



EQUITY MEASURES AND SYSTEMS REFORM AS TOOLS FOR REDUCING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

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ABSTRACT: Many health care quality regulators, including officials of the Centers for Medicare and Medicaid Services and other agencies, have embraced systems reform—largely through mandates that require health care providers to implement Quality Assessment and Performance Improvement (QAPI) initiatives. Currently, however, no QAPI requirements stipulate that individual plans or providers measure racial and ethnic disparities. Performance measurements that do not track data by race and ethnicity, the author says, not only miss inequities but are likely to overlook promising techniques for reaching patients of particular racial and ethnic backgrounds. Incorporating equity measures into existing QAPI requirements, the report finds, would not require statutory amendment or new federal regulations. This report provides a template for developing new administrative policies to mandate equity QAPIs and use financial incentives to encourage their adoption.

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CONTENTS

| | |
|---|----|
| About the Author | iv |
| Acknowledgments | iv |
| Executive Summary | v |
| Introduction | 1 |
| Using Systems Reform to Reduce Racial and Ethnic Inequities | 2 |
| Systems Reform Mandates: Quality Assessment and Performance Improvement (QAPI) Regulations | 4 |
| Bringing Equity Measures into QAPI Requirements | 7 |
| Notes | 12 |

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EXECUTIVE SUMMARY

While Medicaid and Medicare have expanded access to health care for poor and minority Americans, these programs have yet to fully address the relatively low quality of care that many receive. Even when minority Americans have similar access to care as others do—utilizing the same health insurance or institutions of care or managed care plans—they often receive significantly fewer services and poorer quality care.

Some of the disparities in health care result from individual provider and patient behavior: prejudice, stereotyping, poor communication, or uncertainty in decision-making. Others are attributable to institutional policies and structures. Whatever the causes, racial disparities in health care call for quality improvement initiatives. In that spirit, this report proposes the pursuit of “systems reform”—the redesign of the underlying systems of care themselves in order to better serve all patients.

Health care quality regulators, such as the Centers for Medicare and Medicaid Services (CMS) and other agencies, have embraced systems reform, largely through mandates that require health care providers to implement Quality Assessment and Performance Improvement (QAPI) initiatives. In these two-part programs, “quality assessment” involves the use of scientifically validated indicators of care, such as vaccination rates, preventive screenings, and medication rates, to measure quality of care. “Performance improvement” refers to the programs’ data-driven interventions that aim to quantifiably adjust those indicators for the better.

Systems reform is a monumental shift from old-style quality oversight, which focused on the negative and blamed individuals for errors. Instead, this new approach is non-punitive, forward-looking, and positive. Acknowledging that “to err is human,” systems reform envisions quality improvement as an organizational responsibility. Its proponents believe that more can be accomplished by raising the mean performance of all caregivers than by merely eliminating the worst-performing caregivers. Furthermore, these proponents assert that quality improvement is an ongoing process of evaluation, design adjustment, reevaluation, and further adjustment, as needed. The aim is not just to reduce errors, but to deliver ever better care.

A systems reform approach to reducing racial and ethnic disparities requires performance data that stratify quality-of-care indicators according to patient race and ethnicity. However, such information does not currently exist. No government agency or

private accreditation body requires it. And while a few providers have begun to report equity measures voluntarily, most do not.

Performance data stratified by race and ethnicity could provide valuable information about the extent and impact of health care disparities. Moreover, this information could indicate which system designs, training modules, and protocols reduce racial and ethnic disparities and which ones fail to do so. Public reporting of equity performance measures would hold providers and institutions accountable to the communities they serve and to those they should be serving.

Yet, even though QAPI requirements for systems reform are becoming widespread, none of them obliges individual health care plans or providers to measure racial and ethnic disparities in the care they provide. Nor do these mandates require the implementation of quality improvement projects directed specifically at reducing or eliminating treatment inequities.

Incorporating equity measures into existing QAPI requirements does not require legislative action, although a congressional mandate would send a strong message about eliminating racial and ethnic disparities in medical care. For Medicaid and Medicare managed care, CMS and the states already have the necessary regulatory authority—they simply need to issue policy mandating equity QAPIs. For hospitals, CMS could use financial incentives, similar to what it has done with hospital reporting of overall performance, to encourage voluntary equity QAPIs. Finally, private accreditation bodies could take the lead in mandating equity QAPIs as part of their voluntary accreditation process.

Existing law, along with modified federal and state agency policies, offers the means to address inequities in health care. QAPI equity performance measures in particular can assess racial disparities in quality of care and help redress them through systems reform initiatives.

