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Healthcare Discrimination in New Orleans, Louisiana, and Nationwide

A Case Study of Dually Eligible People with Medicare and Medicaid

How Government Policy Decreases Access to Health Care and
Violates Civil Rights of Elderly and Disabled
African Americans in New Orleans
And Five Million People Across the United States

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Executive Summary

Louisiana healthcare policy discriminates against 108,000 of the oldest, poorest, sickest, and most disabled people in the state. These are dually eligible people. They are low-income Medicare beneficiaries who also have Medicaid.

The Congressional Balanced Budget Act of 1997 allowed states to decrease their share of the Medicare payment for poor Medicare beneficiaries who also had Medicaid. Nationally, this Act allowed five million poor Medicare beneficiaries to receive less physician reimbursement than wealthy beneficiaries and created a discriminatory, two-tiered Medicare system.

In 2000, Louisiana joined two-thirds of all states and decreased payment for poor Medicare beneficiaries. In 2003, a Report to Congress by Secretary of the US Department of Health and Human Services Tommy Thompson proved that the Balanced Budget Act decreased access to medical and psychiatric care for low-income Medicare beneficiaries.

Low-income Medicare beneficiaries in New Orleans and elsewhere are disproportionately elderly African Americans and mentally and physically disabled people. These groups have long histories of suffering discrimination and are protected by the Civil Rights Act of 1964 and the Americans with Disabilities Act:

- Wealthy Medicare beneficiaries get full Medicare benefits, while poor beneficiaries get *partial* Medicare benefits. Because African-American Medicare beneficiaries in New Orleans and elsewhere are disproportionately poorer than White beneficiaries, they suffer a disproportionate decrease in healthcare access. This violates the Civil Rights Act.

- Healthy and wealthy Medicare beneficiaries get full Medicare benefits, while poor beneficiaries with severe mental and physical disabilities get *partial* Medicare benefits and decreased healthcare access. This violates the Americans with Disabilities Act.

Five years have passed since Secretary Thompson's report, yet this social injustice continues. If the Louisiana Department of Health and Hospitals restores payments, state-induced healthcare discrimination and disparities will be reduced. By restoring payments for primary medical care, Louisiana will save money by keeping elderly and disabled people in the community and out of expensive hospitals and nursing homes.

All Medicare beneficiaries worked, paid payroll taxes, and earned the same Medicare benefits. A government policy that decreases reimbursement for Medicare beneficiaries solely because they are poor decreases access to health care and causes disproportionate harm to elderly African Americans and mentally and physically disabled people in New Orleans and five million people nationwide. This hurts New Orleans' healthcare recovery and heightens our city's mental health crisis.

Medicare was Born as a Civil Rights Bill

Medicare was born as a civil rights bill in 1965, part of President Lyndon Johnson's Great Society. Following centuries of medical segregation, Medicare promised a single, nationwide system of health care that guaranteed equal access for all beneficiaries. In its Civil Rights Compliance Policy Statement, the Centers for Medicare and Medicaid (CMS)[1] pledged to abolish discrimination in CMS programs. Its goal is to ensure

> all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all [CMS] program operations and activities. . . . These laws include: Title VI of the Civil Rights Act . . . [and] the Americans with Disabilities Act . . . . [CMS will] allocate financial resources to . . . ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.[2]

The Balanced Budget Act of 1997

In 1997, Congress tried to balance the federal budget and passed the Balanced Budget Act. To save money for state Medicaid agencies, the Balanced Budget Act permitted states to stop paying the insurance bill for low-income Medicare beneficiaries that "crossed-over" to Medicaid. This allowed poor Medicare beneficiaries to receive less physician reimbursement than wealthy Medicare beneficiaries. By 1999, two-thirds of states had reduced crossover payments.[3]

Access to health care is a business commodity. Higher physician reimbursement buys better healthcare access. See Figure 1. The Balanced Budget Act created a two-tiered Medicare system: Wealthy beneficiaries get access to *first*-class Medicare, while 108,000 beneficiaries in Louisiana and five million poor beneficiaries across the country get access to *second*-class Medicare. See Figure 2.

The Balanced Budget Act, which involved Congress, CMS, Medicare, and state Medicaid agencies, created several problems:

- It has a "disproportionate impact" on African Americans in New Orleans and elsewhere and violates the Civil Rights Act of 1964.
- It has a disproportionate impact on mentally and physically disabled people in Louisiana and elsewhere and violates the Americans with Disabilities Act.
- It decreases healthcare access for poor people and increases healthcare disparities.
- It inflates state Medicaid nursing home budgets.
- It damages New Orleans' healthcare recovery following Hurricane Katrina.

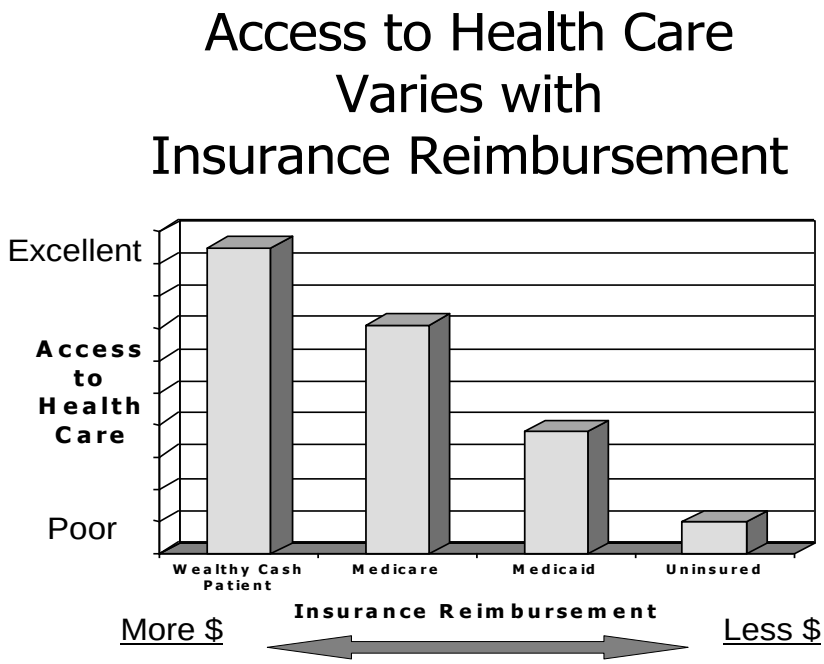

Figure 1. Access to health care varies with insurance reimbursement. Wealthy, cash-paying patients get excellent access. Medicare pays more than Medicaid, so Medicare patients get good access while Medicaid patients get fair access. Uninsured people get poor access.

