

**Redesigning**  
THE MEDICAID PROGRAM



NEW YORK STATE DEPARTMENT OF HEALTH

# Medicaid Redesign Team (MRT)

Health Disparities Work Group

FINAL RECOMMENDATIONS



## **Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011**

### **Work Group Charge:**

- This work group will advise the Department of Health (DOH) on initiatives, including establishment of reimbursement rates, to support providers' efforts to offer culturally competent care and undertake measures to address health disparities based on race, ethnicity, gender, age, disability, sexual orientation and gender expression.
- The work group will also advise DOH about incorporating interpretation and translation services to patients with limited English proficiency and who are hearing impaired.
- This workgroup will advise DOH about data collection efforts related to health disparities including advice to ensure consistency with Federal Requirements as defined under section 4302 of the Affordable Care Act.
- This workgroup will advise DOH about use of a Disparities Impact Assessment to evaluate all MRT recommendations.
- The work group will also address health disparities among people with disabilities, including people with psychiatric disabilities and substance use disorders, and their need for equal access to primary and preventive health care services.
- The work group will explore issues related to charity care and the uninsured.
- Work group membership will include individuals from a range of racial and ethnic groups and community-based organizations with experience serving them; the New York City Health and Hospitals Corporation; other safety net providers; community-based immigrant groups; and legal services representatives.
- This work is related to MRT recommendation # 990, Explore the Establishment of Reimbursement Rates to Support Efforts to Address Health Disparities.



## Work Group Membership:

- **CO-CHAIR: Arlene Gonzalez-Sanchez**, Commissioner, NYS Office of Alcoholism and Substance Abuse Services
- **CO-CHAIR: Elizabeth Swain**, Chief Executive Officer, Community Health Care Association of NYS
- **Noilyn Abesamis-Mendoza**, MPH, Manager, Health Policy, Coalition for Asian American Children & Families
- **Nisha Agarwal**, Director, Health Justice, New York Lawyers for the Public Interest
- **Diana M. Babcock**, Dual Recovery Peer Specialist, Mental Health Empowerment Project
- **LaRay Brown**, Sr. Vice President, Corporate Planning, Community Health and Intergovernmental Relations, NYC Health and Hospitals Corp.
- **Jo Ivey Boufford**, MD, President, New York Academy of Medicine
- **Carla Boutin-Foster**, MD, MS, Associate Professor of Medicine, Weill Cornell Medical College
- **Neil Calman**, MD, President and CEO, Institute for Urban Family Health
- **J. Emilio Carrillo**, MD, VP for Community Health, NY-Presbyterian Hospital
- **Susan Dooha**, Executive Director, Center for Independence of the Disabled in NY
- **Rosa M. Gil**, DSW, President and CEO, Comunilife
- **Charles King**, President and CEO, Housing Works
- **Jonathan Lang**, Director of Governmental Projects & Community Development, Empire State Pride Agenda
- **Glenn Liebman**, CEO, Mental Health Association of NYS
- **Pamela Mattel**, LCSW, CASAC, Chief Operating Officer, Promesa Systems, Inc.
- **Dennis Mitchell**, Associate Dean for Diversity & Multicultural Affairs, Columbia University College of Dental Medicine
- **Ngozi Moses**, Executive Director, Brooklyn Perinatal Network, Inc.
- **Theo Oshiro**, Director of Health Advocacy & Support Services, Make the Road New York
- **Gregson H. Pigott**, MD, MPH, Director, Office of Minority Health Suffolk County Department of Health
- **Chau Trinh-Shevrin**, Director, NYU Center for the Study of Asian American Health
- **Jackie Vimo**, Director of Advocacy, NY Immigration Coalition



## Meeting Dates and Focus:

- **Tuesday, August 9, 2011, 10:30am to 3:30pm.** The first meeting focused on providing background information to ensure that the Disparities Work Group targeted its work from a common knowledge base and identifies major issue areas where specific recommendations are to be developed.
- **Friday, September 16, 2011 from 1:00 pm to 4:00 pm** Following a welcome to the Workgroup's newest member, Glen Liebman, and an overview of the MRT process provided by Jason Helgerson, the majority of the meeting focused on report outs from each of the topical working groups including: Data Collection; Disparities Impact Assessment; Health Homes ; Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning; Chemically Dependent Individuals; Homeless Persons; Persons with HIV (sexual health); and Immigrant Populations. The depth of each of the presentations and number of unique topic areas to be addressed precluded the workgroup from completing the defined agenda. As a result an additional meeting was scheduled for October 3rd to permit full discussion of all issue areas.
- **Monday, October 3, 2011, from 1:00pm - 4:00pm.** This meeting provided an opportunity to complete report outs from the topical working groups which included : Systemic Reform and Access to Health Services; Language Access; Persons Living with Mental Illness; Persons with Disabilities; Maternal, Infant and Child Health and Disease-Specific Proposals. The meeting concluded with a review of next steps including a process to prioritize recommendations.
- **Wednesday, October 12, 2011, 10:30 AM - 3:30 PM.** The fourth and final meeting of the workgroup focused on a discussion of the results of the prioritization exercise and identification of fourteen distinct proposals that scored highest using the scoring and ranking criteria established for this purpose. In addition to the fourteen proposals identified that will be officially forwarded to the full MRT for consideration there were multiple other proposals that will be forwarded for consideration to other MRT workgroups such as the Training and Benefits workgroups. Finally, some broad-based recommendations will be conveyed through a formal letter from the workgroup co-chairs to the Commissioner of Health for consideration for implementation by the Department of Health.



## Outside Experts Consulted with:

No outside experts participated apart from members of the group.

## Brief Summary of Discussions that Led to Focus on Recommendations Included in this Report:

The Work Group began with a review of the data on health disparities in different population groups defined by race/ethnicity, gender and gender identity, disability status, etc. The Work Group then devoted a considerable amount of time to soliciting, developing, reviewing and discussing proposals relevant to specific populations impacted by health disparities. Some Work Group members convened focus groups representing their communities for the purpose of generating proposals. The Work Group developed an overarching recommendation that all MRT Work Groups conduct a health disparities assessment of each MRT proposal. This recommendation was transmitted early on to the other Work Group chairs and is now included as a standard part of the MRT proposal template. Another overarching recommendation of the Work Group relates to the need for enhanced data collection to better measure health disparities by race/ethnicity, gender identity, and housing status for the purposes of program and policy development and targeted interventions as appropriate.

Following review, discussion and analysis of multiple proposals the workgroup undertook a prioritization exercise ranking the 69 proposals that had been proposed. At the last meeting of the group, this prioritization formed the basis of the discussion that result in the 14 final recommendations that were transmitted to the full MRT. These recommendations address the following populations all of which suffer health disparities: persons with disabilities; persons with limited English proficiency; immigrants; Lesbian, Gay, Bisexual and Transgender persons; persons with mental illness, substance use disorders and persons at risk of suicide. In addition several cross-cutting public health proposals were recommended to address health disparities in chronic disease and maternal and child health. These recommendations are listed in order of the priority assigned by the Health Disparities Working Group.



**Summary Listing of Recommendations: (list each recommendation by short name; supplemental information is to be provided on recommendation form)**

- 1) **Data Collection/Metrics To Measure Disparities:** The Medicaid Redesign Team Health Disparities Workgroup recommends that NYS DOH implement and expand on data collection standards required by Section 4302 of the Affordable Care Act by including detailed reporting on race and ethnicity, gender identity, the six disability questions used in the 2011 American Community Survey (ACS), and housing status. In addition the workgroup recommends that funding be provided to support data analyses and research to facilitate SDOH work with internal and external partners to promote programs and policies that address health disparities, improve quality and promote appropriate and effective utilization of services including the integration and analysis of data to better identify, understand and address health disparities.
- 2) **Improve Language Access to Address Disparities:** The Health Disparities Workgroup recommends that Medical Assistance rates of payment for hospital inpatient and outpatient departments, hospital emergency Departments, diagnostic & treatment centers, and federally-qualified health centers are amended to Provide 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.
- 3) **Promote Language Accessible Prescription s:** The workgroup recommends that actions be taken to require all chain pharmacies to provide translation and interpretation services for limited English proficient (LEP) patients, that standardized prescription labels be required to ensure understanding and comprehension especially by LEP individuals and that prescription pads be modified to allow prescribers to indicate if a patient is LEP, and if so, to note their preferred language.
- 4) **Promote Population Health through Medicaid Coverage of Primary and Secondary Community-Based Chronic Disease Preventive Services:** The Workgroup recommends that Medicaid be expanded to include coverage of Pre-Diabetes group and individual counseling services (fee-for-service and managed care); lead poisoning, asthma, home visits and automated home blood pressure monitors for patients with uncontrolled hypertension.
- 5) **Streamline and Improve Access to Emergency Medicaid:** It is recommended that the State take actions to increase awareness about emergency Medicaid among consumers, providers, and local Social Services districts, streamline the application process through prequalification and extend certification periods for certain medical conditions to enable providers to receive appropriate reimbursement from federal funds and reduce hospital and institutional reliance on state charity care dollars.
- 6) **Address Disparities in Treatment at Teaching Facilities:** The Health Disparities Workgroup recommends that actions be taken to ensure that existing standards of care are enforced in teaching hospitals and training clinics to ensure that the care provided to persons who are uninsured, to people covered by Medicaid, and to the privately insured is consistent and is of the highest quality and equivalent to those services provided by the private faculty practices in the same institutions.



