, public health infrastructure, research and tracking, and community prevention).

Data Collection[8]

Data that identifies a population is essential to determining whether a community can be considered as a health disparity population. Health disparities are likely reinforced where the lack of data makes it difficult to 1) identify and eliminate health disparities correlated with demographic factors; 2) develop targeted outreach and quality improvement activities; and 3) promote culturally and linguistically competent services. Without pertinent information and data, providers are unaware of the issues experienced by communities, as well as their obligation as providers to offer culturally and linguistically appropriate services.[9] This lack of awareness is often reinforced by limited opportunities for clinical training on the cultural and health needs of underserved communities.[10]

Accordingly, the ACA includes a requirement for the Department of Health and Human Services (HHS) to collect and report data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants in any federally conducted or supported health care or public health program, activity or survey.[11] HHS must also mandate that any reporting requirement for quality measurement under any ongoing or federally conducted or supported health care or public health program, activity, or survey includes requirements for the collection of data on individuals receiving health care items or services. Race and ethnicity data must also be collected regarding underserved rural and frontier populations.[12] In addition, the Secretary of HHS should monitor concerns of health disparity populations in order to identify health inequities and to collect any demographic data deemed appropriate to the disparities.[13]

Identifying health disparities populations and collecting data on their health status and use of health services is a necessary precondition to developing workable prevention and treatment strategies. This identification is also essential to the success of the ACA provisions that target health disparity populations for prevention efforts, workforce development, and improved quality of care. In spite of its importance to identifying disparities, the data collection

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[8] *See also* NHeLP, *Short Paper #5 – The ACA and Language Access* (Jan. 2011), http://www.healthlaw.org/images/stories/Short_Paper_5_The_ACA_and_Language_Access.pdf (last visited July 1, 2011) (recognizing the problem of tasking HHS with multiple responsibilities for data collection without appropriated funding to do so -- such as collecting and reporting data in any federally conducted or supported health program and other settings; developing national standards for managing data collection, and interoperability and security systems; and analyzing collected data to determine tends in health disparities at the federal and state levels).

[9] *See, e.g.,* Nebraska Dep't of Health and Human Serv. Office of Minority Health and Health Equity, *Cultural Competency Assessment of Health Care Providers Across Nebraska: A Survey of Limited English Proficient (LEP) Individuals* (Apr. 2009), http://www.hhs.state.ne.us/minorityhealth/docs/LEPSurveyFinal.pdf (last visited July 1, 2011).

[10] *See, e.g.,* Center for American Progress, *How to Close the LGBT Health Disparities Gap*, (Dec. 2009) http://tinyurl.com/3ozs9dz (last visited July 1, 2011).

[11] ACA § 4302.

[12] *Id.* § 4302.

[13] *Id.*

provision includes a proviso that data may not be collected unless funds are directly appropriated for this purpose.[14]

On June 29, 2011, HHS released standards for implememting Section 4302 of the Patient Protection and Affordable Care Act (ACA) regarding collection of data related to race, ethnicity, language, gender, and disability status.[15] For race and ethnicity, the new standards build on existing standards from the Office of Management and Budget but would collect more detailed data on Asian and Pacific Islanders, Native Hawaiians, and Hispanic/Latino populations. These new standards will be implemented for HHS surveys, beginning in 2012 as surveys are updated. Additional information is expected this Fall related to data standards for other HHS programs and activities beyond surveys. HHS will also begin integrating questions on sexual orientation and gender identity into national data collection efforts. This includes the testing of questions on sexual orientation and potential incorporation of these questions into the National Health Interview Survey as a first step towards development of a government-wide standard for LGBT data collection.[16]

Prevention Efforts

National Diabetes Prevention Program

The ACA includes a provision to manage a National Diabetes Prevention Program. This program is authorized for new discretionary funding for SSAN for FYs 2010 through 2014.[17]

This program establishes community-based life-style intervention strategies for populations at risk for diabetes.[18] The HHS Centers for Disease Control and Prevention (CDC) is authorized to manage the program, which must include the following elements:

- a grant program for community-based prevention model sites;
- a program to determine eligibility of program participants to offer community-based diabetes prevention services;
- a training and outreach program for lifestyle intervention instructors; and
- a process for evaluation, monitoring, technical assistance, and research.[19]

The National Diabetes Prevention Program is to support collaborative activity between federal agencies, community-based organizations, health providers and others to reduce new