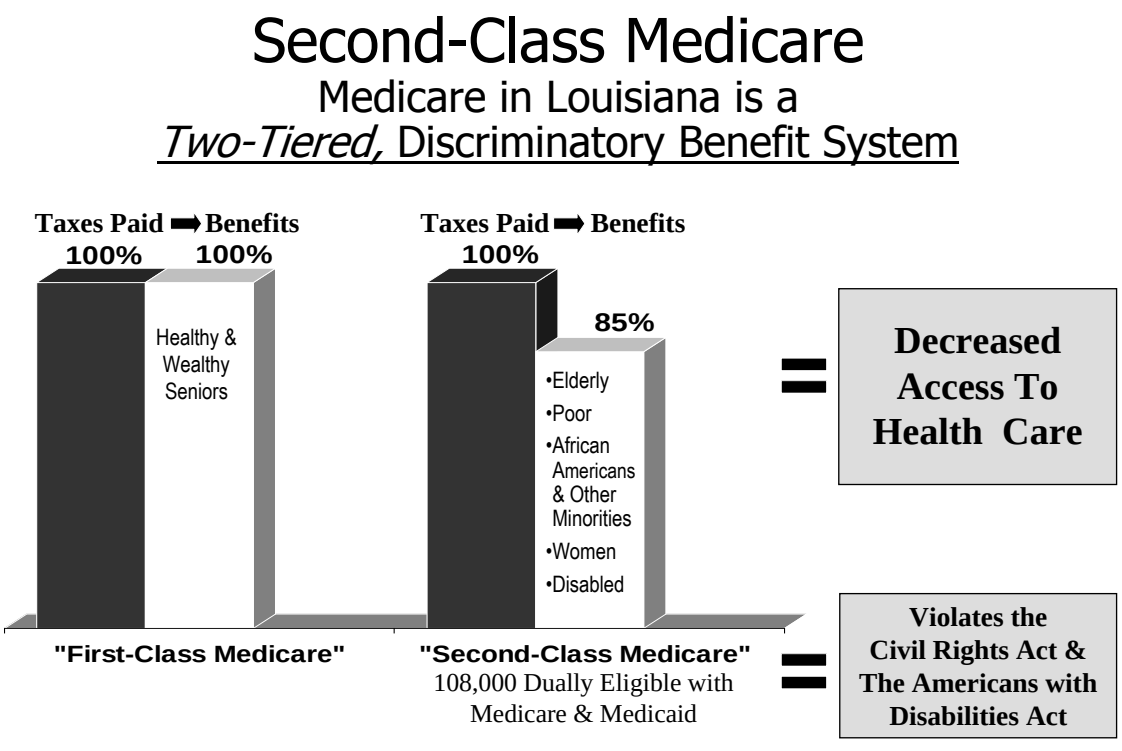

Figure 2. Without crossover payments Medicare is a two-tiered, discriminatory benefit system. Dually eligible people in New Orleans receive about 85% of their Medicare benefit.

How Medicare-Medicaid Crossover Payments Work

For dually eligible patients with both Medicare and Medicaid benefits, Medicare is "first payer" and sets the payment rate for each medical service. Medicare is an earned benefit with a payment schedule that is usually higher than the payment rate for Medicaid. In New Orleans, the 2008 Medicare fee for a 45-minute, new patient office visit, CPT code 99204, is $138.65; the Louisiana Medicaid fee for this service is $118.25 or 85% of the Medicare fee.[*]

Medicare rarely pays the patient's entire bill. Medicare usually pays 80% of its allowed amount, and the patient, or their secondary insurance, is responsible for paying the remaining 20% of the bill. In the past, the remaining 20% of the Medicare bill was paid by Louisiana Medicaid when the dually eligible patient's claim was crossed-over and sent from Medicare to Medicaid for payment. With crossover payments all Medicare beneficiaries, including low-income dually eligible people, received 100% of their promised Medicare benefits.

Instead of paying crossover payments up to the Medicare allowed amount, the Balanced Budget Act allowed Louisiana to pay crossover payments only up to the lower Medicaid fee, which is 85% of the Medicare fee. Louisiana Medicaid now adds a 5% crossover payment to Medicare's 80% reimbursement so dually eligible Medicare beneficiaries receive a total reimbursement of 85% of the promised Medicare fee. See Figure 2.

Low-income Medicare beneficiaries can never receive 100% Medicare reimbursement because the physician is forbidden by law from billing the patient, their family, or any organization willing to help the patient. Louisiana effectively turns dually eligible Medicare patients into lower-paying Medicaid patients, which decreases their access to health care.

DHHS Secretary Tommy Thompson's Report Proves Decreasing Crossover Payments Decreases Access to Health Care

According to the Report to Congress released by Secretary Thompson in 2003,[4] physicians divide their patients based on insurance reimbursement and treat higher paying patients first. When fees are raised physicians treat more dually eligible patients; in Kansas, increasing Medicare-Medicaid crossover payments increased healthcare access for dually eligible Medicare beneficiaries about 5%.

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[*] In March 2008, Louisiana announced it raised its Medicaid rates to about 90% of Medicare rates. However, in New Orleans, for a new patient visit, CPT code 99204, or for an established patient visit, CPT code 99214, Medicaid reimbursement is about 85% of the Medicare fee. Louisiana Medicaid payment rates can vary with state finances; in 2000, when Louisiana had a budget deficit, the Medicaid rate for a new patient office visit, CPT code 99204, was only 27% of the Medicare rate. Payment disparities for dually eligible patients increase if Medicaid payments fall or Medicare payments rise.

When fees are decreased physicians treat fewer dually eligible people and may "stop treating them altogether." In Michigan, after crossover payments for dually eligible Medicare beneficiaries decreased, the number of primary care physicians and psychiatrists treating dually eligible people declined; access to physician services in Michigan decreased about 5%, and access to mental health services decreased more than 21%.

A small number of physicians and psychiatrists treat a disproportionate share of dually eligible Medicare beneficiaries. About 10% to 12% of physicians treat about one-half of all dually eligible Medicare beneficiaries. Physicians treating large numbers of dually eligible people devote a larger share of their total Medicare practice to dually eligible beneficiaries and have greater declines in reimbursement. For psychiatrists with caseloads of 50 or more dually eligible beneficiaries, total Medicare revenue decreased up to 22%. In two-thirds of the states studied there was a "dramatic reduction" in psychiatric visits.[5] The authors of Secretary Thompson's CMS-funded study concluded,

> [D]ually eligible Medicare beneficiaries may be a less attractive patient population for providers in many states. . . . Given a choice between a Medicare beneficiary for whom the physician expects to receive 100% of the fee schedule amount, and one for whom the physician expects to receive only 80%, theory predicts that the physician will prefer the first beneficiary. . . . Absent some type of policy change, however, access to Medicare services for dually eligible beneficiaries may continue to decline.[6]

The Balanced Budget Act Has a Disproportionate Impact Along Racial Lines

Figure 3A. In 1997, of all elderly people in New Orleans 65 years old and older, African Americans were about 42% and White people were most of the rest.[7]

Figure 3B. African Americans are disproportionately poorer than Whites. Decreasing crossover payments and decreasing healthcare access affects only low-income Medicare beneficiaries who also have Medicaid. African Americans are poorer and therefore depend more on Medicaid than Whites. Although African Americans 65 years old and older were 42% of all elderly people in New Orleans, they were 96% of elderly dually eligible people in my medical practice in Mid-City New Orleans. (See Appendix 1: A Case Study of Dually Eligible People in Mid-City New Orleans.)

Figure 3C. Decreasing Medicare benefits based *solely* on low income has a disproportionate impact on African Americans. The percentage of elderly African Americans with decreased healthcare access (96%) is greater than *twice* the percentage of elderly African Americans in the New Orleans population (42%). According to the Civil Rights Act of 1964 this is disproportionate or disparate discrimination. (See Appendix 2.)

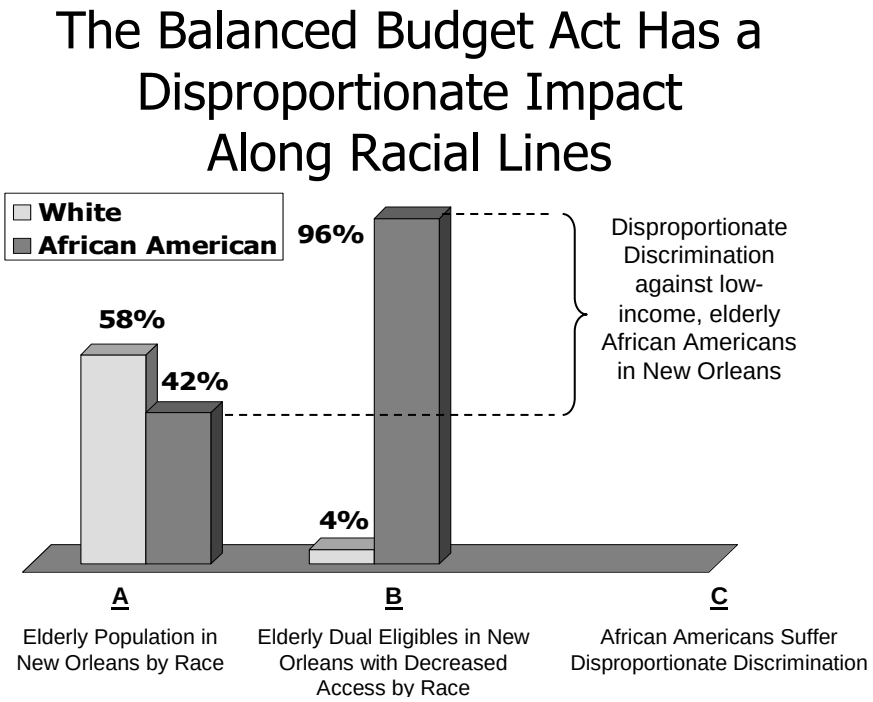

Figure 3. The Balanced Budget Act decreased healthcare access for poor Medicare beneficiaries. Because they are poorer than White Medicare beneficiaries, African-American beneficiaries in New Orleans suffer disproportionate discrimination.