EQUITY MEASURES AND SYSTEMS REFORM AS TOOLS FOR REDUCING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

INTRODUCTION

With his deep ebony skin, six-foot-three-inch frame, baritone voice, and enormous hands, Mr. North is treated differently than are my white, middle-class patients. The echocardiography lab sent him home for being 10 minutes late, having had to stop every block to rest on that particularly windy day. The pharmacy refused to refill his insulin syringes without a written prescription, even though he had been getting them for the past two years. When I send him to new consultants, I call ahead and tell them how smart Mr. North is, how compliant [he is] with every aspect of his treatment, and how much he knows about his condition and medications. I want them to see my patient as I see him now, not as I saw him the first time we met. He needs that chance to get the medical care he requires and deserves.—*Neil S. Calman*¹

Race does matter. Mr. North and other minority patients typically do not get the care they require and deserve. Studies show that minorities receive fewer surgical procedures, diagnostic tests, medical services and less optimal technological interventions than do their white peers. For almost every major medical condition, blacks' survival rates are considerably lower than those of whites.²

While Medicaid and Medicare have expanded access to health care for poor and minority Americans, these programs have yet to fully address the relatively low quality of care that racial and ethnic minorities—particularly, poor minorities—receive compared with whites. Even when minority Americans have similar access to care—utilizing the same health insurance, institutions of care, or managed care plans—they receive significantly fewer services and poorer quality care.³

An array of factors contributes to this gap. Certainly, historic patterns of legalized segregation and discrimination play a part and individual provider behavior may be subconsciously influenced by stereotyping, poor communication, and uncertainty in decision-making. In some cases, minority patients may refuse recommended treatments because of distrust and misunderstanding of white caregivers. Institutional policies and structures, such as the lack of interpreter services or minority caregivers, can also play a role.⁴ Whatever the causes, racial disparities in health care call for quality improvement initiatives.

The Institute of Medicine (IOM) and other organizations have recommended a variety of quality improvement strategies to reduce racial and ethnic health care disparities. These approaches include cultural competency initiatives,⁵ evidence-based clinical

guidelines,⁶ financial incentives,⁷ provision of interpreter services, the involvement of community health workers and the use of multidisciplinary teams, and report cards indexed by patient race and ethnicity.⁸ Such quality improvement techniques can be helpful in redressing racial and ethnic disparities, but only if they are appropriately designed and implemented. In that spirit, this report proposes regulators pursue a “systems reform” approach, focusing on redesigning the underlying institutions to achieve higher quality of care for all patients, but particularly targeting the reduction of racial and ethnic disparities.

Quality regulators, including officials of the Centers for Medicare and Medicaid Services (CMS), have embraced systems reform—largely through mandates that require health care providers to implement Quality Assessment and Performance Improvement (QAPI) initiatives. In these two-part programs, “quality assessment” involves the use of scientifically validated indicators of care, such as vaccination rates, preventive screenings, and medication rates, to measure quality of care. “Performance improvement,” meanwhile, refers to the programs’ data-driven interventions that aim to quantifiably improve these indicators. The private National Committee for Quality Assurance (NCQA) was one of the first organizations to impose QAPI requirements as part of its voluntary accreditation process for managed care organizations. Now, the federal government has mandated that managed care plans, hospitals, and others must implement QAPI programs if they wish to receive Medicare and Medicaid payments.

Yet, even though QAPI requirements are now widespread, none requires health plans or providers to measure racial and ethnic disparities in the care they provide. Performance measurements that fail to track data by race and ethnicity not only miss inequities but are likely to overlook promising techniques for reaching patients of particular racial or ethnic backgrounds. Moreover, race-blind performance improvement initiatives may inadvertently exacerbate disparities. Future QAPI mandates should therefore be augmented accordingly.

USING SYSTEMS REFORM TO REDUCE INEQUITIES

Health care has safety and quality problems because it relies on outmoded systems of work. Poor designs set the workforce up to fail, regardless of how hard they try. If we want safer, higher-quality care, we will need to have redesigned systems of care.—*IOM Committee on Quality of Health Care in America*⁹

In a monumental shift from old-style quality oversight, which focused on blaming individuals for errors, systems reform is a non-punitive, forward-looking approach to quality oversight. With the acknowledgment that “to err is human,” it envisions quality

improvement as an organizational responsibility.¹⁰ Advocates argue that more can be accomplished by raising the mean performance of all caregivers than by merely eliminating the worst performers.¹¹ Quality improvement is seen as an ongoing process of evaluation, design adjustment, reevaluation, and further adjustment.¹² The aim is not just to reduce errors but to deliver ever better care.

Systems reform was first adopted by the anesthesiology community and is credited with dramatically increasing surgical patients' safety.¹³ By 1994, its practice had spread widely, with over three-quarters of hospitals reporting the incorporation of this approach into their quality assurance and risk management programs.¹⁴ In 1999, the IOM Committee on Quality of Health Care in America strongly endorsed systems reform as part of its initiative to improve quality of care by reducing medical error.¹⁵ In 2002, another IOM group, the Committee on Assessing the System for Protecting Human Research Participants, recommended systems reform to protect the health and safety of people acting as subjects in research.¹⁶

While systems reform has great appeal for a variety of health care quality improvement purposes, it offers particular promise for reducing racial and ethnic disparities because it offers an alternative—and complementary—approach to civil rights remedies. Historically, civil rights law—specifically, Title VI of the 1964 Civil Rights Act—has provided the legal framework for redressing racial and ethnic disparities in health care, but civil rights litigation focuses on identifying blame. Plaintiffs in civil rights cases must prove that a health care provider either intentionally discriminated or used policies, practices, or procedures that had a statistically significant, adverse impact on minority patients.¹⁷ But disparity issues are complex and may be deeply embedded in providers' actions and patients' decisions, as well as in institutional policies and practices. Given this genesis, many disparities are unlikely to be suitable to the approach required by civil rights laws. The adoption of systems reform, which moves disparity-reduction efforts from the civil rights arena into the world of health care quality regulation, may ease this limitation.

