



American Cancer Society ☯ Children's Defense Fund/New York ☯ Community Service Society of New York
Institute for Puerto Rican and Hispanic Elderly ☯ Make The Road New York ☯ Medicare Rights Center
Metro New York Health Care for All Campaign ☯ New Yorkers for Accessible Health Coverage ☯
New York Immigration Coalition ☯ Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices ☯ Schuyler Center for Analysis and Advocacy

October 5, 2012

VIA ELECTRONIC SUBMISSION: exchange@health.state.ny.us

Danielle Holahan
Director of Policy
New York State Health Benefits Exchange
90 Church Street
New York, NY 10007

RE: Comments on Addressing Disparities in the Health Benefit Exchange

Dear Ms. Holahan:

Health Care For All New York (HCFANY) is a statewide coalition of over 130 organizations which seek to achieve affordable, quality health care for all New Yorkers. We thank you for the opportunity to comment on how the State Health Benefit Exchange can be used to reduce health disparities. We agree that the three areas you have identified—consumer assistance, access to health services and data collection—are important to reducing health disparities, and we address these below. In addition, we include recommendations on reducing disparities through civil rights compliance monitoring and enforcement.

We join the many stakeholders at the September 7 meeting in urging the State to continue to ensure a transparent and public process as it establishes standards for reducing health disparities through the Exchange and health plans offered on the Exchange. As experts and stakeholders testified at that meeting, addressing disparities requires ongoing monitoring and modification of systems to ensure success. We commend the State for convening a stakeholder meeting to begin this conversation about how the Exchange can be designed to reduce disparities in New York, and recommend that this process of stakeholder engagement continue throughout the life of the Exchange.



Consumer Assistance

New York is home to Community Health Advocates (CHA) and the Facilitated Enrollment program, two statewide consumer assistance and enrollment programs that have proven success. CHA is one of the largest health care consumer assistance programs in the country. CHA has a live-answer hotline, conducts presentations in communities throughout the state, and provides direct assistance to consumers. Much of the success of CHA and the FE programs is attributable to community-based networks that enables the programs to provide linguistically and culturally competent assistance to New Yorkers of all backgrounds in the communities in which they live. Our experience with CHA and the FE program have informed the recommendations made below.

1. The Exchange should be culturally and linguistically competent and provide for effective communication.

Addressing disparities in health outcomes means removing barriers to health care. For immigrants, many of whom are people of color, language can be a significant barrier. Roughly 2.3 million New Yorkers are limited English proficient (LEP); half a million are deaf or have a serious hearing difficulty; and more than 400,000 are blind or have serious difficulty seeing. These individuals will need interpretation and translation services and materials in alternate formats (Braille, large print and audio) that are section 508 compliant to communicate effectively with the Exchange, health insurance plans and government agencies.

A growing number of federal, state and local laws and policies mandate that LEP consumers and consumers with disabilities receive free interpretation and translation and are not excluded from participation in or denied access to services. In order to ensure that the ACA goal of universal coverage is met and that LEP consumers and consumers with disabilities are able to access all health services available through the Exchange, we recommend the Exchange have bilingual staff, interpreters, and telephonic interpretation services and that important consumer information provided by the Exchange is offered in many languages and formats. Health plans should be required to provide interpretation, translation and literacy-appropriate information.

The Exchange should have dedicated staff responsible for creating and implementing Language Access and ADA Compliance policies. A basic standard should be set for language access to ensure that all people can access health coverage and health care in their preferred language. The State should mandate that consumer assistance programs and Navigators have similar policies.

Language services should include: (1) translation of notices and vital documents when at least five percent or 500 LEP individuals are included in an Exchange, with a minimum of 15 languages; (2) inclusion of translated taglines in at least 15 languages on all Exchange notices and vital documents and websites with information on how to access translated materials and



oral language assistance; and (3) provision of effective oral communication for all LEP individual, regardless of whether translation or other thresholds are met.