Dually Eligible People — "the elderly and disabled poor"

Dually eligible people worked, paid payroll taxes, and earned the right to Medicare, which they receive when they become elderly or disabled. Yet they are so poor they also qualify for their state's Medicaid program for the needy. As the oldest, poorest, sickest, and most disabled people in the nation dually eligible Medicare beneficiaries had a 50% higher age-specific mortality rate than non-dually eligible Medicare beneficiaries.[8] Senator John Breaux, Chairman of the Senate Special Committee on Aging, called them "the elderly and disabled poor."[9]

There are almost 7.5 million dually eligible Medicare beneficiaries in the country. About two-thirds, or five million, are elderly people 65 years old and older. The remaining one-third, or 2.5 million, are disabled people under 65 years old.[10] Most disabled dually eligible people younger than 65 years old are men. As men die sooner than women, most elderly dually eligible people are women.[11] The number of dually eligible people in each state varies with that state's population and poverty. Wyoming had 9,000 dually eligible people; California had 932,000.[12]

Poor Medicare beneficiaries with income under 74% of the federal poverty level get full Medicaid benefits. Medicare beneficiaries with income from 74% to 135% of the poverty level get partial Medicaid benefits. Louisiana has 148,000 dual eligibles;

108,000 are full dual eligibles and 40,000 are partial dual eligibles. In Louisiana, dual eligibles are 24% of all Medicare beneficiaries.[13] In 2002, 9,117 dually eligible people lived in New Orleans.[14]

Health problems increase as a person's income decreases. Dually eligible people are poor: 73% of dually eligible people have incomes under $10,000 a year compared with 12% of wealthier, non-dually eligible Medicare beneficiaries. Because African Americans and other minorities are poorer than White Medicare beneficiaries, 43% of dually eligible people are African Americans and other minorities.[15] Two-thirds of dually eligible people are women. The older a Medicare beneficiary is, the more likely that person is poor and dually eligible. Only 10% of all Medicare beneficiaries aged 65 to 69 years old were dually eligible; but for Medicare beneficiaries 85 years and older, over 25% were dually eligible.[16]

Dually eligible people are disproportionately elderly, women, minorities, and mentally and physically disabled people because these groups have lower incomes than other adult groups in the United States. Dually eligible beneficiaries also have more disabilities, less education, and more mental illness and diabetes than wealthier Medicare beneficiaries. More than 60% have difficulty eating, dressing, or bathing. Over 40% of dually eligible patients have a cognitive or mental impairment.[17] More dually eligible people live alone and are socially isolated than other Medicare beneficiaries.[18] They tend to have low health literacy.[19] The Table lists disparities.[20 21]

Table

Dually Eligible Medicare Beneficiaries compared with Non-Dually Eligible Beneficiaries

	Dually Eligible Beneficiaries	Non-Dually Eligible Beneficiaries
Income less than $10,000	73%	12%
Have disabilities	71%	45%
Female	64%	55%
Less than high school education	61%	25%
In fair or poor health	52%	26%
Age 85 years old or older	14%	11%
Disabled under 65 years old	37%	10%
Have a mental disorder	34%	17%
Have diabetes	27%	18%
Have Alzheimer's disease	10%	4%
Live in a nursing home	23%	3%
Live without a spouse	55%	16%
Minority population	43%	16%

The data show that dually eligible people are medically frail. They have more chronic illness than non-dually eligible Medicare beneficiaries, including more heart disease, diabetes, stroke, cancer, arthritis, pulmonary, liver and kidney disease, dementia, alcohol and substance abuse, schizophrenia, depression, mental retardation, and other illnesses.[22]

Because they have extensive medical problems, these patients use more healthcare services than non-dually eligible Medicare beneficiaries. They use more inpatient hospital care, emergency room, hospice, physician and psychiatry services, nursing home, prescription medication, x-ray, laboratory, physical therapy, home health, and other medical services.[23]

Dually eligible people are the fastest growing and most expensive Medicare group. The "non-elderly disabled" (who are disabled Medicare beneficiaries under 65 years old), and people over 85 years old are the fastest growing dually eligible groups. Dually eligible people require care that is *twice* as expensive as non-dually eligible Medicare beneficiaries. These patients are about 16% to 17% of both Medicare and Medicaid enrollment but their treatment costs about 35% of all Medicare and Medicaid spending.[24] See Figure 4.

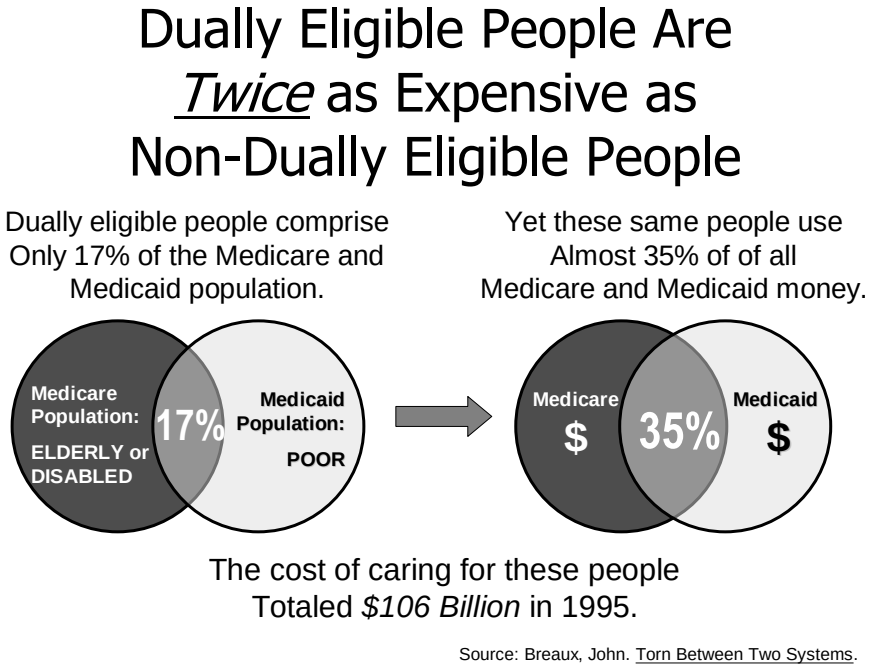

Figure 4. Dually eligible people are twice as expensive as non-dually eligible people.

They were only one-sixth of the Medicaid population but accounted for nearly half of Medicaid's total spending on prescription drugs in 2002.[25] Healthcare costs for a dually eligible person are over eight times higher than Medicaid spending for a low-income child.[26] Of the costliest 1% of all Medicare beneficiaries one-third are dually eligible.[27] The most expensive population served by publicly funded healthcare programs are dually eligible Medicare beneficiaries.[28]

In 2003, Medicaid spent $105.4 billion for dual eligibles. Medicare spent $64.3 billion on dual eligibles in 2002.[29] In 1997, Senator John Breaux said dually eligible people are "only 2% of the nation's population, [but] they account for 10% of the country's health

care spending."[30] Their medical costs are high because the costs of being old or disabled are multiplied by the social problems of being poor.

African Americans are Disproportionately Dually Eligible Because They are Poorer than Whites

Since dual eligibility is determined by poverty African Americans tend to be disproportionately dually eligible people because they are poorer than White people. Therefore, decreasing benefits for poor Medicare beneficiaries injures African Americans disproportionately more than White beneficiaries. This is true in New Orleans, throughout Louisiana, and across the nation.