Implementing this kind of approach, however, requires performance data that stratify quality-of-care indicators according to patient race and ethnicity, and such data are generally not available. No government agency or private accreditation body requires this information.¹⁸ And while a few providers have begun to report equity measures voluntarily, most institutions do not.¹⁹

Equity performance data stratified by race and ethnicity could provide valuable information about the extent and impact of health care disparities. This information, when

combined with targeted performance improvement projects, can also indicate which system designs, training, and protocols reduce racial and ethnic disparities and which ones fail to do so. Public reporting of equity performance measures would hold providers and institutions accountable to the communities they serve and to those they should be serving.

In a demonstration project involving 13 Medicaid managed care entities in six states, the plans stratified their Health Plan Employer and Data Information Set (HEDIS) performance measures by race and ethnicity and used this information to design a variety of systems reform interventions—including patient and provider education, reminder systems, and disease management—for reducing racial and ethnic disparities.²⁰ The initial data from these interventions are currently being compiled and released, but the preliminary results were so encouraging that Michigan, one of the states participating in the project, has already expanded the effort to all of its Medicaid managed care entities.²¹

SYSTEMS REFORM MANDATES: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI) REGULATIONS

The legal mechanism for fostering systems reform quality initiatives are QAPI mandates. These public and private initiatives demand performance measurement and targeted, data-driven, system reforms interventions.

In the private sector, for example, NCQA initiated the use of QAPI requirements as part of its voluntary accreditation process for HMOs. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is similarly moving, albeit slowly, to incorporate QAPIs into its accreditation survey process. And the federal government, as the purchaser of health care for Medicare and Medicaid, is imposing a variety of QAPI requirements on providers who wish to participate in these programs.

QAPI efforts are now mandated as a condition of participation in Medicare Advantage plans²² and Medicaid managed care plans.²³ These mandates also apply to hospitals,²⁴ rural health clinics, federally qualified health clinics,²⁵ and religious, nonmedical health care institutions²⁶ that accept Medicaid or Medicare. Some of these new federal QAPI requirements are prompted by specific statutory language; others are the result of administrative rulemaking by the U.S. Department of Health and Human Services (DHHS) pursuant to more general statutory authority.

All QAPI mandates have two components: quality assessment and performance improvement. The quality assessment portion requires health care institutions to measure clinically validated quality of care indicators such as health screenings, diagnostic tests, and

medication rates. The performance improvement component aims to improve performance measures via specific, targeted interventions. Although the details of various public and private QAPI mandates vary, they typically define the performance measurements that must be collected, set goals for performance improvement projects, and specify reporting of both the measurement and improvement activities.

Managed care QAPI requirements tend to rely on performance measures drawn from HEDIS and the Consumer Assessment of Health Plans Survey (CAHPS), a patient satisfaction questionnaire. Both measurement tools were developed by NCQA and are used by the organization for private plan accreditation and by CMS for Medicare Advantage plans.²⁷ For Medicaid managed care, each state identifies its own standardized performance measures: some states use HEDIS measures, while others use HEDIS measures with state-specific modifications or internally developed performance measures.²⁸ All plans are required to report performance measurements and the results of improvement initiatives to the appropriate body—NCQA, CMS, or the state Medicaid agency—which then makes the information available to the public.²⁹

As for hospitals, federal regulations require institutions that accept Medicare or Medicaid payments to “measure, analyze, and track quality indicators” that “assess processes of care, hospital service, and operations” and to conduct regular performance improvement projects and “show measurable improvement in indicators for which there is evidence that [they] will improve health outcomes and identify and reduce medical errors.”³⁰ Because clinically validated, generally accepted hospital performance measures are just emerging, the hospital QAPI does not require reporting of standardized performance data. Instead, CMS encourages voluntary reporting of 10 performance measures by offering a 0.4 percent Medicare payment enhancement to hospitals that do.³¹

These QAPI mandates seek to improve quality through two avenues. First, performance reporting allows purchasers and the public to judge quality. Second, the requirement of specific performance improvement activities forces health care providers to design, implement, and evaluate systems reform initiatives aimed at improving performance measures.

QAPI mandates can thus enhance effectiveness and patient satisfaction. Studies consistently show that managed care plans that publicly report their HEDIS performance data perform better on the indicators of care than plans that do not report.³² Moreover, successful performance improvement projects abound (both for managed care entities and hospitals); reports document specific interventions that improve measures of effectiveness and patient-centered care.³³

These mandates also offer the possibility of using financial incentives to achieve particular performance goals. The Premier Hospital Quality Incentive Demonstration, for instance, awards Medicare bonus payments of 1 percent and 2 percent to hospitals that score in the top 20th and 10th percentiles, respectively, on a voluntary report of 34 quality performance indicators.³⁴ In Rhode Island, Medicaid managed care plans can get enhanced capitation rates by meeting, or making progress toward, 21 specific performance goals that relate to plan administration, access to care, and clinical measures.³⁵

Regrettably, none of the QAPI mandates requires health care providers to measure, report, or engage in systems reform efforts explicitly designed to reduce racial and ethnic health care disparities and improve health care equity. Thus, providers generally do not measure performance in terms of equity indicators—race, ethnicity, class, source of insurance, age, or gender—or engage in performance improvement projects aimed at reducing racial and ethnic health care inequities.³⁶ Similarly, neither HEDIS, CAHPS, nor the voluntary hospital-reporting measures are stratified by race, ethnicity, or socioeconomic class,³⁷ and no other racial and ethnic performance data are routinely collected by accreditation bodies or federal or state regulators.³⁸