Effective consumer assistance will be essential to help diverse New Yorkers – especially those from vulnerable, hard-to-reach communities – choose health plans that cover their health needs and fit within family budgets. An effective consumer assistance program that meets the needs of hard-to-reach and vulnerable populations should include the following:

Exchange outreach materials and consumer education should be linguistically and culturally competent and provide for effective communication.

Promotional materials, provided in the many languages spoken by New Yorkers produced in alternate formats, should clearly direct consumers to assistance, including specialized assistance for people with disabilities and speakers of languages other than English.

Exchange outreach materials – such as handouts, newspaper and subway ads, billboards and radio public service announcements – should be prepared in the multiple languages (such as Spanish, Mandarin, Korean, Arabic, Farsi, Bengali, French and Russian) spoken by New Yorkers and should depict a diverse array of individuals and families, including people with disabilities, “non-traditional” families such as LGBT couples and single parents and their children.

Outreach materials should be distributed in a targeted way so that consumers receive information that is culturally relevant, in the appropriate language. For example, the Exchange should place announcements in weekly local newspapers and on radio stations dedicated to serving specific communities, such as people with disabilities, LGBT people and speakers of languages other than English.

The Exchange should engage trusted communicators, such as community health workers and promotoras, as are commonly used by Planned Parenthood of NYC, the Hispanic Federation, the Violence Intervention Program Inc. and Voces Latinas, to ensure cultural and linguistic competence. Moreover, we recommend linguistically and culturally competent outreach efforts target hospital emergency departments and federally-qualified health centers where the uninsured often seek treatment.

The design and operation of the Exchange website and call center/hotline should be linguistically and culturally competent.

We recommend that the Exchange website depict diversity in any photos and graphics used. The website should feature a prominent “translate” option allowing consumers to view the entire website and portal in the language they are most comfortable using. The Exchange website should be Section 508 compliant.

The Exchange call center/hotline should have an immediate prompt that allows the caller to choose a language preference. The call center should: direct callers to staff who speak their language; and/or offer recorded messages giving information in the appropriate language; and/or



engage a translator to assist the caller. Call center staff should be trained handle questions from non-traditional families, such as LGBT couples, in a non-discriminatory manner. Staff should provide information in an unbiased manner that does not reflect disapproval of specific services, such as women’s reproductive health care or care needed by transgendered individuals.

2. The Exchange should provide community-based, in-person assistance.

A number of New Yorkers will be unable to access the Exchange through the website or call center. We strongly support the use of face-to-face assistance as is provided by Facilitated Enrollment and Community Health Advocates. Consumers want to get advice from people they know understand them, especially if they are being asked to disclose their disability or sexual orientation.

Consumers at HCFANY’s Health Benefit Exchange Listening Sessions (HCFANY Listening Sessions) emphasized the need for in-person assistance to help with enrollment and other tasks like disputes with health plans. Many New Yorkers have little or no access to a computer or have low computer literacy. Consumers may also have limited phone use, and many prefer to express themselves through direct personal contact.

It is important to provide local, community-based assistance. Participants at the Listening Sessions indicated that it can be alienating to speak with a phone operator in Albany and “having a local office that you can go to makes a huge difference.” Participants stressed the need to use “established organizations that have become part of the local scenery and are known to be part of the community.” As an example of an assistance program that works, a participant who worked with HomeBase, a community-based eviction prevention program, described how assistors will “take you by the hand and show you how to get what you need.”

3. The Exchange should explain benefits and costs of plans offered on the Exchange in a clear and unbiased manner.

The Exchange should provide clear explanations of benefits for all health plans, including costs to the consumer in the form of premiums, deductibles and co-pays. Consumers should also be assisted with choosing a plan level – i.e., bronze, silver, gold or platinum – that best fits their medical and budgetary needs. Exchange staff should be knowledgeable about private and public coverage including all forms of Medicaid coverage, such as Medicaid Buy-in and Medicaid Spenddown.

Consumers should be able to receive unbiased, comprehensive information about plans’ benefits, such as whether abortion is covered, if there are any transgender-specific limits to care, or if there are any other limits on coverage. Call center staff, consumer assistors, and Navigators should be trained to ensure competent, respectful and non-discriminatory provision of information about benefits and costs. The Exchange should conduct periodic surveys of consumers who have sought assistance to ensure satisfactory performance.