Studies show that African-American poverty is broader than White poverty. In 2004, 12.7% of all people in the United States were poor and lived below 100% of the federal poverty level. But 24.7% of African Americans were poor compared with 8.6% of White people who were poor.[31] In the 30 years from 1974 to 2004, the median income of an African-American family decreased from 63% to 54% of the median income of a White family.[32] The median net worth of White households is 14 times greater than African-American households. [33]

African-American poverty also tends to be deeper than White poverty. People living at less than 50% of the federal poverty level may have severe, life-threatening poverty. In 2004, 5.4% of all people lived below 50% of the federal poverty level. But only 4.4% of White people lived below 50% of the federal poverty level, compared with 11.7% of African Americans.[34]

African Americans are poorer than White people at all ages. Elderly African Americans have a poverty rate three times greater than the poverty rate of elderly White people. Among people 65 years old and older, 9.8% of all people were poor. But 23.9% of elderly African Americans were poor, compared with 7.5% of elderly White people who were poor.[35] Elderly African-American women comprise the poorest group.[36]

In 13 of the 15 largest US metropolitan areas, African Americans live in poverty at a rate 50% greater than their percentage in the overall population. In six of the cities, including St. Louis, Chicago, Detroit, Philadelphia, Baltimore, and Newark, African Americans are twice as likely to live in poverty.[37] There are 3,141 counties in the United States. Except for Queens, New York, with its large number of two-parent families and educated African-Caribbean immigrants, in all other counties with a population over 65,000, Whites have a higher median income than African Americans.[38]

In New Orleans African-American poverty is magnified. In 2005, 24.5% of New Orleans population lived below poverty compared with 13.3% of the US population.[39] But 11.5% of Whites in New Orleans lived in poverty, compared with 35% of African Americans who lived in poverty.[40] Of the 15 metropolitan areas with the largest number of African Americans, New Orleans had the highest African-American poverty rate.[41]

In 2001, African Americans and other minorities were only 16% of all Medicare beneficiaries but were 43% of all dually eligible Medicare beneficiaries.[42] Dually eligible people in our nation's inner cities are disproportionately poor minorities. In New Orleans it is African Americans; in Southwestern states it may be Hispanics. The government's policy of decreasing benefits for the poorest Medicare beneficiaries has a disproportionate impact on African Americans and other minorities across the country.

Dually Eligible People are More Disabled than Other Medicare Beneficiaries

The Americans with Disabilities Act of 1990 (ADA) prohibits any public program or agency from discriminating against people with disabilities. The ADA states a "disabled person" is someone who has

> a physical or mental impairment that substantially limits one or more major life activities . . . such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working . . . [or has] orthopedic . . . impairments . . . [or has] cancer, heart disease, diabetes . . . mental retardation . . . emotional or mental illness . . . .[43]

The First ADA Complaint – Dually Eligible People Have Disproportionately More Disability

Disability is caused by physical or mental illness and is measured by limitations in Activities of Daily Living (ADLs) and Independent Activities of Daily Living (IADLs),[44] or by chronic illness burden. Using either measure, dually eligible people have more disability than other Medicare beneficiaries — they qualify for even *greater* protection under the ADA than other Medicare beneficiaries who are not dually eligible.

A person who worked and paid taxes has two paths to Medicare eligibility — through age or through disability. Workers younger than 65 years old may be declared disabled by the Social Security disability program and become a non-elderly disabled beneficiary.

More than 40 million people have Medicare. About six million beneficiaries, or 15%, are under 65 years old and qualify for Medicare because of severe disabilities. Most are men over 50 years old. For an adult to be considered disabled by the Social Security disability program, that person "cannot engage in any substantial gainful activity because of a physical or mental impairment that is expected to result in death or to continue for at least 12 months."[45] Any person declared disabled, according to the rigorous standards of the Social Security disability program, has already proven that he or she meets the more lenient ADA disability requirements and is therefore covered by ADA legislation.

Non-elderly disabled Medicare beneficiaries less than 65 years old have poorer physical, mental, and financial health than elderly beneficiaries. They are twice as likely to live in

poverty and twice as likely to have difficulty performing ADLs and IADLs. Non-elderly disabled Medicare beneficiaries are as likely as elderly beneficiaries to have three or more chronic illnesses. They filled more prescriptions than elderly beneficiaries in 1998.[46] Disabled beneficiaries under 65 years old have greater healthcare access problems than elderly Medicare beneficiaries.[47]

Poverty and disability are related. Low-income, dually eligible beneficiaries are three times more likely to be disabled than wealthier beneficiaries. One-third of dually eligible patients have impairments in three to six ADLs. These people also have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease and other chronic illnesses than other Medicare beneficiaries.[48] Over 40% of these patients have a cognitive or mental impairment compared with 9% of non-dually eligible beneficiaries. More than 60% have difficulty eating, dressing, or bathing.[49] The percentage of dually eligible people who are disabled and under 65 years old has grown from 28% in 1995 to 34% in 2001. Non-elderly disabled patients have a different health profile than elderly patients with more than one-half having mental or cognitive impairments.[50]

Elderly dual eligibles have similar ADL limitations as disabled non-dually eligible Medicare enrollees under age 65.[51] Elderly dually eligible patients often have several ADA-listed impairments, limited major life activities, or named illnesses, and are "qualified disabled persons" protected by ADA rules. Patients with dementia, Alzheimer's disease, stroke, and other disabling illnesses common in the elderly dual eligible population are protected by the ADA because the ADA has no age limit.[52]

Disability increases with age. Dually eligible people are older than non-dually eligible beneficiaries and more likely to live in a nursing home. Of all nursing home residents, 75% needed help performing at least three ADLs; over half needed help with all ADLs.[53] About one-half of nursing home residents were age 85 or older; 42% had dementia and 12% had psychiatric conditions like schizophrenia and mood disorders.[54] Among nursing home residents with severe cognitive impairment, more than one-third had feeding tubes.[55] Two-thirds of all nursing home residents are dually eligible people with multiple disabilities and qualify for protection under the ADA.

By decreasing crossover payments Louisiana is discriminating against many of the five million dually eligible Medicare beneficiaries who are elderly and who meet the ADA definition of disabled. Louisiana is also discriminating against *all* two and one-half million dually eligible Medicare beneficiaries who are under 65 years old, and who qualified for Medicare by being declared mentally or physically disabled by the Social Security disability program.

The US Supreme Court's *Olmstead* decision affirmed that public agencies must make "reasonable modifications," which may include spending more money, to avoid discrimination and institutionalization for disabled persons.[56] Louisiana Medicaid hoped to save $23.5 million in 2000 by decreasing crossover payments. Medicaid is a federal-state program; because Louisiana is a poor state, the federal government pays about 70% of our state's Medicaid bill and would have given Louisiana $16.5 million to help pay these crossover payments.[57] The total cost to Louisiana's treasury to restore crossover

payments in 2000 was the remaining $7 million ─ a "reasonable" amount compared with the estimated 2008-2009 Louisiana budget surplus of $2.2 billion.[58]

The Second ADA Complaint ─ African-American Dual Eligibles Have Disproportionately More Disability

Poverty and disability hasten each other. Poverty causes poor health and disability through poorer nutrition, substandard housing, exposure to environmental hazards, unhealthy lifestyles with more smoking and obesity, physically dangerous jobs, and decreased access to health care. Elderly people living in the community who were poor had twice the number of decreased ADLs and IADLs compared to elderly people who were not poor.[59] Decreasing physician reimbursement for dually eligible people decreases their access to health care and increases the likelihood of further disability and further poverty — perpetuating a downward spiral.