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[14] *See* CRS, *Discretionary Funding in the ACA*, *supra* note 5, at CRS-21.
[15] U.S. Dep't of Health and Human Serv., Office of Minority Health, *Proposed Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status Required by Section 4302 of the Affordable Care Act* (June 29, 2011), http://www.minorityhealth.hhs.gov/section4302/ (last visited July 6, 2011).
[16] *See generally id* .
[17] CRS, *Discretionary Funding in the ACA*, *supra* note 5, at CRS-14.
[18] ACA § 10501(g).
[19] *Id;* CDC, *Diabetes Public Health Resource: National Diabetes Prevention Program*, http://www.cdc.gov/diabetes/projects/prevention_program.htm (last visited July 1, 2011).

cases of Type 2 diabetes, which can result in kidney failure, eye disease (diabetic retinopathy), coronary artery disease, and a greater likelihood of lower extremity amputations. [20]

Efforts to prevent and address diabetes are particularly critical since the disease is the sixth leading cause of death in the United States and disproportionately impacts communities of color:

- African Americans are from 1.4 to 2.2 times more likely to have diabetes than white persons.
- Hispanic Americans have a higher prevalence of diabetes than non Hispanic people, with the highest rates for type 2 diabetes among Puerto Ricans and Hispanic people living in the Southwest.
- The prevalence of diabetes among American Indians is 2.8 times the overall rate.
- Major groups within the Asian and Pacific Islander communities (Japanese Americans, Chinese Americans, Filipino Americans, and Korean Americans) all had higher prevalences than those of whites.[21]

Community Transformation Grants

Another strategy used in the ACA to prevent and address chronic illness in low-income communities requires the CDC to issue competitive community grants to state and local governments and community-based organizations to implement and evaluate community prevention programs.[22] Eligible entities for these grants include: state and local government agencies, national networks of community-based organizations, state or local non-profits, or Indian tribes. At least 20 percent of the grants must be awarded to grantees serving rural or frontier areas. Some of the activities that can be included in the grant are:

- creating healthier school environments,
- developing and promoting programs that advance nutritional, social and emotional wellness;
- prioritizing strategies that will help reduce health disparities, including social, economic and geographic determinants of health; and

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[20] HHS, Pub. Health Serv., Agency for Healthcare Research and Quality, *Fact Sheet: Diabetes Disparities Among Racial and Ethnic Minorities*, (Nov. 2001), http://www.ahrq.gov/research/diabdisp.pdf (last visited July 1, 2011).

[21] *Id.*

[22] ACA § 4201. *See also* NHeLP, *Analysis of the Health Care Reform Law: PPACA and the Reconciliation Act,* http://www.healthlaw.org/images/stories/PPACA_Part_III.pdf (last visited July 1, 2011) (noting that the ACA appropriated $100 million to HHS for state grant funding to support innovative initiatives in Section 4108 that will create incentives for Medicaid enrollees to improve their health and avoid chronic conditions, such as diabetes. While states cannot withhold Medicaid services or eligibility to force enrollees to comply with the initiatives, Section 4108 is silent regarding whether a state could require an enrollee or group of enrollees to participate in an initiative. Similarly, it uncertain whether participants in Section 4201 Community Transformation Grant programs are required to enroll in prevention initiatives).

- assisting special populations including persons with disabilities.

Section 4201 grants can be used by eligible entities to collaborate on specific strategies to address health disparities in their communities, particularly those that impact populations that traditionally have been difficult to identify and reach (e.g., young adults not in college; homeless individuals; lesbian, gay, bisexual and transgender persons; home-bound and frail elderly; or previously incarcerated persons). Grant applications must include an evaluation component with specific outcome measures, which must be reported to the CDC. The CDC also has an obligation to bring the grantees together and provide training in certain areas.

The Community Transformation Grant program is authorized at SSAN for each of FYs 2010 through 2014.

Workforce Development

As the United States has become racially, ethnically, and culturally more diverse, the nation's health care workforce has not kept pace.[23] Having more diverse providers who reflect the racial and ethnic composition of the patient population is essential to building rapport and trust with patients and to improving effective communication and coordination of care with patients, families, and other providers. Minority physicians are also more likely to treat minority patients and practice in poor and underserved areas.[24] There is also a growing need to expand the diversity of the health care workforce as the new health care delivery system moves toward more patient-centered and team-based approaches to health care.