- 7) **Address Disparities Through Targeted Training for NYS' Health Care Workforce:** Mandated cultural competency training is recommended to promote care and reduce disparities for all individuals including but not limited to people with disabilities, Lesbian, Gay, Bisexual and Transgender persons, persons with mental illness, substance use disorders and persons at risk of suicide.
- 8) **Enhance Services to Promote Maternal and Child Health:** The health disparities workgroup recommends that the following Medicaid enhancements and expansions be implemented to promote maternal and child health: Expanded access to contraception and other family planning services including inter-conceptional care following an adverse pregnancy; breastfeeding education and lactation counseling during pregnancy and in the postpartum period; and support of initiatives to demonstrate effective and efficient use of HIT technology between hospitals/health care systems and community-based health organizations to improve care delivery.
- 9) **Enhanced Services for Youth in Transition with Psychiatric Disabilities:** The workgroup recommends that comprehensive programs to serve youth in transition with psychiatric disabilities be developed across all systems of care including foster care, school populations that have youth with a Serious Emotional Disorder diagnosis and the juvenile justice population to ensure that youth with psychiatric disabilities do not end up homeless or in the criminal justice system.
- 10) **Promote Effective Use of Charity Care Funds:** The Medicaid Redesign Team Health Disparities Workgroup recommends that the charity care reimbursement system be revised to ensure that charity care funding is transparent, is used to pay for the care of the uninsured and that there is greater accountability for use of these funds.
- 11) **Promote Hepatitis C Care and Treatment Through Service Integration:** The Health Disparities Workgroup recommends that efforts be taken to promote the integration of hepatitis care, treatment and supportive services into primary care settings including community health centers, HIV primary care clinics and substance use treatment programs.
- 12) **Promote Full Access to Medicaid Mental Health Medications:** The Health Disparities Workgroup recommends that actions be taken to ensure that all Medicaid recipients who are in managed care plans where the pharmacy benefit is no longer carved out continue to have full access to mental health medications.
- 13) **Medicaid Coverage of Water Fluoridation:** To address disparities in access to dental services the Workgroup recommends that Medicaid funding be made available to support costs of fluoridation equipment, supplies and staff time for public water systems in population centers (population over 50,000) where the majority of Medicaid eligible children reside.
- 14) **Medicaid Coverage of Syringe Access and Harm Reduction Activities:** The Health Disparities Workgroup recommends that actions be taken to promote and address health care needs of persons with chemical dependency including allowing medical providers to prescribe syringes to prevent disease transmission; allowing harm reduction therapy as an appropriate and reimbursable treatment modality in OASAS facilities and by authorizing NYS DOH AIDS Institute Syringe Exchange providers to be reimbursed by Medicaid for harm reduction/syringe exchange program services provided to Medicaid eligible individuals.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Data Collection/Metrics to Measure Health Disparities

**Program Area:** Health Disparities

**Implementation Complexity:** Medium

**Implementation Timeline:** January 2013

**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Medicaid Redesign Team Health Disparities Workgroup recommends the following to improve Data Collection and Analyses to Reduce Health Disparities:

1. Implementation and expansion upon data collection standards required by Section 4302 of the Affordable Care Act (ACA) by including detailed reporting on race and ethnicity, gender identity, the six disability questions used in the 2011 American Community Survey (ACS), augmented to correct for undercounting (Hearing, vision, cognitive, ambulatory, self care or independent living difficulty) and housing status.
2. Review of federal Office of the National Coordinator for Health Information Technology (ONC) data requirements to assure consistency.
3. Review of existing disparity and cultural competence measures (HEDIS, QUARR CON, National Quality Forum, PQI and Ambulatory Sensitive Conditions data) for completeness, appropriateness and consistency with ACA and ACS data collection standards.
4. Provision of funding to support data analyses and research to facilitate SDOH work with internal and external partners to promote programs and policies that address health disparities, improve health care and public health program quality and promote appropriate and effective utilization of services including the integration and analysis of child health data to better identify, understand and address health disparities among children.





***More specifically:***

- Broad Implementation of Enhanced data Collection across Payer Types: Ensure implementation of Section 4302 of the PPACA data standards to federally supported programs such as Medicaid, Medicare, and the state health insurance exchanges as well as non-federally-funded health data collection systems such as the Statewide Planning Research Cooperative Systems (SPARCS). The integration of the ACA data provisions as part of public programs, health insurance exchanges, and hospitals will ensure that HHS as well as the state is compliant with Title VI of the Civil Rights Act of 1964 at the same time aligning with the goals of Healthy People 2020 and the National Stakeholder Strategy for Achieving Health Equity.
- Race/ Ethnicity: NYS is urged to adopt HHS proposed data standards which recognize diversity by addressing the need for disaggregated race and ethnicity data. In particular, breakdown of 3 granular Hispanic or Latino, 7 Asian, and 4 Native Hawaiian and Pacific Islander categories which aggregate to broader Office of Management and Budget (OMB) race categories. Additionally, HHS provides an option for individuals from multi-racial heritages to choose more than one race. The “race and ethnicity” questions can be strengthened by including an open-ended option for “Yes, another Hispanic, Latino, or Spanish Origin”, “Other Asian”, and “Other Pacific Islander” where a respondent can identify his/her ethnicity if it is not listed among the 14 Hispanic or Latino, Asian, and Native Hawaiian and Pacific Islander options. This open-ended option is similar to the proposed language standard which allows a respondent to fill-in his/her language. Given that Asian Pacific Americans comprise over 50 different ethnicities and Latinos comprise over 28 ethnicities, providing the ability for self-reported data of smaller Asian, Pacific Islander, and Latino subgroups will give us a more accurate picture of the health of these communities.
- Sexual Orientation and Gender identity. The Institute of Medicine (IOM) in its March 2011 report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*, emphasized the need for collection of gender identity and sexual orientation data on federally supported surveys. HHS is now in the process of developing a national data progression plan intended to begin the integration of sexual orientation and gender identity variables into HHS national surveys. Roundtable discussions on this topic will be completed in 2011; initial field testing of sexual orientation data collection and presentation of a strategy to include gender identity data collection in HHS surveys will be completed in the Spring of 2012 followed by a large scale field test of sexual orientation data collection and finally, if the field test is successful, new data collection on sexual orientation will be implemented in 2013. New York is urged to follow these activities and implement consistent data collection accordingly.



- **Primary Language.** Limited access to language services in the health care setting can impair discussions of symptoms and alternative treatment regimens, resulting in misdiagnoses or poor treatment decisions. Communication barriers also impede the understanding and compliance of treatment plans and therapies among patients with limited English proficiency. The HHS proposed data standards include questions to assess a person’s ability to speak English, primary language spoken at home, and language spoken. This is an important first step in addressing the needs of Limited English Proficient individuals. To strengthen these measures, the Workgroup recommends the following:
  - ✓ That NYS expand the collection and reporting of the spoken language category to also incorporate measures that assess preferred language at the health care setting as well as understanding and reading ability in English. The following modifications and additions based on the 2009 Institute of Medicine’s “Race, Ethnicity, and Language Data” are offered for consideration:
  - ✓ That NYS use the top 6 languages spoken according to the latest U.S. Census. Using the top 6 languages threshold is similar to what NYC’s Executive Order 120 (Citywide Policy on Language Access) uses to determine languages to translate and provide interpretation for at city agencies.
  - ✓ In addition to the expanded spoken language categories, sign language for spoken language and Braille for written language should be part of the national standard language list.
  - ✓ Expansion of language options beyond “Spanish” and “Other Language (identify)” for question “What is this language?”
  - ✓ Addition of a question on the preferred spoken language in a health care setting
  - ✓ Addition of a question on the preferred language a person would like to receive written materials
  - ✓ Addition of a question assessing English literacy level
  - ✓ Addition of a question assessing English comprehension and understanding
- **Disability:** The workgroup recommends that New York State implement data collection standards required by Section 4302 of the Affordable Care Act by including the six disability questions used in the 2011 American Community Survey (ACS), augmented to correct for undercounting. Further, the workgroup notes that the Office of Minority Health of the U.S. Department of Health and Human Services proposed data collection standards for Race, Ethnicity, Primary Language, Sex, and Disability Status do not capture: people with activity limitations due to severe cognitive disabilities or sensory disabilities; speech impediments; learning disabilities; people with chronic health conditions; nervous system conditions and some other conditions. (Correspondence of the American Association on Health and Disability to Garth Graham, Deputy Assistant Secretary for Minority Health, Office of Mental Health, U.S. Department of Health and Human Services, July 27, 2011.) It is recommended that New York State implement data collection standards that address this expanded definition of persons with disabilities.



- Reporting and Small Sample Size. The workgroup recommends that NYS undertake actions to enhance reporting on small ethnic communities and in small geographic units when possible and permissible given existing confidentiality protections and with sufficient funding. Given relatively small numbers in some rural towns or for small ethnic communities data may not be available with which to assess unique health status indicators.
- Housing Status. The workgroup recommends that New York collect information regarding individual's housing status such as: *"Are you homeless?" "Do you reside in a shelter?" and "Do you reside in a domestic violence shelter?" "Do you have a permanent home?"* Additional questions that might be considered as indicators of risk factors for homelessness include: *"Do you live with friends or relatives?" and "Do you have an eviction notice?"* These questions are recommended as a means of learning about the causes of homelessness, to identify strategies to prevent homelessness, and how best to serve people who are homeless.
- Funding to Support Data Integration and Analysis. Funding to support SDOH data integration and data analysis by internal and external researchers is critical to effectively utilize the data collected and will result in numerous benefits including:
  - ✓ Assisting providers with the delivery of timely preventive, diagnostic, and treatment services.
  - ✓ Lowering providers' risks of not having critical medical information about patients to render proper treatment and intervention.
  - ✓ Improving coordination of care across multiple programs and providers.
  - ✓ Reducing potential for duplicative services and delays in care while waiting to manually collect patient records across providers.
  - ✓ Assisting providers in reporting statutorily mandated information.
  - ✓ Enabling clinicians to have a full public health picture of an individual's medical history and public health services to facilitate clinical care and follow-up in a timely manner for improved service delivery and health outcomes; and to monitor the population health of New Yorkers and identify and assess public health needs and issues.
  - ✓ Tracking compliance with national policies.
  - ✓ Estimating and monitoring the prevalence of select health outcomes to better targeted interventions, assistance and health care services.
  - ✓ Investigation of and addressing service gaps among different socioeconomic, race/ethnicity, and gender groups.
  - ✓ Evaluation of screening and case management guidelines to identify and better manage individuals and children with chronic health conditions.



**Financial Impact:** Costs associated with revising data collection forms and to support data analyses and research. (\$1.0M)

**Health Disparities Impact:** High – Collection of detailed data will facilitate enhanced analyses of health status indicators, identification of trends, and development of targeted interventions and ultimately reduction of health disparities.

**Benefits of Recommendation:** Overall these components of this recommendation will achieve the following broad health care system goals:

- Enhanced and more detailed data collection will support improved and more effective service delivery, system development, health care access and population-based health programs
- Collection of detailed data will facilitate enhanced data analysis; program and policy development and measurement of goal achievement with respect to reductions in health disparities.
- Increased data consistency and reliability across systems.
- Reduced time and money from more effectively targeted programs and services.
- Facilitation of disease prevention and health promotion.
- Improves quality of care and service delivery.