4. New York’s Exchange should provide a “no wrong door” experience for consumers.

New York should adopt a “no wrong door” policy. New York has many “mixed status” families that include undocumented immigrants and lawfully residing immigrants and citizens. Family members in mixed-status families will have different options available to them and should be able to receive information about all public and safety net programs at the point of Exchange enrollment. The Exchange should be a one-stop shop where families can get information on, and assistance applying for, *all* programs for which their family members may be eligible.

The Exchange should also facilitate enrollment in and provide information about financial assistance programs at hospitals and community health centers as well as information on where uninsured individuals can access affordable care. The Exchange should train its staff, Navigators, and other enrollment assistors like brokers to help consumers who cannot obtain coverage access affordable care from these sources.

Access to Health Services

The Exchange should monitor health plan network adequacy to ensure enrollees can access the care and services provided by their coverage. Network adequacy is especially important for hard-to-reach and vulnerable populations, as they often have unique health care needs that are not always addressed by available providers. The State should ensure that all health plans offered through the Exchange have the following:

1. Health plans offered through the Exchange should have sufficient numbers of providers who can serve the LGBT community.

The Exchange should ensure that plan networks include providers who are clinically competent to serve the LGBT community. As documented in Health People 2020 and the 2011 Institute of Medicine report on LGBT health, there are significant health disparities affecting LGBT people. Barriers to LGBT people’s accessing clinically competent health care include a lack of providers trained to address the specific health care needs of LGBT people, a lack of culturally appropriate prevention services, and a lack of clinically competent mental health and substance use services.

2. Health plans offered through the Exchange should have sufficient numbers of reproductive health care providers.

Women enrolled in plans sold in the Exchange should have good access to reproductive health care providers. In a 2012 bulletin, the New York State Board of Regents identified eleven counties that have a shortage of obstetricians/gynecologists.¹ In these areas, plans should ensure that women are able to get the care they need in a timely fashion. Plan networks should provide coverage of telemedicine, if available, and include as many reproductive health care providers in its network as possible.



3. Plans should require that their participating providers be accessible.

Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site such as exam tables and medical equipment. Providers should also have protocols for identifying enrollees who require a case manager, audio, visual, mobility aids, or other accommodations and a protocol for determining needs of enrollees with cognitive and mental disabilities.

4. Plans that do not have adequate numbers of providers should be required to eliminate out-of-network costs.

Enrollees should have timely access to health care providers who are culturally competent, linguistically competent, who honor end-of-life choices, and who are willing to provide covered health care services. If an enrollee is unable to find a health care provider in network due to an inadequate number of providers, he or she should not incur additional costs.

5. The Exchange should use data to evaluate network adequacy.

To ensure that a sufficient number of providers who address the diverse needs of New Yorkers are included in a network, the Exchange should evaluate network adequacy at least annually. A network adequacy evaluation should measure a consumer's ability to schedule a timely appointment, office wait time, availability of translators, and ability to provide care covered in an enrollee's plan.

6. The Exchange should provide tools that allow enrollees to determine if a network includes providers that can address their unique needs.

To ensure hard-to-reach and vulnerable populations have access to health services, plans need to provide easy to understand information regarding the availability of providers who can meet their specific needs. The Exchange and health plans should develop tools that allow consumers to identify providers with staff who speak languages other than English or that have staff of a certain gender available for an appointment.

Data Collection

The Exchange provides New York with the opportunity to address health disparities through the collection and analysis of data, as well as through the translation of data into practice.

1. The State Department of Health, in coordination with the Exchange, should establish a system requiring health plans, hospitals and other health care institutions to collect and report – by race, ethnicity, gender, primary language, sexual orientation, gender identity and disability status – the coverage and care and health outcomes, based on State quality measures.