Without such equity indicators, QAPI performance measurements are likely to obscure racial and ethnic disparities and confuse the role of socioeconomic status. A health plan or hospital may report excellent overall performance figures even though its performance among particular races and population groups is relatively poor.³⁹ For example, in a recent study (funded by DHHS's Health Resources and Services Administration) of physicians' treatment of lower-back pain in the workers' compensation system, researchers found that although treatment seemed to correlate with physicians' assessment of overall clinical conditions, the data hid significant race-based disparities. These disparities could only be detected when the data were stratified by race.⁴⁰

Additionally, without equity performance measures from individual providers, it is impossible to determine what portion of national and regional treatment disparities are attributable to specific hospitals and managed care plans that have overall poor performance and high enrollments of minority patients.⁴¹

And finally, without equity performance measurements, performance improvement efforts are likely to overlook systems interventions that have a race-specific benefit. Consider a recent RAND-funded study that analyzed a quality improvement intervention to treat depression. It did little to improve outcomes among whites, but resulted in a dramatic 10 to 20 percent improvement among African Americans and

Hispanics.⁴² If the study had not taken equity performance measures into account, this differential impact would have been missed and a promising intervention discarded.

In 2000, Congress attempted to incorporate racial and ethnic equity concerns into the QAPI mandates for Medicare+Choice (now called Medicare Advantage). But while the resulting Medicare Benefits Improvement and Protection Act (BIPA) amended the Social Security Act to require that these QAPI programs “include a separate focus on racial and ethnic minorities,”⁴³ CMS did not add specific equity reporting or performance improvement requirements to the Medicare+Choice QAPI regulations. Instead, the agency merely tacked the statutory language onto the end of the Medicare+Choice QAPI regulations⁴⁴ and did little to implement BIPA’s equity mandate⁴⁵—which in any case was repealed by the Medicare Modernization Act of 2003.

CMS took only one specific action to implement BIPA’s statutory mandate: in 2003, Medicare+Choice plans were required to develop a performance improvement project designed either to increase access to culturally and linguistically appropriate services (CLAS) or to decrease racial and ethnic disparities for diabetes, pneumonia, congestive heart failure, or mammography.⁴⁶ CMS provided technical support to plans opting for CLAS initiatives, but provided no technical assistance for disparities projects.⁴⁷ It is unclear how many Medicare+Choice plans opted to measure racial disparities and implement a performance improvement project.

Meanwhile, from 2002 until the repeal of BIPA’s statutory mandate, CMS took no further steps to incorporate race and ethnicity equity measures into ongoing QAPI programs or to require other equity-focused performance initiatives. The first data on the 2003 projects are due in 2005,⁴⁸ but it is unclear—given the repeal of BIPA’s “separate focus” language—whether any data will be forthcoming.

BRINGING EQUITY MEASURES INTO QAPI REQUIREMENTS

QAPI mandates should require racial and ethnic performance measures, along with performance improvement initiatives specifically designed to reduce disparities and increase the quality of care for minority patients. This objective need not involve draconian action, however. Incorporating equity measures into QAPI requirements is consistent with existing statutory and regulatory authority, and it is administratively and economically feasible as well.

Hospital and managed care entities already have QAPI infrastructures in place, as well as data about patient race and ethnicity. Seventy-eight percent of hospitals report that

they already collect race and ethnicity information from patients,⁴⁹ and studies show that Medicaid and commercial managed care plans can incorporate equity measures into their HEDIS and CAHPS databases.⁵⁰ Aetna, for example, has stratified its HEDIS and CAHPS data by race and ethnicity since 1999,⁵¹ and Medicare Advantage plans could do so by tapping their monthly membership reports.⁵² More generally, a growing body of literature explains how best to capture race and ethnicity data that are accurate and responsive to local community needs.⁵³

Adding equity QAPI requirements will result in incremental costs but not substantial financial outlays. The Michigan Medicaid managed care demonstration project found that initiating equity QAPI programs required only relatively minor financial cost⁵⁴ that did not deter progress. Aetna, Prudential, and UnitedHealth Group have already undertaken equity PI initiatives,⁵⁵ and 22 percent of hospitals report that they are now incorporating some equity measures into their internal QAPI programs.⁵⁶

Congressional Action

A policy agenda promoting equity QAPI mandates does not require statutory changes to federal law. CMS, state Medicaid agencies, and private accreditation bodies all have sufficient authority to mandate racial and ethnic performance measures and performance improvement initiatives. Progress, however, has been slow, and there has been a lack of leadership at the federal level.

Congress could send an unequivocal message by amending the Social Security Act to require equity QAPIs for Medicare Advantage plans, Medicaid managed care, and hospitals that accept Medicaid and Medicare payments. This kind of forceful action, while not strictly necessary, would jumpstart equity QAPIs.

Alternatively, Congress could employ financial incentives, similar to those used for hospital performance reporting, to encourage the use of equity QAPIs. For example, lawmakers could authorize a Medicare or Medicaid reimbursement bonus to providers who voluntarily report equity measures and undertake equity performance projects.