The ACA recognizes that expanding access to quality health care requires creating and maintaining a well-trained workforce. An entire subtitle of the ACA, entitled "Health Care Workforce" (Subtitle E, Title VI, §§ 5001-5701), is devoted to improving "access and the delivery of health care services for all individuals, particularly low income, underserved, uninsured, minority, health disparity, and rural populations."[25]

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[23] Inst. of Med. of the Nat'l Acad., *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, (2004), http://www.iom.edu/Reports/2004/In-the-Nations-Compelling-Interest-Ensuring-Diversity-in-the-Health-Care-Workforce.aspx (last visited July 1, 2011). The representation of many of these groups (e.g., African Americans, Hispanics, and Native Americans) within health professions, … is far below their representation in the general population. Increasing racial and ethnic diversity among health professionals is important because evidence indicates that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students, among many other benefits." *Id*. at 1, Executive Summary (Abstract).

[24] Am. Pub. Health Ass'n, *Public Health Services Act Title VII and Title VIII: Why Are These Programs So Important?* (May 2009) http://www.apha.org/NR/rdonlyres/13E647B5-E51B-4A47-91A8-652EE973A2DB/0/TitleVIIandTitleVIII.pdf (last visited July 1, 2011).

[25] ACA § 5001.

National Health Care Workforce Commission

One workforce provision establishes the National Health Care Workforce Commission (Commission), which is charged with reviewing the health care workforce and projected workforce needs and making recommendations on national health care workforce priorities, including issues affecting special populations, such as medically underserved populations.[26]

The ACA includes numerous initiatives for education and training programs for health professions and others, particularly for those who are willing to work in underserved areas and with health disparities populations. However, many of these programs have discretionary grant funding for only a few fiscal years and/or SSAN, which leaves it up to Congressional appropriators to formalize funding. These include:

- Workforce development grants to support comprehensive health care workforce development strategies at the state and local levels to increase diversity;[27]
- Funding for interdisciplinary, community-based linkages for community-based training programs to increase the number of primary care providers serving in underserved areas and with health disparity populations;[28]
- Training grants for primary care providers and general internists and pediatricians, [29] and general, pediatric and public health dentists,[30] with priority for those programs that provide training about vulnerable populations, chronic disease management, cultural competency and health literacy;
- Funding to colleges to provide mental and behavioral health education and training that addresses the needs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations, and prioritizes cultural and linguistic competency;[31]

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[26] *Id.* § 5101. The Commission can also make recommendations to create or revise national loan repayment programs and scholarship programs to low-income, minority medical students to serve in their home communities if designated as medical underserved communities. *Id.*

[27] *Id.* § 5102; CRS, *Discretionary Funding in the ACA, supra* note 5, at CRS-11. Planning grants received $8 million for FY 2010, and SSAN for each subsequent fiscal year. Implementation grants are authorized for $150 million for FY 2010, and SSAN for each subsequent fiscal year. *Id.*

[28] ACA § 5403 (b) (appropriating $5 million for each FY for FYs 2010 through 2014 and SSAN for each subsequent fiscal year).

[29] ACA § 5301; CRS, *Discretionary Funding in the ACA*, *supra* note 5, at CRS-4 (appropriating for training and capacity grant programs $125 million for FY 2010 and SSAN for each of FY 2011 through FY 2014). Another authorization of $750,000 for each of FY 2010 through FY 2014 is provided for capacity building grants to integrate academic units to improve interdisciplinary recruitment, training, and faculty development. *Id.*

[30] ACA § 5303; CRS, *Discretionary Funding in the ACA*, *supra* note 5, at CRS-5 (appropriating $30 million for FY 2010 and SSAN for each of FY 2011 through FY 2015. Grantees are permitted to carry over funds for up to three fiscal years. *Id.*

[31] ACA § 5306; CRS, *Discretionary Funding in the ACA*, *supra* note 5, at CRS-10 (appropriating $35 million for FY 2010 through FY 2013). The funding is broken down as the following: $8 million for training in social work, $12 million for training in graduate psychology, $10 million for training in

- Program grants that develop, evaluate, and disseminate research, demonstration projects, and model curricula for cultural competency, prevention, and reducing health disparities;[32] and
- Grant programs to promote positive health behaviors and outcomes for populations in medically underserved communities through the use of community health workers, [33] such as the health promoters ("promotores") model, which creates a pool of fluent and knowledgeable bilingual health workers.[34]