The State currently collects and reports quality measures for certain health plans through the quality assurance reporting requirements (QARR) data system. The existing system needs to be modified to ensure comprehensive data collection of the elements listed above. HCFANY drafted legislation in the 2011-12 Legislative Session (A.8278, Peoples-Stokes), to establish a health care disparities data collection system. We urge the Exchange staff to review this bill as it contains specifics of our proposal.²

Under A.8278, SDOH would design or make available surveys to collect data, such as race and ethnicity, from patients and subscribers. Health plans, hospitals, and other health care institutions would be required to collect the data elements included on the survey. Data should be self-reported in writing, as it is more accurate than other alternatives, such as physical observation or phone surveys. Those reporting data, including hospitals and other facilities regulated under Article 28 of the Public Health Law and health insurers, would be required to update their data at least annually. SDOH would be required to post this data on a website within 90 days of receipt from each institution.

The State should collect data on primary language spoken using population surveys and at the point of care to capture health disparities. Collecting population-level data on primary language is essential to developing interventions to improve health care access for LEP individuals. Health plans, hospitals and other health care institutions should also be encouraged to collect data on written language proficiency. While this information is often correlated with spoken language proficiency, it is important information for developing health interventions and communicating health care information to patients in clinical settings. Written language proficiency is also closely related to health literacy, which has been shown to impact health outcomes.

All data collected should be reported in a manner that is easy-to-use and accessible to the public and policymakers. The Exchange should consider creating “report cards” on health plans and institutions, similar to those created by the State Department of Education for schools and school districts.

Collecting and reporting this data will allow consumers to make informed choices about health plans and the institutions they are considering for their care. The data will also allow state policymakers and health advocates to develop solutions and to hold health plans and health care institutions accountable for health disparities.

Ultimately, the State can use data on health disparities to hold health plans accountable for the reduction of disparities. For instance, the Exchange can build in standards to reduce disparities through the Qualified Health Plan certification process and establish incentives for plans that are leaders in reducing health disparities.

Consumers asked personal information for data collection purposes should be informed: (1) the purpose for which the information is being requested; (2) that providing information is



completely voluntary; and (3) that no personally identifying information – only aggregate information – will be disclosed. In developing A.8278, HCFANY extensively consulted with representatives of the LGBT community – a community which has historically expressed concerns with the possibility of discrimination from the disclosure of their identity. This community gave us the clear message that the need to have comprehensive information about the health status of members of their community far outweighs concerns that people will be deterred from seeking health care services, as long as reasonable measures to protect patient and subscriber privacy are instituted.

2. The Exchange should collect and report information relating to health disparities.

Within the context of the State’s data collection and disparity reduction efforts, the Exchange’s streamlined application should collect information on applicants’ sex, race, ethnicity, preferred language, disability status, sexual orientation, and gender identity. Consumers should be advised that this information is optional and how it might be used to better meet their needs. The application should include a privacy statement at the very beginning of the application that explains how the information will be used, who it will and will not be shared with, how it will be stored, and for how long. For paper applications, this information could be provided as a separate set of instructions, along with rights and responsibilities. Online applications could use “pop-up” boxes to provide this information.

The Exchange should collect and report voluntarily-given sexual orientation and gender identity data.

The Affordable Care Act, Healthy People 2020, and the Institute of Medicine (IOM) recommend gathering sexual orientation and gender identity data in clinical settings. This would be in addition to data on race, ethnicity, gender and other demographic data that are often linked to health disparities in particular population cohorts. This is essential to understanding and reducing health disparities affecting LGBT people. In a 2011 report on LGBT health, the IOM recommends sexual orientation and gender identity data is collected through electronic health records (EHR). Data collected should be used to inform outreach efforts, determine recertification of Qualified Health Plans, and ensure network adequacy.

There are a number of barriers to gathering LGBT data, including patient fear of discrimination, provider discomfort, and confidentiality concerns. However, these can be overcome with proper training of staff, explanation of confidentiality protections in place, and the option to not report sexual orientation and gender identity data.

The Exchange should collect and report data regarding the appropriate delivery of family planning and reproductive health services.