To amend the various sections of the Social Security Act mandating QAPI program, Congress should add the following provisions:

- Performance data must be stratified by race, ethnicity, primary language and socioeconomic class, course of insurance, gender, and other relevant personal characteristics.

- Performance improvement projects must address racial and ethnic disparities in care.

States: Medicaid Managed Care Contracts

States currently have sufficient authority to require Medicaid managed care plans to establish QAPIs aimed at achieving racial and ethnic equity. Federal regulations require that states specify Medicaid managed care performance measures and review the results of performance improvement projects.⁵⁷

State need not wait for federal action. To mandate equity QAPIs for Medicaid managed care plans, states should include the following language in their Medicaid managed care contracts:

- Performance data, as specified in this contract, must be stratified by race, ethnicity, primary language, income status, gender, and age.
- At least one performance improvement project conducted each year must address racial and ethnic disparities in health care.

CMS: Medicaid Managed Care

Existing federal regulations give CMS sufficient authority to force states to act. The Medicaid managed care QAPI regulations state that CMS “may specify performance measures and topics for performance-improvement projects.”⁵⁸

All CMS need do, therefore, is issue policy guidance to state Medicaid directors requiring the following:

- Standardized performance data must be stratified by race, ethnicity, primary language, socioeconomic class, gender, and age.
- At least one performance improvement project conducted each year must address racial and ethnic disparities in health care.

CMS: Medicare Advantage Plans

The Medicare Advantage QAPI regulations provide that plans must measure performance “using measurement tools required by CMS.”⁵⁹ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) specifically limits CMS’s collection of quality, outcome, and satisfaction information to the “types of data that were collected by the Secretary as of November 1, 2003” and allows CMS to alter this data collection

only after consulting with plans and accreditation bodies and submitting a report to Congress.⁶⁰ However, CMS interprets the MMA as allowing it to use current HEDIS and CAHPS measurement systems and to “add, delete, or modify measures” within these systems.⁶¹ Thus, CMS’s interpretation of the MMA allows the agency sufficient authority to require Medicare Advantage plans to submit HEDIS and CAHPS measures stratified by race and ethnicity.

To mandate equity QAPIs, CMS should revise the QAPI provisions of its Medicare Managed Care Manual to include the following requirements:

- Performance data must be stratified by race, ethnicity, primary language and socioeconomic status, source of insurance, gender, and other relevant personal characteristics.
- Performance improvement projects must address racial and ethnic disparities in health care.

CMS: Hospitals Participating in Medicare and Medicaid

While CMS has sufficient statutory authority to require Medicare and Medicaid participating hospitals to track equity measures and implement equity performance improvement projects, the present federal regulations do not give CMS authority to mandate equity QAPIs. Hospital QAPI regulations require that hospital-based programs be data-driven and focus on indicators related to decreasing medical errors, increasing patient safety, and improving health outcomes. Details about the data sets and the performance improvement priorities are left to the discretion of individual hospitals.⁶²

In 2003, when CMS promoted the current QAPI regulations, the agency deliberately did not grant itself regulatory authority to specify QAPI performance measurements for hospitals. At that time, a number of collaborative projects were under way to develop standardized hospital reporting measures, and CMS concluded it was inappropriate to either specify performance measures or give the agency authority to issue standardized measurements without an opportunity for public input. CMS specifically left to future regulatory rulemaking agency authority to specify performance reporting or improvement projects.⁶³

Since that time and pursuant to specific provisions of the MMA, CMS has implemented financial incentives for voluntary hospital reporting of a standardized set of 10 performance measures developed by a private–public collaborative. In addition, CMS has initiated the Premier Hospital Quality Incentive Demonstration, another voluntary

program that offers financial rewards to top-performing hospitals, as well as poorly performing hospitals that show improvement on 34 measurements.

Although CMS does not now have the regulatory authority to mandate equity QAPIS, a policy agenda for hospital equity QAPIS could piggyback onto CMS's two voluntary performance reporting initiatives. CMS could initiate equity reporting by requiring that all voluntarily reported hospital performance data be stratified by race, ethnicity, primary language, source of insurance, and socioeconomic status, as well as gender and age.

Accreditation Bodies

Finally, private accreditation bodies—particularly the NCQA, which helped initiate QAPIS—could mandate equity QAPIS as part of their accreditation processes. Such private policy initiatives would help build the consensus needed to move government initiatives along.

Existing law, along with modified agency policies, offers the means to address inequities in health care. QAPI equity performance measures in particular can assess racial disparities in quality of care and help redress them through systems reform initiatives.

NOTES

¹ Neil S. Calman, “Out of the Shadow,” *Health Affairs* 19 (2000): 170–174.

² Brian D. Smedley et al., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care (Washington D.C.: National Academies Press, 2003): 2–6.

³ Ibid.

⁴ Ibid.

⁵ See, for example, Joseph R. Betancourt, “Cross-Cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation,” *Academic Medicine* 78 (June 2003): 560–569; and Joseph R. Betancourt et al., *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches* (New York: The Commonwealth Fund, October 2002). See also Somnath Saha et al., “Patient–Physician Relationships and Racial Disparities in the Quality of Health Care,” *American Journal of Public Health* 93 (October 2003): 1713–1719.