**Background:** This proposal is particularly important and germane to health care in New York State for the following reasons:

- *Diversity* - New York State is home to 11% of all the immigrants in the United States. One important aspect in which New York differs from many other parts of the United States is the extraordinary diversity of immigrants to New York. Individuals from nearly every country in the world are represented in New York State. Asian Pacific Americans trace their heritage to more than 50 different countries and speak more than 100 different languages. Latinos in the U.S. represent 28 countries. While many Latinos are bilingual and speak Spanish, many have also retained proficiency in indigenous languages and dialects.
- Blacks today are not only African American, but also Caribbean and African, adding new layers to what it means to be a black New Yorker.
- *Immigration Status* - 22% of New York State's (NYS) population are immigrants. More than one third of children in New York State (34%) live in a family with at least one foreign-born adult. While the overwhelming majority is immigrants in the Asian Pacific American and Latino communities, New York's diverse communities represent the full spectrum of immigration status.
- *Language* – 13% of the population aged 5 years and older in New York State speaks English less than “very well” compared with nearly 9% of the U.S. population.
- *Poverty* – According to the New York City Center for Economic Opportunity, Latinos have the highest rate of poverty at 30%, followed by 26% of Asian Pacific Americans, and 24% of Blacks. Twenty percent of all children in New York City live in households with incomes below 100% of the poverty level.



- *Health Insurance* – Racial/ethnic communities in New York City have higher rates of un-insurance than Whites. (27% of Latinos, 16% of Blacks, 14% of Asian Pacific Americans, and 9% of Whites). In addition, many immigrants are self-employed, working in small businesses or in cash-based industries that are less likely to offer health benefits. Uninsured rates are further magnified in the immigrant community due to immigration status, language barriers, and cultural stigmas of accessing public benefits.

Despite these needs, there continues to be a dearth of data on particular racial/ethnic populations. Data collection and reporting efforts for communities of color remains problematic. The reasons are many, including lack of funding and/or staff, confidentiality issues, insufficient sample sizes, and organizational capacity to translate research studies into multiple languages. Ultimately, these inadequacies result in an inaccurate picture of the state of health for particular racial groups, especially for its specific ethnic subgroups.

Many racial and ethnic minorities, people with disabilities, lesbian, gay, bisexual, and transgender (LGBT) communities, and other commonly underserved populations face unique health challenges, have reduced access to health care and insurance, and often pay the price with poorer health throughout their lives. These underserved populations are less likely to get the preventive care they need to stay healthy and are more likely to suffer from serious illnesses like diabetes and heart disease. When these populations do get sick, they are less likely to have access to quality health care. As a result, health disparities persist.

Collection of detailed data will facilitate enhanced data analysis; program and policy development and measurement of goal achievement with respect to reductions in health disparities. New York State is advancing a coordinated strategy and multiple initiatives to improve quality and the health of the population by leveraging existing data systems within the NYS Department of Health (DOH). For example, the Child Health Information Integration (CHI<sup>2</sup>) project is underway to integrate multiple systems to provide a timely, seamless integration of the health information of New York's children. A child health portal will aggregate a context-relevant view of the data into a single interface, and ultimately be integrated within an electronic health record system (EHR) directly within the clinician workflow, to provide decision support for public health practitioners and clinical community.

More broadly providers, public health, and researchers, will be able to study, identify, and address disparities and health care delivery while reducing overall costs. This work of this proposal can also enable the evaluation of critical issues such as regional and patient demographic variations in utilization, quality, and cost and examine the impact of reimbursement methodologies, public health interventions, and health care resources on utilization, quality, outcomes, and/or costs.

Anticipated financial benefits would be due to the increase in the number of individuals who are not lost in the system, and would thus receive early interventions to prevent complications from disorders that would benefit from improved treatment and follow-up. The financial savings would be reflected in such things as a decrease in medical expenditures, special education costs, and an increase in lifetime productivity. In addition, there are savings from improved efficiency and effectiveness of treatment as a



result of practitioners having access to more complete records for each individual that are readily accessible to those involved in their care.

Once implemented, this solution will have several technical benefits as well, by reducing duplication of effort in systems operations, supporting greater standardization in data collection and exchange, and enabling data exchange through the Regional Health Information Organizations (RHIOs) and Qualified Entities (QEs) which provide governance and technical services for health information exchange at the community level.

**Concerns with Recommendation:** Concerns regarding data integration efforts center on data ownership and privacy which will have to be carefully addressed. In addition this proposal depends upon the existence or creation of a technical infrastructure design and development and data modeling and management expertise to ensure timely and reliable system and data integration. Resources will be required to perform the various technical tasks associated with establishing the data linkages, and creating mechanisms to make the data readily available to clinicians, consumers and others. Appropriate privacy and security policies and practices will need to be established and monitored to ensure that state requirements are met.

**Impacted Stakeholders:** Data collection, analysis, and dissemination are integral components in properly identifying, monitoring, and addressing health disparities for the growing and diverse NYS communities. The collection of this data allows providers, advocates, funders, and decision makers to identify needs and resources and develop vital programs. Data can also bring to light when unequal access and treatment occurs within the health care systems. Without adequate mechanisms in which to collect, analyze, and report data, it is impossible to measure improvements in the health and healthcare for communities. Entities and organizations that will benefit from this proposal include:

- Individuals from throughout the State, particularly those who are most at risk for health disparities including racial and ethnic minorities; sexual minorities, persons with disabilities, persons who are homeless and persons of limited English proficiency
- Children , families and individuals who can expect to benefit from improvements in the quality of care and care outcomes;
- Healthcare providers, who will benefit from the ability to view timely and complete patient clinical data to provide better care and reduce unnecessary tests and procedures
- Local, state, and national public health agencies and practitioners, who will benefit from timely retrieval of comprehensive health data on multiple health concerns ranging from chronic and communicable disease, hospitalization, immunizations and reportable conditions;
- Other health and human services agencies
- Medicaid and other third party payers, including private insurers, who will benefit from enhanced information on which to develop programs and policies and integrated data sets that support coordinated delivery modes
- Vendors of health electronic exchange, who will develop products the efficiently transfer standardized information across the relative points of service.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Improve Language Access to Address Disparities

**Program Area:** Health Disparities

**Implementation Complexity:**

**Implementation Timeline:**

**Required Approvals:**

Administrative Action

Statutory Change

State Plan Amendment

Federal Waiver

**Proposal Description:** The Medicaid Redesign Team Health Disparities Workgroup recommends that an adjustment be made to Medical Assistance rates of payment (inclusive of Fee-for-service and managed care plans) for all hospital inpatient and outpatient departments, hospital emergency departments, diagnostic & treatment centers, and federally-qualified health centers throughout the State to specifically 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. To date the Medicaid reimbursement for language services has been limited to \$38M that has been included in the expenditure base that is included in the statewide base price for hospitals. \*

Further, it is recommended that this reimbursement be made for interpretation services provided during the course of a clinical encounter as well as in the process of billing and making appointments. Reimbursement shall only be available for interpretation services provided by individuals with demonstrated competency and skills in medical interpretation techniques, ethics and terminology. In order to be eligible for reimbursement, the provision of language services must be documented in such a manner as to enable reporting to and audit by the Commissioner of Health.

Patients with limited English proficiency” shall be defined as patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patients to interact effectively with health care providers and their staff. “Interpretation services” means language assistance services provided by individuals with sufficient bilingual skills in both English and the relevant language to communicate information necessary for the patient to access services and, in the case of interpretation services provided during the course of a clinical encounter, services provided by individuals with demonstrated competency and skills in medical interpretation techniques, ethics and terminology.

\* Similar proposals have been introduced in the NYS Legislature. See A 661 (Gottfried).



**Financial Impact:** Researchers have found that language assistance services result in lower costs. The use of interpreters “was associated with increased intensity of ED services, reduced ED return rate, increased clinic utilization, and lower 30-day charges, without a simultaneous increase in LOS [length of stay] or cost of visit.”<sup>1</sup> When interpreters were not available during a pediatric emergency room visits by LEP patients “physicians performed more extensive evaluations (more frequent and more expensive diagnostic testing) and treated children more conservatively (more intravenous hydration and more frequent hospital admission).”<sup>2</sup> One study recorded a significantly higher test cost, \$145, for patients with whom a physician encountered a language barrier as compared to when they did not, \$104.<sup>3</sup> Such data suggest a net cost savings to the Medicaid program as a whole if language assistance services are reimbursed, as the cost of such services is significantly less than \$104 per visit.

All told there are significant cost savings, not to mention federal matching funds to be gained, by enabling Medicaid reimbursement for language assistance services. In a time when the state is in financial distress, it is incredibly important that we allocate our dollars in a smart manner, which maximizes the benefits to Medicaid beneficiaries. Drawing down federal funds to reimburse providers for already required services is in line with the goals of the MRT.

### **Other States’ Expenditures:**

Thirteen states and the District of Columbia are already providing reimbursement for language services for LEP individuals and drawing down federal matching funds. Maine and Texas also provide reimbursement for interpreters for deaf and hard of hearing individuals. Below is a brief description of the cost some states incur for providing services. Of the 5 states listed below, all of them are spending less than \$1.50 per year per LEP resident.<sup>4</sup> Most of the data available is from before the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which included a provision for enhanced federal CHIP and Medicaid matching rate of up to 75% for translation and interpretation services provided to children. This means that these states’ costs are probably lower now that they can take advantage of such a high matching rate.

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<sup>1</sup> Bernstein, Judith, *et. al.*, “Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up,” *Journal of Immigrant Health*, Vol. 4, No. 4, October 2002.

<sup>2</sup> Hampers, L. and McNulty, J., “Professional interpreters and bilingual physicians in a pediatric emergency department: Effect on resource utilization,” *Archives of Pediatrics & Adolescent Medicine* 156 (11), 1108–1113, 2002.

<sup>3</sup> Hampers, L., Cha, S., Gutglass, D., Binns H. and Krug, S., “Language barriers and resource utilization in a pediatric emergency department.” *Pediatrics* 103, 1999.