We recommend the Exchange implement quality indicators for health plans offered through the Exchange that will measure the appropriate delivery of family planning and



reproductive health services to girls and women of reproductive health age. Plans should ensure that female enrollees receive family planning counseling that is non-judgmental and in the patient's language of choice. The Exchange should use this data to inform outreach efforts, determine recertification of Qualified Health Plans, and ensure network adequacy.

The Exchange should collect and report data in the baseline application on disability status.

The data elements for the Exchange proposed by CMS do not include disability status in the baseline application. We strongly recommend that New York include disability status as baseline application information. This information is important for tracking health disparities, how well certain populations follow through with enrollment, and will ensure disabilities are accommodated.

The Exchange should collect and report data regarding other existing health disparities.

We recommend the Exchange require insurance companies to collect data showing their performance on addressing other health disparities, such as reducing rates of maternal and infant mortality and morbidity among women and infants of color. Qualified Health Plans should have targeted strategies to address these known problems, and the Exchange should use this data to monitor progress towards eliminating gaps in health care access and health outcomes.

The Exchange should collect and report quality and consumer satisfaction data in the context of health disparities.

We recommend the Exchange collect data regarding insurer performance and patient satisfaction with a specific plan. Measures should be used to track disenrollment, denied claims, misinformation in outreach, etc. This data should be strongly considered during the recertification of a Qualified Health Plan, and should be utilized when addressing consumer complaints. HCFANY details recommendations of quality and consumer satisfaction ratings for the Exchange in our September 28, 2012 comments on New York State Health Benefit Exchange: Developing a Quality and Satisfaction Rating Proposal.

Compliance

The Exchange could also address health disparities through civil rights compliance and enforcement. Fifteen years ago, the disability community worked with New York State to develop ADA Compliance Guidelines for Medicaid beneficiaries that are included as Appendix J in the New York State Department of Health contract, which educates plans regarding their obligations and provides guidance on how to meet them.

Center for Independence of the Disabled New York (CIDNY) recently conducted a review of ADA compliance plans filed by managed long-term care plans and found a pervasive lack of compliance. An Exchange with the right resources and commitment to reducing health



disparities could do a much better job of ensuring members of protected classes are not excluded from participating in or denied access to the benefits of plan services, programs, and activities – from marketing and education through grievances and appeals.

Thank you for considering our comments. If you have any questions, please contact Carrie Tracy at ctracy@cssny.org or at (212) 614-5401.

Sincerely,

Carrie Tracy, JD
Deputy Director of Health Initiatives
Community Service Society of New York

¹ <http://www.highered.nysed.gov/kiap/precoll/documents/2012ShortageBulletin.pdf>

² HCFANY has made several recommendations to improve A.8278 since the bill was introduced. These recommendations are a result of the disparities work group of the Medicaid Redesign Team and can be found in the HCFANY Letter to Mylan Denerstein, Counsel to the Governor (December 12, 2011), *Appendix 1*.



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 Center for Analysis and Advocacy

Sent via Email and Hand Delivered

December 13, 2011

Mylan L. Denerstein
 Counsel to the Governor
 State Capitol
 Albany, NY 12224

RE: Recommendations of Medicaid Redesign Team: Health Disparities Work Group

Dear Ms. Denerstein:

On behalf of Health Care for All New York (HCFANY), a statewide coalition of more than 120 organizations which seek to achieve affordable, quality health care for all New Yorkers, I am writing to urge swift action by the Governor on several of the Final Recommendations of the Medicaid Redesign Team Health Disparities Work Group (hereinafter, "MRT Disparities Work Group Recommendations" or "Work Group Recommendations").

HCFANY shares the concerns of health advocates around the nation as to the critical need for bold actions by the federal government and the states to address health disparities by race, ethnicity, sex, primary language, disability, sexual orientation and gender identity. For this reason, in 2009, we formed a Disparities Task Force to allow community groups to act with a unified voice to address and promote the need for policy solutions to address health equity. Initially, we wish to commend the MRT Disparities Work Group ("Work Group") for its thorough and comprehensive approach to this critical concern. Our priority recommendations follow:¹

I. Data Collection/Metrics to Measure Health Disparities

HCFANY in general endorses the recommendation of the Work Group that the administration implement and expand upon the "data collection standards required by Section 4302 of the Affordable

¹ The recommendations of the Work Group are available at:

http://www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf. Please note that HCFANY is making limited comments in this letter based on our particular areas of organizational focus and expertise. Our failure to address a particular recommendation of the MRT Disparities Work Group should not be taken as implying that we do not support that particular recommendation.