Quality Improvement

The ACA includes provisions that seek to improve the quality of health services, including developing a national strategy and an interagency working group, as well as focusing on ways to measure quality. One provision, Section 3013, authorizes $75 million to be appropriated from FY 2010 – FY 2014 for the HHS Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to create national quality measures by assessing factors such as patient outcomes, efficiency of care, equity of services across health disparity populations and geographic areas, and patient satisfaction.[35]

Another quality measurement provision is Section 3015, which could impact communities experiencing a disproportionate burden of chronic health conditions. Section 3015 requires the Secretary of HHS to make performance information on quality measures publically available through websites. The information is to be disaggregated and include available clinical conditions that are provider-specific and meet the needs of patients with different clinical illnesses. Section 3015 also requires the Secretary of HHS to establish and implement an overall strategy for the public reporting of performance information. This provision is authorized for SSAN for FY 2010 through FY 2014.[36]

Other Opportunities for Addressing Disparities in the ACA

Although not statutorily described as addressing health disparities, the ACA includes other provisions that provide opportunities to impact the health of underserved communities. For example, the ACA authorizes new health insurance Exchanges ("Exchanges") which will give states a centralized forum for individuals seeking access to qualified insurance plans.[37] The

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professional child and adolescent mental health, and $5 million for training in paraprofessional child and adolescent mental health. *Id.*

[32] ACA § 5307(a); *id.* § 5307(b); CRS, *Discretionary Funding in the ACA*, *supra* note 5, at CRS-9 (appropriating SSAN for each FY for FYs 2010 through 2015).

[33] ACA § 5313; CRS, *Discretionary Funding in the ACA*, *supra* note 5, at CRS-8 (appropriating SSAN for each FY for FYs 2010 through 2014).

[34] This model has been used by a number of organizations, especially in the Latino community, to recruit, train and nurture recent immigrant women to become health workers and provide valuable health information in their local communities.

[35] ACA § 3013.

[36] *Id.* § 3015; CRS, *Discretionary Funding in the ACA*, *supra* note 5, at CRS-16.

[37] ACA § 1311; s*ee also* §§ 1301-1302 (2010) (including requirements for "qualified health plans").

Exchanges will offer a range of insurance plans with different levels of coverage for purchase by individuals unable to obtain insurance through their employers or other means.[38] As a condition of participation in the Exchanges, health plans should be required to agree to collect and report data that would be useful in addressing health disparities.[39] This requirement could also be applied to those ACA provisions that create new demonstration programs or test novel payment systems (such as Accountable Care Organizations ("ACOs") and medical homes.

Conclusion

Although several provisions are included in the ACA to improve the health status of health disparity populations, this is only a beginning. Hopefully, the ACA's data collection, prevention, work force, and quality improvement provisions will receive the attention and funding they deserve. Other ACA provisions should also be evaluated to determine their potential to address health disparities, particularly through data collection requirements.

Initiatives to prevent chronic illnesses and improve treatment methods among all patients will ultimately improve health status. The health needs of communities of color, the LGBT community, LEP individuals, and other underserved populations will be better served by investing in initiatives that support racial and ethnic health providers and other providers who are culturally and linguistically sensitive to practice in all health care settings.

It is also essential that advocates work with regulatory authorities to help develop quality measurements that strive to capture an accurate image of the health services provided to various communities. A more recent opportunity for such a collaborative effort was proposed in the June 2011 HHS request for public comments on the development of standards for collecting data based on race, ethnicity, sex, primary language, disability status as required in the ACA.[40] Moreover, HHS has also begun to develop standard approaches for collecting data on sexual orientation and gender identity to reduce health disparities.[41] Lastly, all of these provisions must be adequately funded to ensure their successful creation and implementation, in order to appropriately prevent and address health disparities.

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[38] ACA § 1302; (creating guidelines for essential health benefits packages and establishing levels of coverage for silver, bronze, gold and platinum plans).

[39] *See also* NHeLP, *Comments in Response to OCIIO's Request for Comments for Planning and Establishment of State-Level Exchanges Related to Language Access* (Oct. 4, 2010) http://www.healthlaw.org/images/stories/NHeLP_comments_OCCIO_language_access_Oct10.pdf (last visited July 7, 2011).

[40] Notice of Availability of Proposed Data Collection Required by Section 4302 of the Affordable Care Act, 76 Fed. Reg. 38,396 (June 30, 2011).

[41] *Id.* at 38,397.