<sup>4</sup> Cost data: National Health Law Program., “MEDICAID AND SCHIP REIMBURSEMENT MODELS FOR LANGUAGE SERVICES.” 2007.

LEP Statistics: U.S. Census, American Community Survey, *Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over for the United States*, April 2010, <http://go.usa.gov/bsl> (Excel spreadsheet with a workbook for each state).





- Virginia: In FY06 the state spent a total of \$8,546 for 507 hours of interpretation services; Virginia has an LEP population of 393,554 individuals which means they spent approximately \$0.02 per LEP resident.
- Utah: In FY06 Utah spent \$180,000 for foreign language services. The state's LEP population is 140,456 individuals, so they spend approximately \$1.28 per LEP person per year.
- Hawaii: In 2002, the state spent approximately \$144,000 per year on 2,570 visits. Hawaii has 133,631 LEP residents. This amounts to approximately \$56 per visit and \$1.07 per LEP individual per year in the state.
- Kansas: In 2006 the state spent \$46,479.74 for 41,193 minutes of interpretation services. Their LEP population is 111,696 which means the state spends approximately \$0.40 per LEP individual per year.
- Idaho: In 2006, the state spent \$87,913 on 7,438 interpretive services. Idaho has an LEP population of 56,065. This amounts to approximately \$12 per service and \$1.50 per LEP resident per year.
- Washington: Following a brokering system that is inconsistent with the way the NYS proposal recommended to the MRT is structured, Washington State spent \$1 million per month on all language services, of which \$38,225 was Medicaid spending. This cost was to provide services for 217,865 encounters. The state has 458,999 LEP individuals which means the state's Medicaid spending is approximately \$0.08 per LEP individual per year.

### **New York State Estimates:**

Using the upper limits of the amount these states are spending on language services per LEP resident, if NYS required a similar rate of language assistance services for our LEP population, we could estimate that the total expenditure would be approximately \$3,611,772 ( $\$1.50 \times 2,407,848$  LEP residents). Federal matching dollars should be subtracted from this amount to arrive at the estimated cost to the state, which we anticipate would be at or slightly above \$1M, in view of the 75% FMAP for SCHIP enrollees and the 50% FMAP for others. This is a fraction of a percent of the overall state budget.



**Health Disparities Impact:** High as all Medicaid eligible persons of limited English proficiency will benefit.

**Benefits of Recommendation:** Provision of language services in health care settings improves quality of care, reduces use of costly and unnecessary testing, and improves patient outcomes. As one reviewer noted, “research amply documents that language barriers impede access to health care, compromise quality of care, and increase the risk of adverse health outcomes among patients with limited English proficiency.”<sup>5</sup> Another study went on to show that Spanish-speaking patients who had an attending physician fluent in Spanish significantly reduced post-discharge ED visits, reducing costs by \$92 per Spanish-speaking patient over the study period.<sup>6</sup> In a State such as New York with such a large LEP population, there will be significant financial benefits to providing language services.

Among the individual benefits, researchers have found evidence that LEP individuals benefit from the immediate receipt of services, and the availability of longer-term preventative measures. One study showed that “language barriers are associated with poor quality of care in emergency departments (EDs); inadequate communication of diagnosis, treatment, and prescribed medication; and medical errors.”<sup>7</sup> This study also showed that LEP patients “have fewer physician visits and receive fewer preventive services, even after such factors as literacy, health status, health insurance, regular source of care, economic indicators or ethnicity are controlled for.”<sup>8</sup> Researchers have found that during hospital visits, LEP individuals suffer from a statistically higher incidence of adverse events resulting in physical harm than English-speaking patients. When asked, most doctors listed “communication” as the most significant factor leading to the events in cases of LEP patients.<sup>9</sup>

Researchers have found that language assistance services result in lower costs. The use of interpreters “was associated with increased intensity of ED services, reduced ED return rate, increased clinic utilization, and lower 30-day charges, without a simultaneous increase in LOS [length of stay] or cost of visit.”<sup>10</sup> When interpreters were not available during a pediatric emergency room visits by LEP patients “physicians performed more extensive evaluations (more frequent and more expensive diagnostic testing) and treated children more conservatively (more intravenous hydration and more frequent hospital admission).”<sup>11</sup> Thirteen states and the District of Columbia are already providing reimbursement for language services for LEP individuals and drawing down federal matching funds. Maine and Texas also provide reimbursement for interpreters for deaf and hard of hearing individuals.

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<sup>5</sup> Ku, Leighton and Glenn Flores, “Pay Now Or Pay Later: Providing Interpreter Services in Health Care,” *Health Affairs*, Volume 24, Number 2, 2005.

<sup>6</sup> Jacobs E, Sadowski L, Rathouz . “The Impact of Language Barriers on Hospital Costs and Length of Stay,” *Journal General and Internal Medicine*. S2: 306-11, 2007.

<sup>7</sup> Brach, Cindy, Irene Fraser and Kathy Paez, “Crossing the Language Chasm,” *Health Affairs*, 24, no. 2, 2005.

<sup>8</sup> *Id.*

<sup>9</sup> Divi, Chandrika, Richard Koss, Stephen Schmaltz and Jerod Loeb, “Language proficiency and adverse events in US hospitals: a pilot study,” *International Journal for Quality in Health Care*, February 2, 2007.

<sup>10</sup> Bernstein, Judith, *et. al.*, “Trained Medical Interpreters in the Emergency Department: Effects on Services, Subsequent Charges, and Follow-up,” *Journal of Immigrant Health*, Vol. 4, No. 4, October 2002.

<sup>11</sup> Hampers, L. and McNulty, J., “Professional interpreters and bilingual physicians in a pediatric emergency department: Effect on resource utilization,” *Archives of Pediatrics & Adolescent Medicine* 156 (11), 1108–1113, 2002.



**Concerns with Recommendation:** Implementation of this proposal will require a statutory change.

**Impacted Stakeholders:** Over 2.3 million New Yorkers are limited English proficient (LEP).

Organizations/Individuals in Support:

- Bronx Health Link
- Language Line Services.
- Farm worker Legal Services of New York, Inc.
- Community Healthcare Network
- International Medical Interpreters Association
- The Korean Community Services of Metropolitan New York, Inc.
- Community Engagement/Outreach Center for the Elimination of Minority Health Disparities  
University at Albany, SUNY
- Office of Government & Community Relations, University of Rochester

**Background:**

National: Over 2.3 million New Yorkers are limited English proficient (LEP) and have the right to health care in a language they understand. Title VI of the federal Civil Rights Act of 1964 prohibits any recipient of federal funding, including health care facilities, from discriminating on the basis of race, color or national origin. According to the U.S. Supreme Court, the failure to provide interpretation and translation services to LEP individuals constitutes discrimination on the basis of national origin under Title VI. Likewise, the Americans with Disabilities Act (ADA) requires that health care providers make communication assistance services available to people who are deaf or hard of hearing to ensure equal access to health services. In 2000, the Centers for Medicare & Medicaid Services issued a letter to State Medicaid Directors reminding them that federal matching funds are available for states' expenditures related to the provision of language assistance services. Further, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included a provision for enhanced federal CHIP and Medicaid matching rate of up to 75% for translation and interpretation services provided to children.

The context in New York: Since 2003, advocates and health care providers from across New York State have supported legislation that would enable Medicaid reimbursement for interpretation services at hospital inpatient and outpatient departments and Emergency Rooms; diagnostic and treatment centers; and federally-qualified health centers. The legislation authorizes reimbursement only for interpretation services provided by individuals with demonstrated competency and skills in medical interpretation techniques, ethics and terminology, and only to the extent that the provision of services is documented so as to ensure that state and federal funds are distributed for the purposes intended.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Promote Language Accessible Prescription Labels

**Program Area:** Health Disparities

**Implementation Complexity:** High

**Implementation Timeline:**

**Required Approvals:**

Administrative Action

Statutory Change

State Plan Amendment

Federal Waiver

**Proposal Description:** The Medicaid Redesign Team Health Disparities Workgroup recommends that the public health law and the education law be amended to require that the State Board of Pharmacy develop regulations and standards to guide creation of standardized prescription label instructions; that pharmacies with five or more stores and mail order pharmacies provide translation and interpretation services for limited English proficient (LEP) patients and that NYS prescription pads be modified to allow prescribers to indicate if a patient is LEP. These provisions would build upon existing requirements codified in New York City law and as a result of a 2009 agreement reached by the State of New York with seven major pharmacy firms in New York State and would extend the requirements of the current New York City law to chain pharmacies in all regions of New York State. More specifically, the Workgroup recommended that the New York City law pertaining to the provision of language assistance services in pharmacies be extended to apply to pharmacies through the State of New York that are part of a group of five or more (pharmacies) that are owned by the same corporate entity. \*

Patient advocates and researchers agree that language barriers and information inconsistencies are the a major cause of patient confusion over how to properly take prescription medications and result in lack of adherence to prescribed medications that threaten the health of the patient. Standardizing the information on prescription labels and providing translation and interpretation services will prevent costly outcomes. This proposal has four components, the first two are consistent with existing New York City law; the second are new proposals:

\* Similar legislation has been introduced in the NYS Legislature. See A7342-A(Gottfried)/S.5000-A (Hannon).



1. Pharmacies should be required to make available written translations of the standardized prescription drug labels into the top seven languages of patients who are LEP in New York. Pharmacies with five or more stores and mail order pharmacies should also be required to have interpretation services available for all patients who are LEP.
2. Pharmacies should be given flexibility to decide if bilingual staff, telephonic translation services, or other modalities of interpretation are the best option for them. This will ensure that most patients receive prescription drug information and counseling in a language they understand.
3. The State Department of Health should modify the official New York State prescription forms and electronic prescriptions to include a section for prescribers to indicate whether their patients are LEP, and if so, what their preferred language is. This will assist pharmacists in serving patients who are LEP by allowing them to easily determine and accommodate customers' language preferences.
4. In addition, the Workgroup recommends that the State Board of Pharmacy be given the authority to develop regulations and standards to assure clear and understandable prescription drug labels that address unique patient needs such as those of the elderly and those with limited vision. This will improve comprehension of labels by all consumers and provide unambiguous and straightforward directions for prescription drug use. The effective date would be flexible (one to two years) to allow compliance at the next scheduled software update.