Health Care for All New York
 c/o Elisabeth Ryden Benjamin, Community Service Society of New York
 105 E. 22nd Street, New York, New York 10010
 (212) 614-5461



Care Act.”² We support the development of a comprehensive system of reporting and public dissemination of health care outcomes by race and ethnicity, gender and other factors, building on the ACA and existing state efforts. For this reason, HCFANY has drafted legislation with the participation of several organizations in HCFANY’s Disparities Task Force to require the creation of a state “Health Care Disparities Data Collection System” so that health disparities information is easily accessible to policymakers, researchers and the general public.

Our proposal, introduced as Assembly Bill 8278, would require the State Department of Health (SDOH) to establish a system to require health care plans, hospitals and other health care institutions to report the following items, among others, by race, ethnicity, gender, primary language, sexual orientation and disability status: the coverage or care provided to applicants, patients and subscribers, and the health outcomes of patients or subscribers based on quality measures developed by the state, like asthma and diabetes management. We urge the administration to use our bill as the basis for legislation it submits to the Legislature next year on data collection, hopefully as part of the administration’s FY 2012-13 Executive Budget Proposal. While we of course support A.8278, we believe the administration should consider certain revisions to this proposal. We have become aware of the need for these changes through our participation in a HHS proceeding to develop data collection standards under section 4302 of the ACA,³ and our examination of the MRT Disparities Work Group recommendations. The changes we propose are as follows:

- While A.8278 explicitly provides for data collection for each of the seven U.S. Census subcategories of “Asians” (see proposed Public Health Law § 246(7)), it is less clear that our bill would require that the “Hispanic, Latino, or Spanish Origin” category be similarly be broken down by the major U.S. Census subcategories of this ethnic group. This oversight on our part should be addressed.
- We endorse the Work Group recommendation that questionnaires developed under the data collection system created by the bill give respondents of Asian or Hispanic origin the option of filling in their own ethnicity if it is not provided as a specific response in the questionnaire.
- A.8278 should be revised to clarify that in responding to questionnaires on race and other factors, people of mixed race have the option of selecting more than one race if they desire, as recommended by the Work Group.
- The bill should be revised to include data based on gender identity as well as sexual orientation.
- We support the Work Group proposal to “incorporate measures that assess preferred language at the health care setting:” either through legislative language or subsequent regulations.
- We agree with the Work Group recommendation to include the six disability questions used in the 2011 American Community Survey, augmented to correct for undercounting.⁴

We also endorse the Work Group’s proposal that additional state funding be provided to support data analyses, research, and promotion of programs to address health disparities.⁵ The administration should also investigate the appropriateness of using grant funding provided under the ACA to enhance its

² MRT Disparities Work Group Recommendations, Recommendation 1, at 8 (Recommendation on Data Collection/Metrics to Measure Health Disparities).

³ Notice of Availability of Proposed Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status Required by Section 4302 of the Affordable Care Act; Docket ID Number HHS-OMH-2011-0013. HCFANY’s comments in this proceeding are attached.

⁴ MRT Disparities Work Group Recommendations, at 10 (Recommendation on Data Collection/Metrics to Measure Health Disparities).

⁵ Work Group Recommendations, Recommendation 4, at 8 (Recommendation on Data Collection/Metrics to Measure Health Disparities).



data collection efforts, especially given the key role the future state Health Benefit Exchange could play in addressing health disparities.