⁶ Council on Ethical and Judicial Affairs, “Black–White Disparities in Health Care,” *Journal of the American Medical Association* 263 (May 2, 1990): 2344–2346; Kevin Fiscella et al., “Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care,” *Journal of the American Medical Association* 283 (May 17, 2000): 2579–2584.

⁷ Sidney D. Watson, “Race, Ethnicity and Quality of Care: Inequalities and Incentives,” *American Journal of Law & Medicine* 27 (2001): 203–224.

⁸ David Barton Smith, “Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards,” *Journal of Health Politics, Policy and Law* 23 (February 1998): 75–105.

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¹¹ Donald M. Berwick, “Continuous Improvement as an Ideal in Health Care,” *New England Journal of Medicine* 320 (January 5, 1989): 53–56.

¹² Jost, “Oversight of the Quality,” 839; Berwick, “Continuous Improvement,” 54. For an explanation of the impact of human-factors research on safety and error reduction, see Lucian L. Leape, “Error in Medicine,” *Journal of the American Medical Association* 272 (December 21, 1994): 1851–1857.

¹³ Leape, “Error in Medicine,” 1855. Anesthesiology adopted a systems approach to error reduction and over a 10-year period mortality rates declined from one in 10,000 to 20,000 to only one in 200,000. Ibid.

¹⁴ See Barry R. Furrow et al. (eds.), *Health Law* (Eagan, Minn.: West Group, 2001), 28 (citing Linda Oberman, “Quality Quandary: Little Clinical Impact Yet,” *American Medical News* 37 (April 25, 1994): 3. (Two-thirds of hospitals surveyed were adopting a total-quality-management or continuous quality improvement systems approach.)).

¹⁵ Kohn et al., *To Err Is Human*, 1999, 1–5.

¹⁶ Daniel D. Federman et al. (eds.), *Responsible Research: A Systems Approach to Protecting Research Participants* (Washington, D.C.: National Academies Press, 2002).

¹⁷ See Watson, “Race, Ethnicity, and Quality of Care,” 217–220. See also Sidney D. Watson, “Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn’t Be So Easy,” *Fordham Law Review* 58 (1990): 964–971.

¹⁸ David Barton Smith, *Eliminating Disparities in Treatment and the Struggle to End Segregation* (New York: The Commonwealth Fund, 2005).

¹⁹ See, for example, Aetna, “Working Toward Our Goal: Eliminating Racial and Ethnic Disparities in Health Care,” Task Force Report (Spring 2004).

²⁰ David R. Nerenz and Debra Darling, “Addressing Racial and Ethnic Disparities in the Context of Medicaid Managed Care: A Six-State Demonstration Project,” presented May 2004 at the Unequal Treatment in Healthcare Roundtable, Harvard Civil Rights Project.

²¹ *Ibid.*

²² 42 U.S.C. 1395w-22(e); 42 C.F.R. §422.152 (2005). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 changed the name of private Medicare managed care plans from Medicare+Choice to Medicare Advantage.

²³ 42 U.S.C. 1396u-2(c); 42 C.F.R. § 438.240 (2003).

²⁴ 42 C.F.R. § 482.21 (2003).

²⁵ 68 Fed. Reg. 74792, 74794 (Dec. 24, 2003) (to be codified at 42 C.F.R. pt. 491.11).

²⁶ 42 C.F.R. § 403.732 (2003).

²⁷ *Medicare Managed Care Manual*, Chapter 5, section 40.1, available at http://www.cms.hhs.gov/manuals/116_mmc/mc86c05.pdf. Medicare Advantage plans use a subset of the HEDIS measures relevant to the Medicare population.

²⁸ 42 C.F.R. 438.240©(2003); see, Lee Partridge and Carrie Ingalls Szlyk, *National Medicaid HEDIS Database/Benchmark Project: Pilot-Year Experience and Benchmark Results* (New York: The Commonwealth Fund, February 2000). Some states have health plans calculate the measures and then report them; other states calculate the measures themselves using plan-submitted encounter data and medical-chart reviews. *Ibid.*

²⁹ 42 C.F.R. 422.152(b)(3)(i) and (d)(5)(Medicare Advantage); 42 C.F.R. 438.240 (Medicaid).

³⁰ 42 C.F.R. § 482.21(a)(1) (2003).

³¹ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 510(b), 42 U.S.C. 1395(b). See <http://www.hhs.gov/news/press/2003pres/20030710.html>. See also <http://www.cms.hhs.gov/quality/hospital/premierfactsheet.pdf> (last visited Aug. 4, 2004).

³² Joseph W. Thompson et al., “[Health Plan Quality-of-Care Information Is Undermined by Voluntary Reporting](#),” *American Journal of Preventive Medicine* 24 (January 2003): 62–70. See also National Committee for Quality Assurance, *The State of Health Care Quality: 2003* (Washington, D.C.: NCQA, 2003), 12.

³³ See, for example, Medicare Quality Improvement Community, “Surgical Infection-Prevention Intervention Tools,” available at <http://www.medqic.org/content/nationalpriorities/topics/interventionTools/interventionToolsList.jsp?topicID=461> (last visited Aug. 04, 2004). See also National Committee for Quality Assurance, “Quality Profiles,” available at <http://www.qualityprofiles.org>.