## Background

**State Agreement:** On April 21, 2009 the New York State Attorney General [signed agreements](#) with seven major pharmacy chains requiring that they provide limited English proficiency customers with interpreting and translation services in all of their New York stores. These agreements were signed with 7 of the largest pharmacy chains in New York State: A&P, Costco, CVS, Duane Reade, Rite-Aid, Target and WalMart. For purposes of this agreement an individual is considered to be LEP if his or her knowledge of English is not sufficient for communicating about the safe and effective administration of prescription medications. For written translation, the agreement covers 11 languages. Six languages are fixed at the start: Chinese, French, Italian, Polish, Russian, and Spanish. Within 6 months after full implementation of their new pharmacy computer systems (scheduled to take place by March 31, 2010), each pharmacy chain is to add five additional languages based on their assessment of demographics and need in each chain's service area.

The pharmacies have to provide their LEP customers whose primary language is one of the 11 languages specified above the translated versions of the following: Directions for Use of the Drug; Warning Labels with information regarding the safe and effective use of the drug, including common side effects or adverse effects and contraindications; Notices of Privacy Practices; and Written offers of counseling. If an LEP customer does not speak one of the 11 primary languages for the pharmacy, the above-specified information does not need to be provided to the person in written form in their language. However, that information has to be relayed to the person orally (e.g., via telephone interpreting) in their primary language.



Oral Interpreting Requirements for the Pharmacies: Interpreting is to be available in **all languages** reasonably expected to be requested by each chain's customers. Pharmacy staff who are not able to communicate adequately with an LEP individual in their primary language have to utilize, free of charge to the customer, an interpreter, either in-store or over the phone, when soliciting information to maintain in a patient medication profile, offering prescription drug counseling, providing prescription drug counseling where such counseling is not "refused by the Customer", and accepting prescription refill requests, either in-person or over the telephone.

New York City Legislation: Legislation enacted by the New York City Council effective 2009 requires that every chain pharmacy provide free, competent translation of prescription medication labels, warning labels and other written material to each LEP individual filling a prescription at such chain pharmacy if that individual's primary language is one of the pharmacy primary languages, in addition to providing such labels and materials in English. Under this law chain pharmacies are permitted to provide dual- or multi-language medication labels, warning labels or other written materials to LEP individuals who speak one of the pharmacy primary languages if one of the languages included on such labels or sheets is the LEP individual's primary language.

**Financial Impact:** Proposal costs will be borne by the impacted pharmacies. In conversations between the New York State Board of Pharmacy with both chain and independent pharmacies, the regulated parties indicated that the cost of standardizing prescription labels may be significant. According to Health Disparities Work Group members, experience with similar legislation passed in California suggests that development of standardized labels may not be significant.

Costs for translation services (as currently required by NYC local law) are as follows based on information from two translation vendors and one pharmacy:

- **Vendor 1:** Monthly subscription fees – no limit on transaction - \$.83/ day/ store (even lower price per store if huge pharmacy); volume pricing available; 17 languages (will soon have 20)
- **Vendor 2:** Both interpretation and translation costs (computer-based system) \$1 - \$2/ day or \$62/month/ store (retail list price is \$90/month/store, but they always scale their contracts to make it as cost effective as possible). All languages are included for the same price. The current languages include: English, Spanish, Mandarin, Cantonese (Note: Chinese written text is available in both Simplified and Traditional), Korean, Bengali, Arabic, Haitian Creole, Italian, French, Russian, Polish (coming soon)
- **Vendor 3:** This is from a small independent pharmacy, which pays the following for translation for 7 languages: \$500 startup, plus about \$25/month subscription fee; \$2100 per year for 7 languages plus the \$500 initial fee.



**Health Disparities Impact:** Significant - particularly with respect to persons of limited English proficiency.

**Benefits of Recommendation:** The consequences of misunderstanding prescription labels can be dire and costly. Unintended misuse of prescription medications causes over one million yearly “adverse drug events,” resulting in visits to the emergency room, hospitalization and, in some cases, even death. Indeed, patient non-adherence with prescription instructions due to low levels of health literacy and other factors is responsible for 22% of all hospitalizations nation-wide. This problem places additional burdens on already under-resourced emergency rooms and hospitals and costs an extra \$3 billion per year in healthcare spending.

Injuries related to medication used in the outpatient setting result in over 700,000 emergency room visits annually, and over 100,000 of these emergency room visits result in hospitalizations. Over a quarter of emergency room visits for medication-related injury are by seniors, and over half of the patients hospitalized in these situations are seniors.<sup>12</sup> Emergency room visits and hospitalizations are a very expensive form of care. A study conducted by researchers at the Harvard Medical School found that the cost per preventable drug injury at a major urban hospital was \$10,375, resulting in a total cost for a single hospital of \$1.2 million per year.<sup>13</sup> As the state seeks to reduce unnecessary Medicaid expenditures, reducing the rate of needless, preventable, and costly Emergency room visits and hospital admissions is a strong initial step.

Recent data also shows that hospital readmissions cost New York State \$3.7 billion this year.<sup>14</sup> Ensuring medication compliance is one of the most straightforward and effective methods for preventing re-admissions. If enacted, this policy will help hospitals to reduce readmissions and increase treatment quality while also conserving financial resources.

With dozens of ways for a pharmacist to write “take once a day,” it is often challenging for patients to understand and act correctly on just one prescription instruction. For those who take multiple medications, such as the elderly, this challenge is even greater. Age-related declines in vision, memory and cognitive skills means that small print and cluttered labeling are particularly problematic for the elderly. Similarly, for the over 2.4 million LEP New Yorkers, the lack of translation makes labels literally incomprehensible.

Without standardized prescription labels or consistent access to translation and interpretation services, millions of elderly and LEP individuals are unable to fully understand medication information. As such, they are deprived of effective care, and their health and safety is seriously jeopardized. Despite this,

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<sup>12</sup> Daniel Budnitz, et al, *National Surveillance of Emergency Department Visits for Outpatient Adverse Drug Events*, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (JAMA) vol. 296, no. 15 (October 18, 2006), pp. 1858-1866.

<sup>13</sup> Ashish K. Jha, et al, *Identifying Hospital Admissions Due to Adverse Drug Events Using a Computer-Based Monitor*, PHARMACOEPIDEMIOLOGY AND DRUG SAFETY vol. 10 (2001), pp. 113-119.

<sup>14</sup> NYS Health Foundation, “Reducing Hospital Readmissions in New York State: A Simulation Analysis of Alternative Payment Incentives,” available at [http://www.nyshealthfoundation.org/userfiles/NYSHF\\_Mathematica%20Final\\_v5.pdf](http://www.nyshealthfoundation.org/userfiles/NYSHF_Mathematica%20Final_v5.pdf)



there is no state law that requires chain pharmacies to print prescription drug labels in a standardized format to aid in consumer comprehension or to translate them so that all patients can understand them.

This proposal gives New York, and New York's chain pharmacies, the opportunity to be industry leaders in not only curbing unnecessary medical costs, but doing so while simultaneously ensuring that all patients, including the elderly and patients who are LEP, can understand their prescription drug labels. As the MRT seeks ways to spend money more wisely while improving health care, and given the simple, cost-effective, and efficient solutions to this serious health problem, enacting this proposal is a practical way to increase access to and improve the quality and safety of health care for all New Yorkers.

**Concerns with Recommendation:** In conversations between the New York State Board of Pharmacy with both chain and independent pharmacies, the regulated parties indicated that the cost of standardizing prescription labels may be significant. These costs may be alleviated by allowing adequate time to phase in the requirement.

#### **Impacted Stakeholders:**

##### **Organizations/Individuals in Support:**

- Fort Greene Strategic Neighborhood Action Partnership
- Coalition for Asian American Children & Families (CACF)
- Polyglot Systems, Inc.
- Community Healthcare Network
- Hispanic Counseling Center
- Bronx Health REACH
- Department of Pediatrics New York Presbyterian Hospital - Weill Cornell Medical Center
- The Korean Community Services of Metropolitan New York, Inc.
- Health Literacy Special Interest Group Academic Pediatric Association
- University at Albany, SUNY, Community Engagement/Outreach Center for the Elimination of Minority Health Disparities
- New York Asian Women's Center
- South Asian Bar Association of New York





## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Medicaid Coverage of Primary and Secondary Community-Based Chronic Disease Preventive Services.

**Program Area:** Health Disparities

**Implementation Complexity:**

**Implementation Timeline:**

**Required Approvals:**

Administrative Action

Statutory Change

State Plan Amendment

Federal Waiver

**Proposal Description:** Promote Population Health through Medicaid Coverage of Primary and Secondary Community-Based Chronic Disease Preventive Services, by adding services listed below to the basic benefit package. Large disparities in health outcomes attributable to chronic disease persist in the United States and in New York State. Racial and ethnic minorities are among the fastest growing of all communities in the U.S. and comprise approximately 34 percent of the total U.S. population. Yet data on health status point to significant evidence of poorer health outcomes among racial and ethnic minorities with respect to death and preventable disease. Racial and ethnic minority communities experience higher rates of heart disease, stroke, cancer, obesity and diabetes. Within the African American and Hispanic demographic, nearly 40 percent of children are overweight or obese. Some examples of chronic disease health disparities are:

- High blood pressure – a major risk factor for coronary heart disease, stroke, kidney disease and heart failure – is nearly 40 percent greater in African Americans than in Whites. In addition, African Americans continue to experience a higher rate of strokes, have more severe strokes, and are twice as likely to die from strokes as White Americans.
- Diabetes. Racial and ethnic minorities, especially the elderly, are disproportionately affected by diabetes. On average, African Americans are 2.1 times as likely as Whites to have diabetes, and are more likely than Whites to experience complications of diabetes, such as amputations of lower extremities. American Indians/Alaska Natives are 2.3 times as likely as non-Hispanic Whites of similar age to have diabetes. Hispanics are 1.7 times as likely to have diabetes as Whites, with Mexican Americans – the largest Hispanic subgroup – more than twice as likely.