II. Language Access Issues

A. Reimbursement for Costs of Interpretation Services

We support the Work Group recommendation to adjust Medical Assistance rates of payment to provide for reimbursement for the costs of interpretation services for patients with limited English proficiency (LEP) and communication services for people who are deaf and hard of hearing. Further, as the Work Group recommends, reimbursement should be made for interpretation services provided during the course of treatment as well as in other situations, such as making appointments and billing encounters. Moreover, as the Work Group recommends, interpreters must be skilled in medical interpretation and terminology in the case of clinical encounters.⁶

B. Prescription Labels

HCFANY supports the Work Group recommendation that the State Board of Pharmacy be required by legislation to develop regulations and standards to: 1) create standardized prescription label instructions, 2) require that pharmacies with five or more stores and mail order pharmacies provide translation and interpretation services to LEP patients, and 3) modify state prescription pads to allow prescribers to indicate if a patient is limited English proficient.⁷ We note that these proposals will not only benefit the LEP community, but, as noted in the Work Group report, aid in patient safety, both for LEP and non-LEP populations.

III. Emergency Medicaid

HCFANY strongly supports the recommendations to streamline and improve access to Emergency Medicaid by issuing guidance about the program and implementing outreach initiatives among consumers, providers and local social services districts. We also support the recommendations to establish advanced screening and prequalification for this critical program, and to extend certification periods for certain emergency medical conditions.⁸ These changes will allow providers to receive appropriate reimbursement from federal funds and reduce hospital and institutional reliance on state and federal funding intended to pay for care to uninsured patients.

Currently, the Emergency Medicaid application process is unnecessarily complex and burdensome. HCFANY has long supported proposals to streamline the application process for Emergency Medicaid by allowing prequalification of eligible community members and extending the certification periods to relieve patients, providers, and facilities of the need to re-apply for coverage before a patient has recovered.

IV. Cultural Competency Training

⁶ Work Group Recommendations, at 15 (Recommendation on Improving Language Access to Address Disparities).

⁷ Work Group Recommendations, at 20 (Recommendation on Promoting Language Accessible Prescription Labels).

⁸ Work Group Recommendations, at 30-31 (Recommendation on Streamlining and Improving Access to Emergency Medicaid).



HCFANY supports the Work Group recommendation that New York address disparities through training for various members of the New York State health care workforce. Specifically, we support the recommendation mandating annual training of staff of programs licensed by the Office of Alcohol and Substance Abuse Services and the Office of Mental Health on Sexual Orientation and Gender Identity and Expression. We also support the recommendation that the state apply for available funding under ACA § 5307 for the purpose of developing curricula on cultural competency, prevention, public health proficiency and working with individuals with disabilities.⁹ These trainings or separate trainings should address the needs of people of different racial and ethnic backgrounds, people with disabilities, and people at risk of suicide. We believe that with better educated health professionals, the state can reduce barriers and improve communication with individuals in health care, which will result in better health outcomes.

V. Use of Charity Care Funds

HCFANY agrees with the Work Group that the charity care reimbursement system “must be revised to ensure that charity care funding ... is used to pay for the care of the uninsured.”¹⁰ We strongly support the principle that funding should fully follow the patient: hospitals should be paid from the Indigent Care Pool (ICP) based solely on the costs of services provided to patients who receive financial assistance.

To ensure that this recommendation is effectively implemented, we support the recommendation of the MRT Payment Reform and Quality Measurement Work Group that a new work group be convened to recommend means to strengthen compliance with the state’s Hospital Financial Assistance Law (HFAL) and consider appropriate links between the ICP distribution methodologies and the HFAL.¹¹ We urge the Governor to convene this work group, including significant consumer representation, as soon as possible.

The current ICP distribution methodology allows hospitals to receive payments for uncompensated care including bad debt. In other words, a hospital can send its uninsured patients to collections for bills they cannot pay, and then receive ICP funds to pay for that care. This methodology provides no incentive for hospitals to follow the requirements of the HFAL. HFAL requires hospitals to provide discounted care to uninsured patients with income at or below 300 percent of the Federal Poverty Level. It also requires hospitals to create simple application materials and procedures, to inform all patients about the availability of financial assistance, and to implement consumer protections in their collections procedures.

Research by the Community Service Society of New York, to be released in a forthcoming report, resulted in the following findings:

- Many New York hospitals do not fulfill their obligations to provide public access to financial assistance materials as required under the HFAL.