³⁴ See Centers for Medicare and Medicaid Services Fact Sheet, “The Premier Hospital Quality-Incentive Demonstration: Rewarding Superior Quality Care” (February 18, 2004), available at <http://www.cms.hhs.gov/quality/hospital/PremierFactSheet.pdf> (last visited Aug. 04, 2004). See also Centers for Medicare and Medicaid Services, “The Premier Hospital Quality-Incentive Demonstration: Clinical Conditions and Measures for Reporting,” available at <http://www.cms.hhs.gov/quality/hospital/PremierMeasures.pdf> (last visited Aug. 04, 2004).

³⁵ Sharon Silow-Carroll, *Building Quality into RItE Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations* (New York: The Commonwealth Fund, January 2003), 8–13.

³⁶ The only equity measure presently tracked is geographic location. One of the impetuses for adopting QAPIs was to move toward clinically validated performance standards and away from local practice patterns that were not evidence-based.

³⁷ Smith, “Addressing Racial Inequities.”

³⁸ U.S. Department of Health and Human Services, Office of Minority Health, “Assessment of State Laws, Regulations, and Practices Affecting the Collection and Reporting of Racial and Ethnic Data by Health Insurers and Managed Care Plans” (Washington, D.C.: OMH, 2003), available at <http://www.omhrc.gov/omh/sidebar/datastats13.htm>.

³⁹ See Eric C. Schneider et al., “[Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care](#),” *Journal of the American Medical Association* 287 (March 13, 2002): 1288–1294.

⁴⁰ See Raymond C. Tait et al., “Management of Occupational Back Injuries: Differences Among African Americans and Caucasians,” *Pain* 112 (2004) 389–396.

⁴¹ Schneider et al., “Racial Disparities,” 2002. Racial disparity in HEDIS measures was partly explained by the disproportionate enrollments of African Americans in lower-performing health plans. For example, substantial parts of the racial disparities in diabetic eye exams, beta blockers, and mental illness were explained by different quality of care for African Americans and whites within health plans. *Ibid.*

⁴² Kenneth D. Wells et al., “Five-Year Impact of Quality Improvement for Depression: Results of a Group-Level Randomized Controlled Trial,” *Archives of General Psychiatry* 61 (April 2004): 378–386.

⁴³ HR 5661 § 616(b)(5)(b), 106th Cong., 2d sess. (2000), codified at 42 U.S.C. 1395w-222(e).

⁴⁴ See 42 C.F. R. § 422.152(f)(4) (2003).

⁴⁵ See Tim Jost, Racial and Ethnic Disparities in Medicare: What the Department of Health and Human Services and the Centers for Medicare and Medicaid Services, Can, and Should, Do, National Academy of Social Insurance Study Panel on Sharpening Medicare’s Tools to Reduce Racial and Ethnic Disparities (2005).

⁴⁶ Medicare Managed Care Manual, Chapter 5, section 20.3.3.1.

⁴⁷ Centers for Medicare and Medicaid Services, “The Medicare Advantage Organization National QAPI Project for 2003,” at <http://www.cms.hhs.gov/healthplans/quality/project03.asp>.

⁴⁸ *Medicare Managed Care Manual*, Chapter 5, Appendix A, available at http://www.cms.hhs.gov/manuals/116_mmc/mc86c05.pdf. CMS specified that the project could involve any, all, or a subset of the following populations: American Indian/Alaskan Native; Asian; Black/African American; Native Hawaiian/Pacific Islander, and Hispanic/Latino. The PI project had to demonstrate improvement in performance indicators for the selected population(s). The Medicare+Choice plan could measure the disparity between a given minority group and the

overall enrolled population, but the project did not have to show a reduction in disparities between groups. Ibid.

⁴⁹ Romana Hasnain-Wynia et al., [*Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals*](#) (New York: The Commonwealth Fund, May 2004).

⁵⁰ See Nerenz and Darling, “Addressing Racial and Ethnic Disparities.”

⁵¹ Aetna, “Working Toward Our Goal.”

⁵² *Medicare Managed Care Manual*, Chapter 5, Appendix A.

⁵³ See, for example, Arlene S. Bierman et al., “Addressing Racial and Ethnic Barriers to Effective Health Care: The Need for Better Data,” *Health Affairs* 21 (May/June 2002): 91–102.

⁵⁴ See Nerenz and Darling, “Addressing Racial and Ethnic Disparities.”

⁵⁵ Bierman et al., “Addressing Racial and Ethnic Barriers,” 92; Aetna, “Working Toward Our Goal.”

⁵⁶ Hasnain-Wynia et al., *Who, When, and How*.

⁵⁷ See, 42 C.F.R. § 438.240(a)(2) and (e)(2003).

⁵⁸ 42 C.F.R. § 438.240 (2003).

⁵⁹ 42 C.F.R. 422.152(b)(3)(i).

⁶⁰ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, HR 1-282, section 722(a)(3)(B).

⁶¹ 69 Fed. Reg. 46866, at 46886 (Aug. 3, 2004).

⁶² See 42 C.F.R. § 482.21 (2003).

⁶³ 68 Fed. Reg. 3435, at 3448 (Jan. 24, 2003).

RELATED PUBLICATIONS

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[*Limited English Proficiency, Primary Language at Home, and Disparities in Children's Health Care: How Language Barriers Are Measured Matters*](#) (July/August 2005). Glenn Flores, Milagros Abreu, and Sandra C. Tomany-Korman. *Public Health Reports*, vol. 120, no. 4. In this article, the authors' analysis shows that, even when factoring in multiple variables, parents with limited English proficiency are three times more likely than parents who report speaking English very well to have a child in fair or poor health.