The Health Disparities Workgroup recommends the following changes/enhancement to ensure Medicaid coverage of primary and secondary chronic disease prevention and treatment:

1. Diabetes. Currently New York State does not cover pre-diabetes treatment, a condition that affects 1 in 3 adults in the nation, 40% of whom will go to develop diabetes. In New York State, diabetes disproportionately impacts people of color and low income persons. Individual and group lifestyle counseling has been demonstrated to lead to a 58% success rate in delaying or preventing onset of diabetes. The Workgroup proposes that Medicaid (fee-for-services and managed care) cover pre-diabetes group and individual counseling services including services offered by community-based providers.
2. Asthma. Extending Medicaid coverage for home-based assessments is expected to reduce asthma hospitalization and ED visits for children and adults with poorly controlled asthma by reducing exposure to common asthma triggers that contribute to preventable exacerbations, by helping parents and children learn self-management skills such as using medication properly and what to do when asthma symptoms worsen, and by assisting individuals with accessing medical care. These actions will both improve health and reduce overall costs. Medicaid accounts for 43% of the total asthma hospitalizations and incurs 37% of the total asthma hospitalization costs in NYS, but current funding and infrastructure to provide environmental services to this population are limited. This funding constraint means that individuals who may benefit from environmental services (in terms of both improved quality of life and reduced healthcare utilization) may currently lack access to these services. New Yorkers with asthma often live in environments that can exacerbate their symptoms and lead to preventable hospitalizations and ED visits. Compared to the nation, New York has higher asthma, ED and hospital discharge rates for all age groups and New York State's rates are roughly two times higher than the levels targeted in Healthy People 2010. The financial impact of New York's higher burden of asthma is significant. In 2007, the total annual cost of asthma hospitalizations in NYS was estimated to be \$535 million<sup>3</sup>. For 2005-2007, Medicaid accounted for 43% of the total asthma hospitalizations and incurred 37% of the total asthma hospitalization costs in NYS (Medicare accounted for 23% of the total asthma hospitalizations and 34% of the costs)<sup>3</sup>.
3. Lead Poisoning. To address this critical public health issue which disproportionately impacts minority children it is proposed that Medicaid be expanded to include coverage for costs associated with environmental investigations, confirmatory and follow-up testing, and care coordination for children on Medicaid with lead poisoning. It is estimated that coverage of these services, and reduction in the number of children exposed to lead and for those exposed, assuring prompt access to appropriate care and treatment will result in \$1.15 million in State and local savings. Clinical lead screening, confirmatory and follow up testing are currently eligible for reimbursement by Medicaid however the cost of environmental investigations and care coordination for lead poisoned children are not. Previous analysis of NYC and upstate data has demonstrated that approximately 77 % of lead poisoning cases identified were to MA-eligible children, i.e. approximately 825 children annually with incident blood lead levels of 15 mcg/dL or higher. Provision of follow-up services by local Health Departments costs on average \$ 2,750 per child.



4. **Medicaid reimbursement for automated blood pressure cuffs for home use.** Validated automated home blood pressure monitors are inexpensive, easy to use and becoming widely available. [Pickering, Hypertension 2008] Several short term studies have suggested cost neutrality to payers, based on reduced need for hypertension-based office visits or changes in medication [Shogikan, Med Care 1992; McManus, BMJ 2005] Currently, although MCO's can provide this benefit at their discretion, there is no requirement to do so and there is currently a cumbersome prior authorization process which limits use in populations that could benefit. Manual blood pressure cuffs where the patient must manually inflate a cuff, use a stethoscope for auscultation of Korotkoff sounds and visualize blood pressure readings from a manual dial are currently covered. However these are of questionable utility in patients with limited numeracy, health literacy, older patients, and in patients with limited eye-sight and manual dexterity. In addition, the majority of high quality studies have used automated cuffs, so inasmuch there is evidence of benefit it lies in use of automated blood pressure cuffs.

The challenge to New York is to adequately address poor racial and ethnic minority health status and persistent racial and ethnic health disparities at a time of rapidly increasing racial and ethnic diversity. In a report issued in September, 2009, the Urban Institute reported that by simply addressing racial and ethnic health disparities overall national health care costs could be reduced by nearly \$24 billion per year. The study examined a select set of preventable diseases among the Latino and African American communities, including diabetes, hypertension and stroke, and concluded that if the prevalence of such diseases in the African American and Latino communities were reduced to the same prevalence as those diseases occur in the non-Latino white population \$23.9 billion in health care costs would be saved in 2009 alone.

Nationwide health care costs for all cardiovascular diseases are \$442 billion annually; diabetes-associated costs are approximately \$174 billion annually; obesity related costs are approximately \$147 billion annually; and lung disease costs are approximately \$154 billion annually. In fact, cigarette smoking costs the nation an astounding \$193 billion in health costs and lost productivity each year. Society—and business—also incurs the indirect costs of these conditions, including absenteeism, disability and reduced productivity. A proven program that prevents diabetes can save costs within 3 years. A 5% reduction in the prevalence of hypertension would save \$25 billion in 5 years.<sup>15</sup>

The Trust for America's Health, in an analysis of potential annual net savings and return on investment (ROI) for States within 5 Years of an Investment of \$10 per person per year in strategic disease prevention programs in communities, found that New York would realize potential annual savings of \$1.3 billion or a 7: 1 return on investment see <http://www.healthyamericans.org/reports/prevention08>. These economic findings are based on a model developed by researchers at the Urban Institute and a review of evidence-based studies conducted by the New York Academy of Medicine. They found that many effective prevention programs cost less than \$10 per person, and that these programs have delivered results in lowering rates of diseases that are related to physical activity, nutrition, and smoking. The evidence shows that implementing these programs in communities reduce rates of type 2

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<sup>15</sup> TESTIMONY OF HOWARD K. KOH, M.D., M.P.H ASSISTANT SECRETARY FOR HEALTH  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, "THE STATE OF CHRONIC DISEASE PREVENTION" COMMITTEE ON HEALTH, EDUCATION,  
LABOR AND PENSIONS U.S. SENATE OCTOBER 12, 2011



diabetes and high blood pressure by 5 percent within 2 years; reduce heart disease, kidney disease, and stroke by 5 percent within 5 years; and reduce some forms of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years.

The Affordable Care Act also provides States the option to provide recommended preventive services with no cost-sharing requirements for patients in Medicaid, with incentives for eliminating cost sharing. A primary example of services that would both enhance health outcomes and reduce health care costs is pre-diabetes treatment. Currently New York State does not cover community-based services for pre-diabetes treatment, a condition that affects 1 in 3 adults, 40% of whom will go on to develop diabetes. In New York State, diabetes disproportionately impacts people of color and low income persons. Individual and group lifestyle counseling has been demonstrated to lead to a 58% success rate in delaying or preventing onset of diabetes (citation). The workgroup recommends that Medicaid fee-for-service and managed care plans cover pre-diabetes group and individual counseling services.

**Financial Impact:** Potential savings of at least \$1.3 billion annually based on the Trust for America's Health analysis. Savings specific to identified intervention are as follows:

- **Lead – Investigations and Care Coordination:** Based on the surveillance figures above, the total cost of providing follow-up services to MA-eligible children in this BLL group would be approximately \$ 2.3 million; at least 50% of this cost, or \$1.15 million, could be saved for the state overall (combined state and local shares) by claiming federal financial participation. The addition of MA reimbursement would represent a significant step in the Department's comprehensive agenda to eliminate childhood lead poisoning in NYS. Both CMS and CDC have provided guidance to states encouraging Medicaid coverage for these services. Annual Cost: \$2.3 million; Annual Net Savings: \$1.15 million
- **Asthma:** Total Medicaid cost associated with supporting a home environmental assessment and intervention program is estimated at \$6,500,000 annually (20,000 X \$325). Total return on investment is estimated at \$58,675,200 (cost of asthma hospitalizations prevented) and net savings are estimated to total \$52,175,200 annually (the difference between the two). These figures assume approximately 20,000 homes with asthmatics are visited annually at a cost of \$325, and asthma related hospitalizations cost \$12,224 per hospitalization, and are reduced by 24% by the home visit program. Additional savings in reduced emergency room utilization, unscheduled office visits, pharmacy cost, etc. are also anticipated to be reduced but are not factored in to the cost analysis. Annual Cost: \$28.5 million; Annual Net Savings: \$52.1 75 million
- **Automated Blood Pressure Cuffs:** Several short term studies have suggested cost neutrality to payers, based on reduced need for hypertension-based office visits or changes in medication [Shogikan, Med Care 1992; McManus, BMJ 2005] The short term studies do not capture the expected reductions in high-cost cardiovascular events attributable to lower blood pressure. Although long term studies of self-blood pressure monitoring are lacking, it is well established through multiple randomized therapeutic trials that lowering blood pressure in individuals with hypertension reduces high-cost cardiovascular events. [Staessen, Lancet 2001.]



**Health Disparities Impact:** Significant given the disproportionate impact of chronic disease on racial and ethnic minorities in New York State.

**Benefits of Recommendation:** A 2009 report by the Urban Institute estimates that in 2009, disparities among African Americans, Hispanics, and non-Hispanic whites will cost the health care system \$23.9 billion dollars. Over the 10-year period from 2009 through 2018, the authors estimate that the total cost of these disparities is approximately \$337 billion. With respect to Medicare and Medicaid, the report notes excess costs for both African Americans—more than \$12 billion annually in combined costs—and Hispanics—nearly \$5 billion—as a result of health disparities. As an example, a Medicaid-reimbursed diabetes prevention program will significantly delay and even prevent onset of diabetes, thus improving health outcomes and yielding significant savings to the state. Research published in 2010 found that for middle-age or older adults and for the obese, every screening method evaluated was projected to reduce costs to the healthcare system over a three year span even when factoring in medication costs and false negatives, (*Chatterjee R, et al "Screening for diabetes and pre-diabetes should be cost-saving in high-risk patients" ADA 2010; Abstract 65-LB.*) When averaged across screening tests, the chance to catch cases early and potentially prevent complications actually would shave an estimated 7.3% off the healthcare costs for those with a body mass index of 25 to 35 kg/m<sup>2</sup> and 21.5% for those in the over 35 kg/m<sup>2</sup> range. For the 40- to 55-year-old set, screening would cut costs 8.1%, while the savings were 17.1% for those over 55.

**Concerns with Recommendation:** Current investment required for longer- term savings.

**Impacted Stakeholders:** Persons with pre-diabetes, health care providers, adults and children with Asthma, children at risk for lead poisoning, patients with uncontrolled hypertension and Medicaid funded health plans.