⁹ Work Group Recommendations, at 43 (Recommendation on Addressing Disparities Through Targeted Training for NYS’ Health Care Workforce).

¹⁰ Work Group Recommendations, at 49 (Recommendation on Promoting Effective Use of Charity Care Funds).

¹¹ Payment Reform and Quality Measurement Work Group Final Recommendations, Recommendation 3, at 16. (Recommendation on Indigent Care Funding Program).



- Of 201 hospitals surveyed, 20 (10%) did not release information about their financial assistance policies upon request and do not publicly post HFAL information on their websites. In 2010, these hospitals received \$87,397,389 in ICP payments.
 - Of 181 hospital financial aid applications obtained and reviewed, 102 (56%) do not comply with five basic requirements under the HFAL. In 2010, these hospitals received \$400,025,366 in ICP payments.
 - Of the 181 applications reviewed, 63 hospitals (35%) include unlawful requirements (and received \$204,845,679 in ICP payments) and 45 hospitals (25%) ask for impermissible patient financial information (and received \$169,259,198 in ICP payments).
- A review of data reported to the State by hospitals receiving ICP payments revealed errors and inconsistencies.
 - Hospital reporting in many cases is flawed and/or inconsistent with other related reports. In 2010, hospitals reporting patently flawed and/or inconsistent data received \$87,103,901 in ICP payments.
 - Hospitals' cost reports and ICP payments are used to compensate hospitals for costs in a manner that will soon be impermissible under federal law (e.g. 70% of hospitals reported that more than 50% of their uncompensated care costs were bad debt). In 2010, hospitals reporting more than 50% bad debt received \$673,510,656 in ICP payments.
 - Many hospitals reporting the highest level of "targeted need" report providing lower than average financial assistance to their patients. In 2008, 39 hospitals reported a higher than average (4.3%) level of targeted need, but approved fewer than the average 15.8 applications per certified bed. These hospitals received \$266,008,905 in ICP payments in 2010.
 - Hospitals using unlawful HFAL applications approved far fewer financial assistance applications than their lawful counterparts (e.g. unlawful hospitals approved an average of 5 applications per hospital bed; lawful hospitals approved an average of 23 applications per bed). In 2010, the hospitals using unlawful HFAL applications received \$204,845,679 in ICP payments.
 - Many hospitals send patients who cannot pay to collections and are aggressively pursuing liens on patients' homes. In 2010, the state provided \$246,174,421 in hospitals ICP payments to hospitals that had placed over 4,000 liens on patients' homes in 2008.

VI. Transgender-Related Health Care Services

Finally, we were disappointed that neither the Work Group nor the Basic Benefit Review Work Group adopted the proposal of the Empire Justice Center (EJC) to reconsider 18 N.Y.C.R.R. § 505.2(1), a regulation that bars Medicaid coverage for transgender-related health care services. We are attaching EJC's October 14, 2011 letter to both work groups, which details the defects of this outdated and discriminatory regulation. As the EJC letter indicates, the regulation creates extraordinary barriers to the receipt of safe, medically appropriate care to this population and is inconsistent with both the Fourteenth Amendment to the U.S. Constitution and Article XIV of the New York State Constitution. The state



constitutional provision imposes an affirmative duty to provide medical assistance to the needy and prohibits the use of standards in providing that assistance that have nothing to do with need. If the administration is unable to address this discriminatory policy in the context of the MRT process, we would urge you to ask the SDOH to reexamine this discriminatory regulation.

Thank you for the opportunity to offer comments on the critical subject of reduction of health care disparities in New York State and the Medicaid Redesign Team recommendations on this topic. We offer any assistance your office requires to develop any of the proposals outlined in this letter. If you want to discuss this further, please contact me at bcohen@citizenactionny.org or at (518) 465-4600 x104.

Sincerely yours,

Bob Cohen, Esq.

Policy Director, Citizen Action of New York and Public Policy and Education Fund
On Behalf of HCFANY and the HCFANY Disparities Task Force

Attachments