Elderly African Americans have higher rates of disability than elderly White people. Of people 65 years old and older, Whites had a disability rate of 40% versus 53% for African Americans. Among community-dwelling people 70 years old and older, African Americans were 50% more likely to have ADL limitations than White people were. In 1997, the percentage of people over age 65 needing help with everyday activities was 15.4% for Whites and 24.8% for African Americans.[60] About 27% of African-American Medicare beneficiaries live with diabetes compared with 18% of White beneficiaries.[61]

Non-elderly disabled Medicare beneficiaries under 65 years old are disproportionately African American. In 2002, of all Medicare beneficiaries 79.2% were White and 9.4% were African American; but only 12% of White beneficiaries were under 65 years old and disabled compared with 26.1% of African-American beneficiaries who were under 65 years old and disabled. An African-American Medicare beneficiary is more than twice as likely to be non-elderly disabled as a White beneficiary.[62]

Nursing homes residents have the most severe disabilities, and African Americans in nursing homes are more disabled than Whites in nursing homes. African-American women in nursing homes are more likely than White women to be bed-bound. African-American men in nursing homes have greater impairment than any other race or gender category.[63] Compared with White residents over 85 years old, African-American nursing home residents are more likely to have bedsores or be in restraints.[64]

In the New Orleans metropolitan area, parishes with more poverty and African Americans have more disabled people. St. Tammany Parish has less poverty, disability, and African Americans than Jefferson Parish, which in turn has less poverty, disability, and African Americans than Orleans Parish.[65] African-American neighborhoods in New Orleans with concentrated poverty have more disabled people than other neighborhoods. In 2000, the percentage of community-dwelling residents over five years old with a disability living in Orleans Parish was 23.2% compared with 30.9% of residents living in the Lower 9th Ward.[66]

Disability, poverty, and minorities are linked. A government policy that decreases reimbursement for Medicare beneficiaries because they are disabled and poor causes disproportionate harm to dually eligible African Americans in New Orleans and elsewhere.

Funding for Crossover Payments Will Be Available by Keeping Dually Eligible People out of Nursing Homes

Secretary Thompson's report showed that decreasing crossover payments decreased access to primary care physicians. As access to primary care physicians decreases, expensive emergency room visits, hospitalizations, and nursing home admissions increase.[67] Louisiana citizens already visit the state's emergency rooms 23% more than the national average and are admitted to the state's hospitals 15% more than the national average.[68]

For dually eligible people, health care in the community, including physician, hospital, and home health services, is covered mostly by *federal Medicare* dollars. Nursing home services are covered mostly by *Louisiana Medicaid* dollars. To save money Louisiana must encourage dually eligible people to live in the federally supported medical community; it hurts the state's treasury when a dually eligible person enters a Louisiana Medicaid-supported nursing home. To do this Louisiana must attract, not repel, primary care physicians.

Louisiana spends about 36% of all Medicaid money on dually eligible beneficiaries, and two-thirds of their Medicaid expenses is for long-term nursing care.[69] Multiplying 36% by 67% shows that Louisiana spends almost one-quarter of *all* Medicaid money to keep dual eligibles in nursing homes. Only about 4% of Medicaid money spent on dually eligible patients is spent on physician services — including crossover payments.[70] Yet this small physician portion holds the key to decreasing Louisiana's nursing home costs. Without access to primary care physicians, dually eligible people lose their physician-gatekeeper-advocate who helps them live in the community. Dually eligible people with multiple illnesses, multiple medications, and low health literacy have difficulty navigating a complicated healthcare system without primary care physician help.

The Louisiana Medicaid nursing home budget is bloated. Louisiana spent $500 million on nursing facilities in 2000,[71] which grew to $650 million in 2004.[72] Louisiana has one-third more nursing homes (4.8%) as a percentage of the 65 years old and older population than other states (3.6%) in the United States.[73] Louisiana has a higher percentage of nursing home residents who can dress themselves and live independently than almost any other state.[74] In 2005, nursing home occupancy rate in Louisiana was 75%, compared with the national average occupancy rate of 83%.[75] Louisiana subsidizes the 25% of nursing home beds which are empty, a higher percentage than almost any other state. The New Orleans Times-Picayune stated, "Fixing that absurdity [the nursing home payment formula] would have reduced [Louisiana's nursing home] annual budget by $42 million"[76] — enough to restore crossover payments for dually eligible people statewide.

The costliest 20% of dually eligible people are in nursing homes and account for 60% of total Medicaid spending on this group.[77] In 2000, the average annual healthcare cost for dually eligible nursing facility residents was $44,600, four times higher than spending for dual eligibles in the community.[78] Community-based long-term care costs less than nursing home care and is also what patients and families prefer. Nursing home expenses rise sharply with age, and dually eligible people are older than non-dually eligible Medicare beneficiaries. See Figure 5. About 65% of nursing home admissions come from a hospital.[79] To decrease nursing home admissions we must avoid unnecessary hospital admissions.[80]

Dually eligible people have more chronic conditions, take more medications, have lower health literacy, and have more medication errors; in 2001, elderly dual eligibles were 40% more likely than other Medicare beneficiaries to have a preventable hospital admission.[81] Identifying these vulnerable people before they enter a nursing home and providing them with access to high-quality, primary medical care can save millions of dollars for Louisiana and billions for our nation. Without restoring crossover payments for community-based primary care physicians this goal remains elusive.

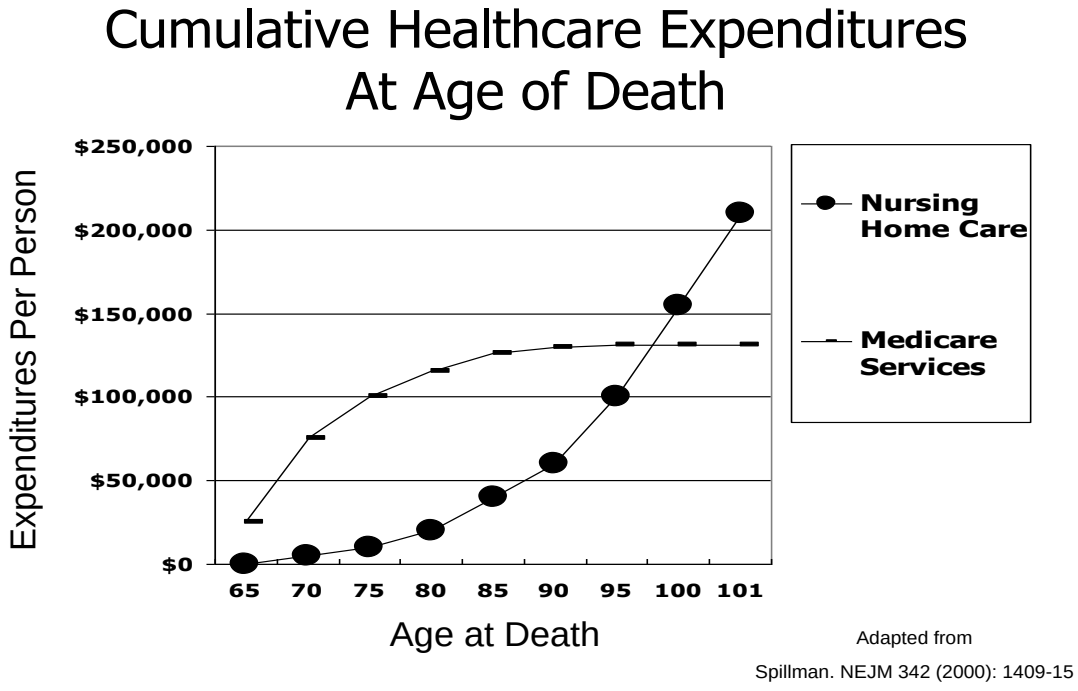

Figure 5. Nursing home expenses rise sharply with age. Dually eligible people are older than non-dually eligible Medicare beneficiaries. About two-thirds of nursing home residents are dually eligible people.

A Call to Action

Healthcare disparities have many causes. It will take decades to decrease concentrated poverty, eliminate racial and residential segregation, redistribute primary care physicians, and improve health literacy. But it takes only the flip of a switch to decrease Louisiana healthcare disparities created by the legislative policy that allowed low-income Medicare beneficiaries to receive less reimbursement than wealthy beneficiaries. An administrative decision by the Louisiana Department of Health and Hospitals decreased crossover payments in 2000; an administrative decision can restore them.