Organizations in support include:

- American Diabetes Association
- Alliance of New York State YMCAs
- Center for Independence of the Disabled, NY
- Housing Works
- Medicaid Matters New York
- Medical Society of the State of New York
- New York Chapter, American College of Physicians
- New Yorkers for Accessible Health Coverage
- New York Academy of Medicine
- New York City Department of Health and Mental Hygiene
- New York State Academy of Family Physicians
- New York State Association of County Health Officials
- New York State Dietetic Association
- New York State Healthy Eating and Physical Activity Alliance
- New York State Public Health Association
- The Bronx Health Link



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Streamline and Improve Access to Emergency Medicaid.

**Program Area:** Health Disparities

**Implementation Complexity:** Low

**Implementation Timeline:**

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** Healthcare providers are eligible to receive reimbursement for treatment and services provided to undocumented immigrants suffering from emergency medical conditions through the Emergency Medicaid program. However, the current process to obtain reimbursement under the Emergency Medicaid program is burdensome on both providers and patients, leading to delayed or inadequate care and increased cost. Increasing awareness about the program among consumers, providers, and local Social Services districts and streamlining the application process through prequalification and the extension of certification periods for certain medical conditions will enable providers to receive appropriate reimbursement from federal funds and reduce hospital and institutional reliance on state charity care dollars.

The Health Disparities Workgroup recommends the following with respect to Emergency Medicaid:

1. Clarify Emergency Medicaid Application Procedures. The State Department of Health and other relevant agencies are urged to implement outreach initiatives and issue guidance to increase awareness about the availability of the Emergency Medicaid program and the ins-and-outs of its application process among potential consumers, local Social Services districts, and providers. Doing so would help ensure that eligible patients make use of the program and providers and hospitals are able to appropriately tap into available federal funding to cover the costs of providing emergency care to undocumented patients. Disseminating additional clarifying information about the program would also help local Social Services offices correctly identify and efficiently process paperwork for Emergency Medicaid-eligible consumers.



2. Prequalify Medicaid Financial Eligibility: It is recommended that New York State create a limited scope Emergency Medicaid enrollment category code, which would enable local Social Services offices and facilitated enrollers to screen individuals who satisfy financial and other relevant criteria for Medicaid to determine whether they would likely qualify for Emergency Medicaid, should an emergency arise. Several states already implement Medicaid prequalification procedures, including California, Massachusetts, Michigan and Oregon.<sup>16</sup> Advanced screening and prequalification would *not* expand the scope of coverage available to undocumented immigrants in any way. Individuals would still need to suffer from an emergency medical condition as defined by federal and state statutes. Advanced prequalification would flag a patient's eligibility for Emergency Medicaid and eliminate the need for undocumented patients to complete an entire Medicaid application should an emergency medical condition arise. Prequalification would help to streamline the Emergency Medicaid process and ensure that providers and hospitals receive appropriate reimbursement for emergency care provided to undocumented immigrants from available federal funds. In addition, advanced screening may have the added advantage of increasing potential eligible patients' awareness of the availability of the Emergency Medicaid program.
3. Implement a 12-month Certification Period for Certain Emergency Medical Conditions. The MRT health disparities workgroup recommends that New York State extend certification periods for certain emergency medical conditions, such as cancer or renal failure, which help ensure that providers receive appropriate reimbursement for the care and services they provide under the Emergency Medicaid program. With extended one year certification periods for emergency treatment related to certain chronic illnesses, physicians would no longer need to complete and submit additional certification forms every 90 days. Several states, including California, Connecticut, Maine, Virginia and Washington, have adopted extended certification periods for certain medical conditions. Extending certification periods for certain illnesses would reduce paperwork for treating physicians, patients, and staff at local Social Services Offices as well as reduce potential disruptions in coverage and reimbursement.

**Financial Impact:** This proposal is likely to be cost neutral with a slight increase resulting from increased usage, a modest decrease in administrative costs and in utilization of charity care funds.

**Health Disparities Impact:** High

**Benefits of Recommendation:** Under the Medicaid program, healthcare providers may receive reimbursement for the treatment of an emergency medical condition provided to undocumented immigrants residing in New York State who otherwise satisfy Medicaid's income and other eligibility criteria.<sup>17</sup> These immigrants are ineligible for full coverage under the Medicaid program due to their immigration status. Emergency Medicaid provides limited coverage to undocumented immigrants in extremely narrow circumstances.

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<sup>16</sup> LEGAL MOMENTUM, EMERGENCY MEDICAID FOR NON-QUALIFIED ALIENS (2007), available at [www.legalmomentum.org/assets/pdfs/4\\_emergency\\_medicaid\\_chart.doc](http://www.legalmomentum.org/assets/pdfs/4_emergency_medicaid_chart.doc).

<sup>17</sup> 42 U.S.C. § 1396b(v)(3); 42 C.F.R § 440.255; N.Y. Soc. Servs. L. § 122(1)(e)(2011)



In order to access Emergency Medicaid coverage and reimbursement, an individual suffering from an emergency medical condition and his or her treating physician must complete three steps. First, the treating physician must certify, using form DOH-4471 “Certification of Treatment of an Emergency Medical Condition”, that the individual suffers from an “emergency medical condition”, which “manifest[s] itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in – (A) placing the person’s health in serious jeopardy, (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part”<sup>18</sup> within thirty days of the emergency.<sup>19</sup> The treating physician must also obtain the patient’s signature on the certification form in order to authorize the release of protected health information. The certification may cover a maximum of 90 days of treatment, with up to 30 days of retroactive coverage and up to 60 days or prospective coverage.<sup>20</sup> If the treating physician anticipates that the patient will need care for more than the maximum 90 day period, the physician must renew the certification by completing additional forms, as needed.<sup>21</sup> Secondly, the patient must complete a full Medicaid application. Lastly, the hospital at which the patient received care or the patient must submit the completed certification form and Medicaid application to a local Medicaid office, which will determine the patient’s eligibility for Emergency Medicaid.

#### **Problems in Current System that will be addressed by this proposal include:**

Lack of awareness among patients: Many individuals suffering from emergency medical conditions are unaware of the existence of Emergency Medicaid. The application process begins only after patients receive emergency treatment. Typically, eligible individuals fail to receive any information from their providers or hospital staff about the availability of Emergency Medicaid. As a result, despite being eligible for the program, many individuals end up receiving large medical bills, which they are unable to pay. In addition, concerns about accumulating additional medical debt prevent many individuals from seeking much-needed follow-up care.

Lack of awareness among social services offices: Community advocates also report that employees at some local social services offices, which process Emergency Medicaid applications, appear unfamiliar with the requirements of the program, rejecting completed Medicaid applications for the patient’s failure to enter a social security number, which is not required for Emergency Medicaid applications, thereby creating additional paperwork burdens and access impediments.

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<sup>18</sup> 42 U.S.C. § 1396b(v)(3); 42 C.F.R § 440.255

<sup>19</sup> Determining whether a particular condition qualifies as an emergency medical condition depends on the facts of each particular case as well as the medical judgment of the patient’s treating physician. *Scottsdale Healthcare Inc. v. Arizona Health Care Cost Containment Sys. Admin.*, 75 P.3d 91, 98 (Ariz. 2003) (noting that determining whether a particular condition qualifies as an “emergency medical condition” “should be largely informed by the expertise of the health care providers”). Coverage under Emergency Medicaid is not specific to a particular site or setting; depending on the nature of the emergency medical condition, Emergency Medicaid may cover treatment and services received outside of the in-patient or emergency room setting. *Szewczyk v. Dep’t of Soc. Servs.*, 881 A.2d 259, 269 n.15 (quoting *Scottsdale*, 75 P.3d at 98) (noting that “whether a patient suffers from an emergency medical condition does not depend upon the type of bed or facility the patient may be in”).

<sup>20</sup> GIS 10 MA/012

<sup>21</sup> GIS 10 MA/012





Lack of awareness among health care providers: In addition, advocates report that treating physicians are often unaware of their critical role in certifying a patient's emergency medical condition and may fail to complete and sign the certification form. Patients may subsequently encounter substantial difficulties in tracking down their treating physicians to complete and sign the certification form. Without the certification form, patients either fail to apply for Emergency Medicaid entirely or submit incomplete and ultimately unsuccessful Emergency Medicaid applications.

Failure to capitalize on available reimbursement streams: Lastly, in instances where the hospital has failed to initiate the Emergency Medicaid application process and a patient has unpaid medical bills, the hospital may seek reimbursement for the care provided from state charity care funds or other reimbursement sources, even though federal dollars are available to help defray the costs of providing care to undocumented immigrants.

**Concerns with Recommendation:** New York State Medicaid will need to take concrete actions to conduct outreach and provide education to providers, consumers and advocates who work with this population to ensure full understanding and in turn utilization of this benefit. In addition implement Medicaid prequalification procedures and implementation of a 12-month Certification Period for Certain Emergency Medical Conditions will required specific systemic changes along with education of providers, consumers, facilitated enrollers and managed care plans.

#### **Impacted Stakeholders:**

- Individuals who otherwise have intermittent and/or delayed access to critical health care services.
- Hospitals and other providers who will be able to realize more timely payment for services rendered and reduced reliance on charity care dollars.
- Social Service agency staff who through education about this program will realize reduced paperwork.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Address Disparities in Treatment at Teaching Facilities

**Program Area:** Health Disparities

**Implementation Complexity:** Moderate

**Implementation Timeline:**

**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Health Disparities Workgroup recommends that administrative actions be taken by the New York State Department of Health (Department) to assure that the health care delivered by academic medical teaching facilities to persons who are uninsured, to people covered by Medicaid and to people who are privately insured is comparable and meets the same standards of care. Draft Medicaid Primary Care Standards developed by the Department in 2008 [http://www.health.ny.gov/health\\_care/medicaid/standards/](http://www.health.ny.gov/health_care/medicaid/standards/) that were to apply to all primary care clinicians in all clinical settings and draft Additional Standards for Article 28 Facilities with Training Programs in Internal Medicine, Pediatrics, and/or Family Practice [http://www.health.ny.gov/health\\_care/medicaid/standards/draft\\_standards.htm#additional\\_standards](http://www.health.ny.gov/health_care/medicaid/standards/draft_standards.htm#additional_standards) should be enforced to eliminate disparities in care between clinics and faculty practices and to ensure consistent delivery of high quality care to all individuals regardless of insurance or coverage status.