[*Caring for Patients with Diabetes in Safety Net Hospitals and Health Systems*](#) (June 2005). Marsha Regenstein, Jennifer Huang, Linda Cummings, Daniel Lessler, Brendan Reilly, and Dean Schillinger. According to this report's authors, "safety net hospitals," those public institutions that care for a large volume of underserved Americans, provide care to patients with diabetes that is generally as good as the national average.

[*Providing Language Services in Small Health Care Provider Settings: Examples from the Field*](#) (April 2005). Mara Youdelman and Jane Perkins, National Health Law Program. Community health centers and small physician practices can have a particularly difficult time effectively serving patients with limited English proficiency. The authors show how a number of solo practitioners, small group practices, and clinics around the country have found creative methods for meeting the needs of these patients.

[*Cultural Competence and Health Care Disparities: Key Perspectives and Trends*](#) (March/April 2005). Joseph R. Betancourt, Alexander R. Green, J. Emilio Carrillo, and Elyse R. Park. *Health Affairs*, vol. 24, no. 2 (*In the Literature* summary). The authors report that culturally competent health care—broadly defined as services that are respectful of and responsive to the cultural and linguistic needs of patients—is gaining attention not only as a strategy to reduce racial and ethnic disparities, but as a means of improving health care quality. Cultural competence initiatives may even help control costs by making care more efficient and effective.

[*Creating a State Minority Health Policy Report Card*](#) (March/April 2005). Amal Trivedi et al. *Health Affairs*, vol. 24, no. 2 (*In the Literature* summary). In the first "report card" to evaluate all 50 states on their progress in addressing disparities in minority health care, the authors found region of the country to be a significant predictor of performance, with high- and low-performing states tending to cluster geographically.

[*Quality Report Cards, Selection of Cardiac Surgeons, and Racial Disparities: A Study of the Publication of the New York State Cardiac Surgery Reports*](#) (Winter 2004–05). Dana Mukamel et al. *Inquiry*, vol. 41, no. 4 (*In the Literature* summary). According to the authors, quality report cards can work to level

the playing field for minorities by improving their ability to see high-quality health providers, in addition to helping consumers make informed health care choices.

[*Addressing Unequal Treatment: Disparities in Health Care*](#) (November 2004). Gillian K. SteelFisher. Prepared for the 2004 Commonwealth Fund/John F. Kennedy School of Government Bipartisan Congressional Health Policy Conference, this issue brief reports that health care services in the U.S. have been improving for decades, but in many instances, racial and ethnic minorities receive fewer health care services, lower quality services, and services later in the progression of illness.

[*Policies to Reduce Racial and Ethnic Disparities in Child Health and Health Care*](#) (September/October 2004). Anne C. Beal. *Health Affairs*, vol. 23, no. 5 (*In the Literature* summary). The author argues that while a variety of public and private sector programs are taking on the issue of disparities in health care, better coordination and monitoring at the federal level is needed to maximize their effectiveness.

[*R-E-S-P-E-C-T: Patient Reports of Disrespect in the Health Care Setting and Its Impact on Care*](#) (September 2004). Janice Blanchard and Nicole Lurie. *Journal of Family Practice*, vol. 53, no. 9 (*In the Literature* summary). The authors find that minorities are significantly more likely than whites to report being treated with disrespect or being looked down upon in patient-provider relationships.

[*A Review of the Quality of Health Care for American Indians and Alaska Natives*](#) (September 2004). Yvette Roubideaux. The author documents health care disparities for American Indians and Alaska Natives (AIANs) and reports on progress made in the last five years to reduce or eliminate gaps in care. In examining the demographics of this group, she notes in particular a substantial urban AIAN population that is both understudied and which may be underserved by the traditional AIAN health care infrastructure.

[*Child Health Disparities: Framing a Research Agenda*](#) (July/August 2004). Ivor B. Horn and Anne C. Beal. *Ambulatory Pediatrics*, vol. 4, no. 4 (*In the Literature* summary). In this article, the authors set forth a research framework for identifying racial disparities in children's health, determining their root causes, and developing effective interventions. They emphasize preventive care, culture, and language, and the social determinants of health, including housing, nutrition, and stress factors prevalent in low-income communities.

[*A State Policy Agenda to Eliminate Racial and Ethnic Health Disparities*](#) (June 2004). John E. McDonough, Brian K. Gibbs, Janet L. Scott-Harris, Karl Kronebusch, Amanda M. Navarro, and Kimá Taylor. The authors of this report detail a wide range of state initiatives to reduce racial and ethnic disparities in health and health care, along with practical strategies for improving insurance coverage, access to care, and medical outcomes for minority Americans.

[*Who, When, and How: The Current State of Race, Ethnicity, and Primary Language Data Collection in Hospitals*](#) (May 2004). Romana Hasnain-Wynia, Debra Pierce, and Mary A. Pittman. The authors of this study find that, although the majority of hospitals are now collecting information on patients' race, ethnicity, and primary language, many say there are drawbacks, including problems with accuracy and confidentiality. The authors recommend standardizing the data collection process—relying on patients to provide information and giving them a uniform rationale for doing so.