CMS has the responsibility to ensure that any person who contributes to the Medicare program receives fair and nondiscriminatory health care. Any government program that subtracts benefits based solely on a person's poverty will have a disproportionate impact on African Americans and disabled people in Louisiana and nationwide. All Medicare beneficiaries paid Medicare taxes and therefore are entitled to first-class Medicare access.

What violates civil rights in Louisiana violates civil rights throughout the nation. The Congressional Balanced Budget Act of 1997 enabled Louisiana and two-thirds of states to decrease Medicare-Medicaid crossover payments for dually eligible people. As a result, about two-thirds of 7.5 million dually eligible people, or about five million low-income Medicare beneficiaries, have decreased access to health care. As Medicare guarantees equal access to health care, the Balanced Budget Act violates these patients' civil rights.

Appendix 1. A Case Study of Dually Eligible People in Mid-City New Orleans

Dually Eligible Statistics from My *Pre*-Katrina Medical Practice

I have practiced internal medicine and geriatrics in New Orleans for 31 years, and I treat many elderly and disabled dually eligible patients. In 2002, I published a study of my Mid-City New Orleans Medicare practice.[82] My case study of 303 dually eligible patients is, to my knowledge, the largest study of community-dwelling dually eligible people by a practicing physician. My report documented that decreased reimbursement for dually eligible Medicare beneficiaries in New Orleans decreased their access to health care. One year later, Health and Human Services Secretary Tommy Thompson's Report to Congress confirmed my findings.

In 2000, 63% of my patients had Medicare insurance. Of these patients with Medicare insurance, 72% or 303 patients also had Medicaid and were dually eligible. Secretary Thompson reported physicians treating large numbers of dually eligible patients devote a disproportionate amount of their practice to these people. My 72% dually eligible population is much larger than the national 17% dually eligible Medicare population and supports Secretary Thompson's statement.

Of these 303 dually eligible patients in my practice, 79% were women and 21% were men. One-third or 34% were under the age of 65 and receive Medicare benefits because they were declared disabled by the Social Security disability program.

Of these 303 dually eligible patients, 89% were African American and 11% were White. In 2001, African Americans were 7% of the national Medicare population but were 21% of the national dually eligible population. This extreme 89% preponderance of African-American dually eligible patients in my practice reflects the concentrated poverty and demographics of many New Orleans neighborhoods.

The racial demographics of my two Medicare populations, the elderly and the non-elderly disabled, are extreme. Only 11% or 32 patients in my Medicare-Medicaid dually eligible practice are White. But of these 32 White persons, 25 patients are under 65 years old and receive Medicare benefits because they are disabled, while only seven of my White patients receive Medicare because they are elderly. Of all my *elderly* dually eligible Medicare-Medicaid patients, 96% are elderly African Americans.

From 1999 through 2000, I performed 78 home visits to dually eligible patients. Of these home visits, 100% were to the homes of African-American patients. All these patients were disabled, as defined by the Americans with Disabilities Act, and all were homebound with severe medical problems.

Because Medicare-Medicaid crossover payments were reduced I was forced to change two parts of my geriatric practice. First, I stopped making house calls to new dually eligible patients.[†] Second, I decreased my geriatric clinic office hours by 10% and did other medical work which paid better. My decisions to stop making house calls and decrease geriatric clinic hours affected, disproportionately, elderly African-American women, and mentally and physically disabled people. If the physician next door to me does the same, who is left to treat these frail patients except the local emergency room?

Dually Eligible Statistics from My *Post*-Katrina Medical Practice

In August 2005, Hurricane Katrina destroyed my medical office in Mid-City New Orleans with 7 ½ feet of floodwater. One year later, in August 2006, I opened a new medical office in the Guste High-Rise in Central City New Orleans. "The Guste," which did not flood during Katrina, is open to low-income elderly citizens and is managed by the Housing Authority of New Orleans and the US Department of Housing and Urban Development.

Central City New Orleans is racially and residentially segregated and poor. Census Tract 68, where my new office is located, is a neighborhood with concentrated poverty. African Americans are 98% of the population, the high school graduation rate is 27%, and the poverty rate is 72%.[83]

[†] In 2000, the Louisiana Medicaid rate for a home visit, CPT code 99343, was about 19% of the Medicare rate; the Medicaid rate for a new patient office visit, CPT code 99204, was about 27% of the Medicare rate.

From August 2006 through December 2007, 90 patients in my new office had Medicare insurance. Of these patients with Medicare insurance, 69% or 62 patients also had Medicaid, which made them dually eligible. My current 69% dually eligible population is similar to my 72% dually eligible Medicare population before Hurricane Katrina. Of these 62 dually eligible patients in my practice, 81% are women, 29% are non-elderly disabled beneficiaries under 65 years old, and 90% are African American.

Only six patients in my new Medicare-Medicaid dually eligible practice are White. But of these six White persons, five patients are under 65 years old and receive Medicare because they are disabled, while only one White patient is elderly. Of all my elderly dually eligible Medicare-Medicaid patients, 98% are African American.

The post-Katrina racial, gender, and disability demographics of dually eligible people in my new office in New Orleans zip code 70113 are similar to the demographics at my pre-Katrina office in zip code 70119. After Hurricane Katrina, dually eligible people in New Orleans continue to be, disproportionately, elderly African Americans and mentally and physically disabled people.

Appendix 2. The Civil Rights Act, Dually Eligible People in the Southern Black Belt and the Legacy of Slavery

The Civil Rights Act and Disparate Discrimination

Title VI of the Civil Rights Act of 1964 states:

> [N]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

Besides barring intentional discrimination, the Civil Rights Act states that *indirect*, or disparate discrimination, is illegal:

> The Supreme Court has held that . . . regulations may validly prohibit practices having a disparate impact on protected groups, even if the actions or practices are not intentionally discriminatory.
>
> A recipient [of federal funds, such as the State of Louisiana] . . . may not . . .utilize criteria or methods of administration *which have the effect* of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respects individuals of a particular race, color, or national origin. [Emphasis in the original]

> In a disparate impact case, the focus . . . concerns the consequences of the recipient's [the State of Louisiana's] practices, rather than the recipient's intent.[84]

The consequences of Louisiana's crossover payment reduction are decreased healthcare access and disparate or disproportional discrimination against dually eligible African-American Medicare beneficiaries in New Orleans and elsewhere. The State of Louisiana, a recipient of federal funding, is in violation of the Civil Rights Act of 1964.

Dually Eligible People in the Southern Black Belt and the Legacy of Slavery

Dually eligible people in New Orleans are mostly African American. According to the 2000 US Census, African Americans represent about 12% of the total United States population.[85] But African Americans are not evenly spread across the country. Over 50% of older African Americans are concentrated in the Southeastern United States, an area which 100 years ago Booker T. Washington called the "Southern Black Belt." See Figure 6: African-American Population and the "Southern Black Belt."[86]

According to the New Orleans Times-Picayune, the "[Southern] Black Belt is an 11-state swath of counties with large Black populations and high poverty rates. . . . stretching across the South from Texas to Virginia." This area, which has been called the "Third World of the United States," has poor physical and social infrastructure, poor employment rates, poor healthcare access, poor housing, poor educational statistics, and high infant mortality rates. "The Black Belt is one of the most overlooked by the federal government, despite its staggering demographic data. Once home to cotton plantations and slavery, these communities haven't really recovered . . . ."[87]

The wealth or poverty of our ancestors can influence our economic status through several generations.[88] The twenty-first-century map of the Southern Black Belt resembles the nineteenth-century map of slavery in Figure 7, which outlined where African-American slaves lived in 1860.[89] The poverty of African Americans today in the Southern Black Belt began centuries ago with slavery. It extended from colonial times through the Civil War, Reconstruction, the Jim Crow period, the Civil Rights era, and into the twenty-first century. The Southern Black Belt, with its intergenerational culture of poverty, is the geographic, demographic, and economic legacy of slavery.

