Congress of the United States
House of Representatives
Washington, D.C. 20515

June 24, 2002

The Honorable Tommy G. Thompson
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Thompson:

On March 20, 2002, the Institute of Medicine (IOM) released a landmark report entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.*[1] Among other key findings, the report documented that minorities in the United States receive fewer life-prolonging cardiac medications and surgeries, are less likely to receive dialysis and kidney transplants, and are less likely to receive adequate treatment for pain. The report included a series of recommendations for policy changes to eliminate these unacceptable disparities.

We are writing to bring to your attention major policy changes that have either recently been adopted or are pending within HHS that directly contradict six recommendations of this landmark report. These changes have already undermined patient rights for millions of low-income minorities and other disadvantaged Americans in the Medicaid program, threaten to compromise innovative programs to reduce health disparities run by the Agency for Healthcare Research and Quality (AHRQ), and aim virtually to eliminate government support for increasing the number of disadvantaged and minority health care professionals. By so directly undermining the Institute of Medecine's recommendations, the Department's plans in these areas risk increasing health disparities in the United States.

We urge you to stop these ill-advised policies. The remainder of this letter explains our concerns in more detail.

Medicaid Managed Care Rule

On January 19, 2001, the previous Administration published a final rule to provide patient protections within the Medicaid program.[2] After President Bush took office, this rule's

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[1]Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (March 2002).

[2]66 Federal Register 6228-6426 (Jan. 19, 2001).

implementation was delayed several times before being postponed on August 17, 2001.[3] In its place, the Centers for Medicare & Medicaid Services (CMS) proposed[4] and then, on June 14, 2002, finalized[5] a substantially weaker substitute. The changes to this rule run counter to at least four recommendations in the IOM report.

First, the IOM report recommended that the government should "apply the same managed care protections to publicly funded HMO enrollees that apply to private HMO enrollees" (Recommendation 5-4). The protections in the recently implemented Medicaid managed care rule, however, are substantially weaker in key areas than managed care protections for privately insured patients supported by the Administration. The Administration's views on appropriate protections for privately insured patients are embodied in H.R. 2563, the "Patient Bill of Rights" legislation that passed the House last year and was supported by President Bush. Key provisions included in H.R. 2563 do not apply to Medicaid patients under the managed care rule.[6] For example, H.R. 2563 requires health plans to make emergency medical authorizations within "72 hours."[7] The previous Administration's managed care standard also required that Medicaid plans make such emergency decisions within "72 hours."[8] However, the rule just adopted by CMS changes this standard for Medicaid patients to "3 working days."[9] In other words, the weekend now does not count when emergency decisions are being made for Medicaid patients.

Second, the IOM report recommended that the government should "strengthen the stability of patient-provider relationships in publicly funded health plans" (Recommendation 5-

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[3]66 Federal Register 43090-43091 (Aug. 17, 2001).

[4]66 Federal Register 43614-43677 (Aug. 20, 2001).

[5]67 Federal Register 40988-41116 (Jun. 14, 2002).

[6]Henry A. Waxman and John D. Dingell, *Comments on the Medicaid Managed Care Rule* (Oct. 19, 2001) (on line at http://www.house.gov/reform/min/inves_medi/index.htm).

[7]H.R. 2563, section 103(b)(3)(B).

[8]January 2001 final rule, section 438.210(e).

[9]June 2002 final rule, section 438.210(d)(2).

2).[10] Contrary to this recommendation, however, the Medicaid managed care rule requires some pregnant women and other Medicaid patients to find new doctors within just 60 days if their doctors do not join a managed care network.[11] By contrast, in H.R. 2563, which the President supports for privately insured patients, pregnant women can stay with their doctors who drop out of their managed care networks until the conclusion of postpartum care.[12] This double standard risks increased disparities in birth outcomes.

Third, the IOM report recommended that government programs should "avoid fragmentation of health plans along socioeconomic lines" (Recommendation 5-1).[13] The report explained this recommendation by stating that "public healthcare payors such as Medicaid should strive to help beneficiaries access the same health products as privately insured patients."[14] Contrary to this recommendation, however, the managed care rule dropped a provision that would prohibit discrimination against Medicaid enrollees.[15]

Fourth, the IOM report recommended programs to "integrate cross-cultural education into the training of all current and future health professionals" (Recommendation 6-1).[16] The basis of this recommendation was the IOM's finding that cultural competence is essential for clinicians to be able to connect with patients of different races and ethnicities. To support these skills, the previous Administration's managed care rules would have required health plans to assist physicians in delivering culturally competent care.[17] This requirement has been eliminated from

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[10]Institute of Medicine, *supra* note 1, at 146.

[11]June 2002 final rule, section 438.52(b)(2)(ii)(B)(*2*).

[12]H.R. 2563, Section 117(b)(4).

[13]Institute of Medicine, *supra* note 1, at 145.

[14]*Id.*

[15]June 2002 final rule, section 438.206.

[16]Institute of Medicine, *supra* note 1, at 168.

[17]January 2001 final rule, section 438.206(e)(2).

the managed care rule finalized on June 14.[18] In its place is a provision requiring plans to participate in state cultural competency efforts. However, because states are not required to have any cultural competency initiatives, this provision accomplishes little.