Dually eligible African Americans have deep roots in the Southern Black Belt. In Georgia, which forms part of the Southern Black Belt, 45% of dually eligible people are African American, compared with just 6% in Colorado, which lies outside the Southern Black Belt.[90] Coupled with inferior education, health care, employment, housing, and other essential social services, poverty heightens the rate of disability and dual eligibility. For many elderly and disabled African Americans in New Orleans and elsewhere, dual eligibility is a manifestation of lifelong social problems presenting in a medical fashion.

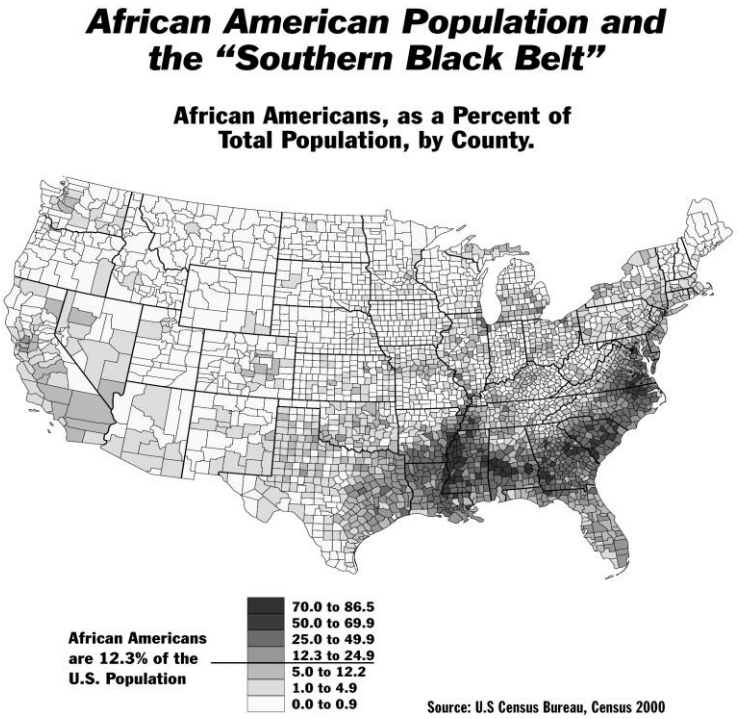

Figure 6. African-American population and the Southern Black Belt in 2000.

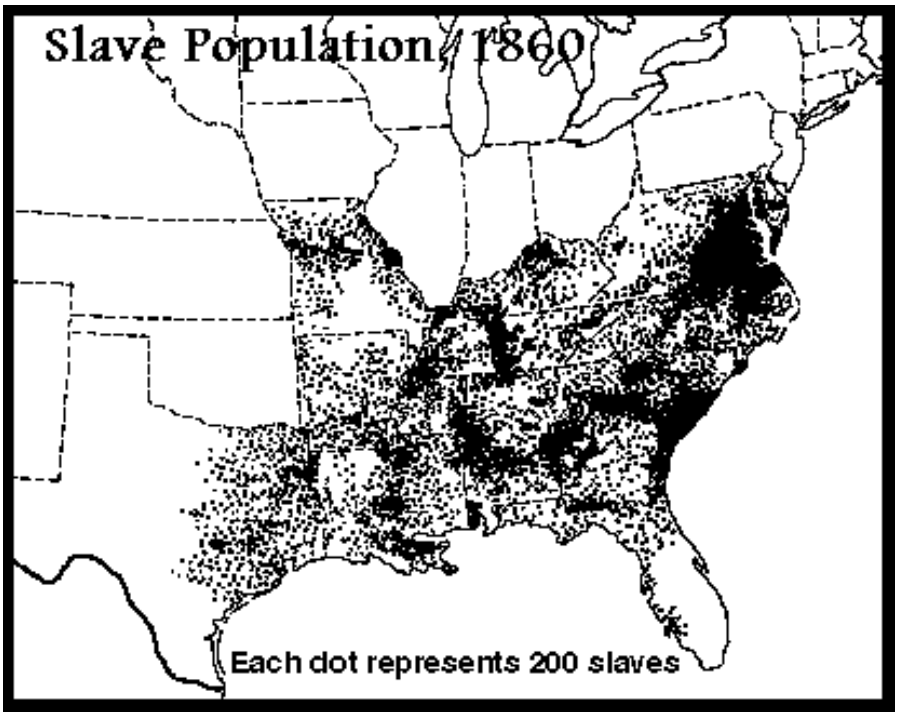

Figure 7. African-American slave population in 1860: The origin of the Southern Black Belt.

The Civil Rights Act of 1964 made racial segregation illegal. In 1997, the Balanced Budget Act turned an informal, *de facto* segregated medical system, into a legal, *de jure* segregated medical system. In its Civil Rights Compliance Policy Statement, CMS pledged to ensure equal access to health care and to remedy past acts of discrimination. By reducing crossover payments for low-income African-American dually eligible people, CMS is *perpetuating* "past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability." [91]

New Orleans Demographics

Within the Southern Black Belt sits Louisiana and New Orleans. Although the national percentage of African Americans is 12%, Louisiana has an African-American population of 33%, and in New Orleans African Americans were 67% of the city's population.[92]

New Orleans has five City Council Districts numbered A through E, going west to east across the city. As Districts go from west to east the percentage of African Americans increases, and the percentage of White people decreases. In City Council District A, which includes several of the city's wealthier areas, the White population in 2000 was 58% and the African-American population was 39%. Continuing east through poorer sections, the African-American population steadily increased until District E, which contained 84% African-American citizens and only 9% White citizens.[93]

New Orleans is an African-American majority city. But as the city's population ages, African Americans lose their numeric advantage because they die several years earlier than White persons of the same age, largely through illness and by violence.[94] The percentage of African Americans decreases as the population ages until in the 80-years-and-older group, White persons are 64% and African Americans are 35% of the population. Because African-American men die younger than African-American women, in the 85-years-and-older African-American population, 73% are female and only 27% are male, resulting in the high concentration of elderly African-American women in the dually eligible population in New Orleans.[95] Decreasing access for dually eligible people further imperils the survival of elderly African-American men.

Appendix 3. Concentrated Poverty and Residential Segregation In New Orleans and Elsewhere

According to Secretary Thompson's Report to Congress, most physicians have few dually eligible people in their practices, and a medical practice with 100 dually eligible people is a large practice. I was able to gather 303 community-dwelling dually eligible Medicare beneficiaries in my practice because of concentrated poverty and residential segregation in New Orleans.

African-American poverty in cities is greater than White poverty. In 1999, Michigan had an average poverty rate of 10.5%, but the poverty rate in Detroit was 26%.[96] If healthcare access for dually eligible Medicare beneficiaries decreased an *average* of 5% to 21%

across the entire state of Michigan, which includes many wealthy areas, how much more did healthcare access decrease in poorer neighborhoods in Detroit, where African Americans make up 82% of the population?[97]

Healthcare access is local and varies with neighborhood income. Studying poverty and healthcare access at the neighborhood level, rather than the city, state, or national level, gives a clearer picture of local healthcare access. Census tracts are proxies for neighborhoods and average about 4,000 people.[98] A census tract with at least a 40% poverty rate is a "concentrated poverty" neighborhood.[99]

New Orleans is a city of neighborhoods, and many neighborhoods were once racially and economically mixed. In the mid- and late-twentieth century, new land, much of it reclaimed wetlands, opened up around New Orleans. Between 1970 and 2000, as middle-class families and jobs moved from city to suburb, New Orleans lost population as surrounding parishes grew.[100]

As Whites left town and poor people stayed behind, neighborhoods that were formerly mixed-income and mixed-race became mainly poor and African American. By 2000 the number of census tracts in New Orleans with extreme or concentrated poverty "exploded" from 28 to 47, even though the city's overall poverty rate changed little. Most African-American neighborhoods with concentrated poverty were close together in the mid-city and downtown area and across the eastern half of the city.[101]

Poor African Americans were residentially segregated in the 47 neighborhoods of concentrated poverty, where 82% of their neighbors were African American. In 2000, African Americans made up 67% of the city's total population, but were 84% of its poor population. Among large US cities with concentrated poverty, New Orleans ranked second.[102] African Americans have the highest poverty levels in the country and are the group most residentially segregated from Whites.[103]

Nationally, 75% of concentrated poverty is in central cities.[104] Most major American cities, including Cleveland, New York, Atlanta, and Los Angeles, have poor, racially and residentially segregated neighborhoods that mirror New Orleans' Lower 9th Ward. In 2000, there was at least one extreme poverty neighborhood in 46 of the 50 largest cities in the US.[105] Access to health care is local. Neighborhoods with concentrated poverty and residential segregation have more dually eligible people but less access to health care. This is true in New Orleans and in cities across the nation.

Decreased Access for Dual Eligibles – the Connecticut Experience

> Migration from the South rose through the early decades of the 20th century as tens of thousands of African-Americans left to escape segregationist Jim Crow laws and a poor economy. That led to a rise in black populations in Northeastern and Midwestern cities, where black people came for jobs in steel mills, automobile factories, and other industrial plants.[106]

States may have a majority of White persons and still have cities where "minority groups" form the majority population. Poor inner cities have concentrated poverty and racial and residential segregation similar to New Orleans. The wealthy State of Connecticut has an 82% White majority, but the poor, inner city of Hartford is only 28% White and 72% African American, Hispanic and other minorities.[107]

In 1999, Connecticut reduced crossover payments for its dually eligible Medicare beneficiaries, just as Louisiana did in 2000. According to a survey by Connecticut's Fairfield County Medical Association, as a result of reduced payments 42% of physicians limited or stopped accepting new dually eligible patients, 16% stopped seeing Medicaid patients in nursing homes, and 14% quit the Medicaid program.[108]

Access to health care is determined locally. Because of Hartford's demographics, most of that city's dually eligible people affected by Connecticut's crossover cuts were minorities and disabled people. Connecticut physicians, patients, legislators, and the media formed a coalition and restored crossover payments for dually eligible patients.

Appendix 4. African Americans Receive Inferior Health Care

> *Of all the forms of inequality, injustice in health care is the most shocking and inhumane.* — Martin Luther King, Jr.[109]

Disparities in health care are rooted in poverty, race, and geography. African Americans receive lower quality health care than Whites. African-American patients and White patients are often treated by different physicians. Eighty percent of physician visits by African Americans were to only 22% of physicians, who provided little care to White patients. Physicians providing care for African-Americans patients tend to be less well-trained and less likely to be board-certified than physicians treating White patients. Physicians treating African-Americans often practice in low-income neighborhoods with poorer medical resources and larger Medicaid caseloads.[110]

In addition nursing home care for African Americans is segregated and mirrors urban residential segregation patterns. Two-thirds of all African-American nursing home residents live in only 10% of all nursing homes. These facilities provide poorer care and have more deficiencies, lower nursing staff ratios, more Medicaid income, and less financial stability.[111]

Hospital care for African Americans is segregated and of lower quality. Five percent of hospitals treated 44% of all African-Americans beneficiaries; 25% of hospitals treated 90% of all African-American beneficiaries. Hospitals with high volumes of African-American beneficiaries were often large urban teaching hospitals — like Charity Hospital of New Orleans. They treated more Medicaid patients, had lower nursing staff ratios, provided lower quality of care, and were less financially secure.[112]

Hospitals serving African Americans and other minorities are poorer than hospitals serving Whites. Grady Memorial Hospital, Atlanta's only public hospital, is "staggering" under debt and struggling to survive financially. Most of its patients are poor and African American and 75% have Medicaid.[113] Martin Luther King Jr.-Harbor Hospital, "built in the aftermath of the Watts riots and one of the few hospitals serving the poorest residents of South Los Angeles" closed because of substandard medical care.[114]

Racial, residential, and economic segregation worsen disparities and limit private practice-physician care for African Americans. As people moved from cities to suburbs, private physicians followed. Physician services in wealthy White suburbs increased, and physician services in poor, minority inner cities decreased. Minorities in poor urban areas now rely on medical schools, teaching hospitals, and public clinics, and less on private physician offices: "In North Philadelphia, a predominantly African American and Hispanic low-income community, no private practice physicians remain. Instead, residents must rely on care from the clinics of medical schools and teaching hospitals."[115]

Poorer neighborhoods have poorer medical insurance reimbursement and poorer medical resources. Medicaid reimbursement averages 69% of Medicare reimbursement.[116] Because of lower reimbursement only 70% of physicians were willing to accept new Medicaid patients, compared with 96% of physicians willing to accept Medicare patients.[117] Twice as many African Americans reported difficulty accessing medical care than White beneficiaries.[118] Between 1993 and 2003, emergency room visits for elderly persons aged 65 to 74 years old increased 26% for White people compared with an increase of 93% for African Americans.[119]

The premature death rate for African Americans is almost 50% greater than the rate for White people.[120] Former Surgeon General David Satcher estimated 83,000 excess deaths could be prevented each year if the mortality gap between African Americans and Whites could be eliminated.[121] Economics drives healthcare disparities.[122] Decreasing reimbursement for Medicare-Medicaid crossovers injures the entire African-American healthcare safety net.

Appendix 5. Decreasing Crossover Payments Hurts New Orleans Healthcare Recovery

Hurricane Katrina devastated the New Orleans medical community. Decreasing crossover payments hurts New Orleans' medical recovery; it makes poor neighborhoods in New Orleans less attractive for physicians to set up medical practice.

Before crossovers were reduced in 2000, physicians could practice anywhere in New Orleans and Louisiana and receive full Medicare reimbursement for dually eligible people. Now, with crossovers reduced, a physician's Medicare income varies with neighborhood demography and geography. Physicians setting up practice in New Orleans make a financial and geographic choice: do they accept less Medicare payment working in poor African-American neighborhoods where many dually eligible people

live, or earn more money — doing the same work — in wealthy neighborhoods where fewer dually eligible people live.

Two years after Katrina the New Orleans Times-Picayune declared: "Medical care in east N.O. [City Council District E is] on life support."[123] Neighborhoods in New Orleans City Council Districts D, or E, or near downtown have concentrated poverty, residential segregation, and large African-American and dually eligible populations. Coupled with large Medicaid-only patient loads, these locations are financially unattractive.

Physicians seeking fewer dually eligible people can move to wealthier District A, or relocate to a wealthier parish outside New Orleans. The best financial decision for a physician or psychiatrist to increase Medicare income is to move outside Louisiana, to a state that allows the entire Medicare insurance payment for dually eligible people.

Two-thirds of nursing home residents are dually eligible people. Physicians with large nursing home practices must choose to practice inside Louisiana and lose Medicare reimbursement for most of their patients, or move to a different state that allows crossover payments.

Twice as many African Americans (72%) as Whites (32%) in New Orleans reported problems getting health care since Katrina.[124] Residents are reluctant to move back home without adequate health care. New Orleans Mayor Ray Nagin declared health care is in "crisis" since Hurricane Katrina.[125] Because of Katrina New Orleans lost 77% of our primary care doctors and 89% of our psychiatrists. Suicide and mental illness increased after the storm, including post-traumatic stress disorder, depression, anxiety, and substance abuse.[126] About one-third of the 9,117 dually eligible people in pre-Katrina New Orleans had mental illness. Decreasing Medicare-Medicaid crossover payments for these 3,000 low-income residents decreased their access to psychiatric care and heightens our city's mental health crisis.

Physicians are business people who vote with their feet and their pocketbooks. The most cited reason doctors left New Orleans following Hurricane Katrina was reduced income.[127] Without Medicare-Medicaid crossover payment reform, it will be difficult to retain physicians who work at financial disadvantage in poorer neighborhoods of New Orleans.

Before Hurricane Katrina dually eligible people had decreased access to health care. Katrina multiplied the problems but cut medical resources. On top of Katrina's devastation, the government policy that decreased crossover payments further decreases healthcare access for low-income Medicare beneficiaries and hurts New Orleans' healthcare recovery.

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