AHRQ Funding

At a hearing before the Criminal Justice Subcommittee of the Government Reform Committee on May 21, 2002, acting AHRQ director Dr. Carolyn Clancy described the initiatives undertaken by her agency to attack health disparities. One of the most important of these is the EXCEED program, which funds centers of excellence to eliminate health disparities in nine cities around the country. These include efforts to address diabetes care for Native Americans, disparities in cancer rates among rural African American adults, and premature birth in ethnically diverse communities in Harlem, New York. According to Dr. Clancy, "EXCEED encouraged the formation of new research relationships as well as building on existing partnerships between researchers, professional organizations, and community-based organizations instrumental in helping to influence change in local communities."[19]

The EXCEED program exemplifies the type of initiative recommended by the IOM report, which urged "further research to identify sources of racial and ethnic disparities and assess promising intervention strategies" (Recommendation 8-1).[20] Yet the Administration's 2003 budget would curtail these efforts. In the budget, total AHRQ funding falls from $300 million in 2002 to $251 million in 2003. About $192 million of the AHRQ budget is protected from the cutbacks, meaning that $49 million must be trimmed from the remaining $108 million of spending, a 46% cut. Key parts of the EXCEED program and other research grants to study and reduce health disparities fall into this vulnerable $108 million.

According to Dr. Clancy's testimony, because some of EXCEED's funding comes from other agencies, the net effect of the President's budget on the EXCEED program would be a cut of approximately 25%. This loss of funding would threaten years of work building up the clinical infrastructure around the country to develop programs to fight disparities and discourage institutions from entering the field in the first place.

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[18]June 2002 final rule, section 438.206(c)(2).

[19]Dr. Carolyn Clancy, Testimony before the Subcommittee on Criminal Justice, Drug Policy, and Human Resources, Committee on Government Reform (May 21, 2002).

[20]Institute of Medicine, *supra* note 1, at 190.

Initiatives for Health Professionals

Because diversity in the health professions offers numerous benefits, the IOM report called for efforts to "increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals" (Recommendation 5-3). Such efforts were supported by HHS in the past, but now are threatened with extinction.

The spring 1999 issue of the HHS Office of Minority Health's newsletter *Closing the Gaps* focused on the theme of "Putting the Right People in the Right Places." The newsletter highlighted the startling underrepresentation of ethnic and minority groups within the health professions and stressed the important role of three programs: (1) the Health Careers Opportunity Program, which trains more than 6,000 high school and undergraduate students each year and is associated with acceptance rates to health professional schools that are 20% higher than the national average; (2) the Minority Faculty Fellowships Program, which addresses the problem that "just four percent of faculty at U.S. health profession schools are minorities"; and (3) the Centers of Excellence Program, which works with Historically Black Colleges and Universities and Hispanic Serving Health Professions Schools to "recruit and retain minority faculty and students, carry out research specific to racial and ethnic minorities, provide culturally appropriate clinical education, and develop curricula and information resources that respond to the needs of minorities."[21]

Unfortunately, the very same programs highlighted by HHS in 1999 as successful have disappeared from the President's 2003 budget. The Health Careers Opportunity Program, funded at $34.7 million in 2002, receives $0 in the President's 2003 budget. The Minority Faculty Fellowships Program, funded at $1.3 million in 2002, is also targeted for extinction by the Administration. The Centers of Excellence Program, currently funded at $32.6 million in 2002, is scheduled for elimination by HHS. The President's budget would also cut scholarships for disadvantaged students from $46.2 million to $10 million.

The Administration's budget request justifies these cutbacks by arguing that the programs did not meet the goal of placing physicians in underserved areas. In fact, while many physicians trained by this program do work in underserved areas, this is not the only goal of these programs. The IOM report makes abundantly clear that disparities in health care exist throughout the medical system, not just in access to primary care. Diversity among other types of physicians, such as transplant physicians and cardiovascular surgeons, is also important.

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[21]Claude Earl Fox, *HRSA [Health Resources and Services Administration] Opens Doors for Minorities in Health Professions*, Closing the Gaps, 2 (May-June 1999).

We recognize that the Administration has proposed sizable increases in the Community Health Center program and the National Health Service Corps, which trains physicians to work in underserved areas. However, these programs -- while serving an essential role -- are not intended to encourage disadvantaged and minority youth to seek careers in medicine. It is shortsighted to abandon efforts to encourage these youth to enter medical careers. Attention must be paid both to increasing the numbers of disadvantaged and minority medical students and to increasing access to primary care services in underserved communities. For all the reasons documented by the IOM's report, these should not be competing priorities.

Conclusion

Unequal Treatment is both an indictment of our health care system and a challenge for the medical profession and government to do better -- much better -- in order to have any chance of reaching the *Healthy People 2010* goal of eliminating health disparities. In July, you are planning to host the first Secretary's National Leadership Summit for Eliminating Racial and Ethnic Disparities in Health. This gathering has the potential to be a catalyst for renewed efforts to promote justice in health care. However, your commitment will be measured ultimately not in the number of meetings you hold, but rather in the quality of the policies you implement and the vigor with which you support them.

In advance of this summit, we urge you to halt your agency's plans to undermine the Institute of Medicine's recommendations. Specifically, we ask that you instruct CMS to strengthen the Medicaid managed care rule so that it does not exacerbate health disparities. We also ask that you submit a revised budget request with full funding for AHRQ and significant increases for federal programs to promote diversity in medicine. Your actions will demonstrate the level of your commitment to ending the unacceptable racial and ethnic disparities in healthcare found by IOM.

We respectfully request a reply to this letter by July 8, 2002.

Sincerely,

Henry A. Waxman
Ranking Minority Member
Committee on Government Reform

Elijah E. Cummings
Ranking Minority Member
Subcommittee on Criminal Justice, Drug Policy and Human Resources
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