Workgroup members felt that faculty medical practices and general and specialty teaching hospital outpatient clinics differ in the services offered to patients. Workgroup members noted differences in continuity of care; patient access to physicians; on call after-hours; continuity through hospitalization; communication (reporting) back to referring physicians; access to appointments; and quality of supervision. Workgroup members felt that New York State is unique in the fact that it allows teaching hospitals (those that train residents) to establish two models of care within their walls that provide substantially different levels of quality in the care they deliver. Faculty practices, which may have agreements to use space within state licensed teaching hospitals, provide care to privately insured patients and those covered by Medicare in a setting that the workgroup believes provides better continuity of care with an attending physician, patient access to physicians on-call after-hours, and good communication with referring community providers. General and specialty teaching hospital clinics, which often provide care for the uninsured, people on Medicaid including those in Medicaid



Managed Care, are staffed by rotating residents and fellows and rotating staffs of supervising attending physicians and therefore may provide little to no continuity of care over time, may have inadequate communication with referring community providers and may refer patients to the emergency room if they call after-hours. All providers, regardless of type of practice should be required to comply with a consistent set of standards that guides the quality of care provided to patients.

**Financial Impact:** By requiring a single level of care that affords all patients quality services, after-hours call, effective communication with community providers and comprehensive and coordinated care overall costs to the system will be reduced. New York State has substantially increased payment to these institutions for ambulatory care and may be paying, in some cases, more for people covered by Medicaid than private insurers pay for their enrollees, yet Work Group members felt these individuals are provided care inferior to that provided in faculty medical practices providing services in the same physical settings. In the long run this inferior care leads to increased costs to the Medicaid system. A lack of communication with referring community providers means that care is duplicated, errors in medication administration are increased and care is often maintained in higher cost hospital settings than in lower- cost community settings. Furthermore, the lack of continuity of care has been shown to reduce the speed at which diagnostic work-ups and therapeutic interventions are completed, leading to adverse outcomes and greater overall costs. Finally, a lack of after-hours coverage for the clinics leads to unnecessary emergency room use and hospitalizations.

**Health Disparities Impact:** This proposal will improve the quality of care delivered to persons who are uninsured and who are covered by Medicaid including many persons who currently suffer significant health disparities.

**Benefits of Recommendation:** By requiring a single level of care that affords all patients quality services, after-hours call, effective communication with community providers and comprehensive and coordinated care health status will improve for all patients along with reductions in overall systemic costs to the Medicaid system. Metrics to track savings include reduced emergency room visits, reduced hospitalizations and Increased access to timely hospital-based out-patient specialty care.

#### **Concerns with Recommendation:**

- The Primary Care Medical Home (PCMH) waiver program was recently approved by CMS and will be implemented in primary care training sites (Partnership Plan Waiver). The program has the goal of addressing many of the issues related to communication, access, follow up, referral management that are being raised in the proposal without specifically requiring changes in service delivery models.
- There is currently a perception among institutional providers that there are prohibitions regarding use of clinic facilities for faculty medical practices which would need to be clarified and addressed before this recommendation could be fully adopted.
- Department resources and staff would be needed for oversight and enforcement of these standards.

**Impacted Stakeholders:** Teaching hospitals, consumers and the Department of Health



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Enhance Services to Promote Maternal and Child Health

**Program Area:** Health Disparities

**Implementation Complexity:** Medium

**Implementation Timeline:**

**Required Approvals:**

- Administrative Action
- Statutory Change
- State Plan Amendment
- Federal Waiver

**Proposal Description:** The Health Disparities Workgroup recommends that the following actions be taken as part of a comprehensive initiative to improve maternal and child health in New York State particularly among racial and ethnic minorities:

1. Expand access to coverage in the Medicaid Program for contraception and other family planning services to prevent unintended pregnancies
2. Expand Medicaid coverage for inter-conceptional care following an adverse pregnancy
3. Expand Medicaid coverage to include breastfeeding education and lactation counseling during pregnancy and in the postpartum period and provide financial incentives to hospitals to provide breastfeeding support
4. Support initiatives to demonstrate effective and efficient use of HIT technology between hospitals/health care systems and community-based health organizations to improve care delivery for women and infants (quality, timely access, appropriate utilization) to reduce costs while improving health outcomes.

The specifics of each of these proposals follow below. These actions should result in improved maternal and child health and reduced costs to the Medicaid program.

- **Expand financial eligibility for Medicaid coverage for contraceptive and other family planning services from 200% FPL to 300% FPL.** This will require a parallel expansion of criteria for MA coverage for pregnant women. Both are expected to yield overall cost savings through reduced expenses associated with unintended pregnancies and poor birth outcomes.



- **Consider only the income of the applicant in determining Medicaid eligibility for contraceptive and other family planning services.** Under both the current Family Planning Benefit Program and the new State Plan service under development, individuals under age 21 may be considered in this way, but not applicants over age 21. A good cause exception should be established to allow applicants over age 21 to request this consideration, including applicants involved in abusive relationships.
- **Determine Medicaid income eligibility for contraceptive and other family planning services by counting the applicant as a household of two (or more) rather than one.** Currently in NYS, MA eligibility for pregnant women is determined based on counting the applicant as a household of two (or more) rather than one, using this same methodology for determining eligibility for family planning services will increase access and ensure eligibility parity for both pregnant women and women seeking family planning services.
- **Provide Medicaid coverage for contraceptive and other family planning services for undocumented women who are not pregnant.** Currently in NYS undocumented women are eligible for MA during pregnancy and, through the Family Planning Extension Program (FPEP), for MA coverage for Family Planning services for 26 months post-pregnancy, but are not otherwise eligible for MA coverage of family planning services. Coverage for family planning services should be extended to all undocumented women to ensure parity, to be funded at 100% state share, as is currently done for post-pregnant women through FPEP.
- **Provide Medicaid coverage for a dedicated preconception visit for all women and adolescents of reproductive age on Medicaid,** particularly those women and teens with chronic health conditions that have high potential for adverse impact on a pregnancy. Reimbursement for a preconception visit is particularly important for women and teens with chronic health conditions that have high potential for adverse impact on a pregnancy. Encouraging patient visits with an obstetrician prior to conceiving may result in improved prenatal care. This visit can be reimbursed at an enhanced rate to encourage physicians and primary care clinics to provide the service.
- **Provide Medicaid coverage for breastfeeding education and lactation counseling** during pregnancy and in the postpartum period and provide financial incentives to hospitals that provide breastfeeding support (as recommended by the World Health Organization; i.e. have been certified by “Baby Friendly USA, Inc.”). *The Baby-Friendly Hospital Initiative* (BFHI) is a global program to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding.
- **Coordinate service delivery among and between community-based social health organizations (CBHOs) and clinical providers using Health Information Technology (HIT) and uniform screening criteria for perinatal risks.** These risks, if identified and ameliorated in a timely manner can contribute to significant reductions in Medicaid costs due to poor health outcomes with life span consequences.



The steps outlined above, implemented as whole, will significantly reduce barriers and expand access to family planning services to high-need populations. Careful consideration should also be given to replicating the eligibility criteria and determination process used in the California FPACT Program which has been in existence since 1999. This 1115 waiver program was recently approved by CMS as a California State Plan Amendment and has been proven to be highly effective in averting unintended pregnancies. Specifically, FPACT applicants do not need to provide an SSN; may self declare their income and do not need to provide documentation; may self declare the size of their household; and do not need to provide documentation of CA residency. These eligibility criteria have greatly expanded access to family planning services, especially among adolescents.

### Financial Impact:

- Expanded Medicaid coverage. A reduction of only 1% of premature births to MA-enrolled women would result in average annual savings of \$64,384,376. Implementing enhanced case management services for all MA women with adverse pregnancy outcomes and maintaining eligibility of women in the expanded eligibility categories to result in reduced high-risk births is cost-effective. Every dollar invested in helping women avoid pregnancies they did not want to have saves \$4.02 in Medicaid expenditures that otherwise would have been needed for pregnancy-related care (Guttmacher Institute, 2009) According to the March of Dimes, the average cost for management of a premature or low birth-weight baby is \$49,000 in the first year. By comparison, cost of care for a newborn without complications is \$4,551 in the first year, a difference of \$44,449. MA accounts for 50% of births in NYS.
- Breastfeeding Education and Lactation Counseling. Increasing breastfeeding rates can reduce the prevalence of various illnesses and health conditions which will in turn lower health care costs. A recent academic article estimated that if 90% of US families complied with medical recommendations to breastfeed exclusively for 6 months, the health care savings would be \$13 billion per year nationally, and save over 900 deaths per year, almost all exclusively infants. Babies exclusively breastfed in the hospital are 40% more likely to be continue breastfeeding at 6-8 weeks.<sup>22</sup> Assuming that each counseling visit costs \$20, and an average of 3 visits per infant, the proposal would cost \$60 per birth. There were ~250,000 births in New York in 2009.<sup>23</sup> Coverage for all births would cost \$15 million. Savings would be derived in the long term by increasing the rate of exclusively breastfeed infants, improved health and reduced health care costs<sup>24</sup>. Assuming a savings of \$475 per infant who is breastfed, a 15% increase in breastfeeding rate would amount to a net savings of \$2.8 million savings in health care costs.

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<sup>22</sup> New York State Department of Health, unpublished dataset, 2009.

<sup>23</sup> Ibid.

<sup>24</sup> **The Economic Benefits of Breastfeeding: A Review and Analysis.** By Jon Weimer. Food and Rural Economics Division, Economic Research Service, U.S. Department of Agriculture. Food Assistance and Nutrition Research Report No. 13.



- **Incentives paid to baby Friendly Hospitals.** An \$25 incentive paid to Baby Friendly Hospitals per birth, for 249,970 births translates to \$1.9 million in annual Medicaid costs associated with Breastfeeding support assuming that 25% of births were at hospitals that were Baby Friendly and 25% of mothers took advantage of breastfeeding education/lactation counseling. These costs are balanced against \$475 savings in health care expenses for each infant who exclusively breastfeeds for the first 6 months of life, for a net benefit of \$317 per infant. Thus the potential maximum savings to the state Medicaid program are \$ 29 million (based on 249,970 births in 2009, approximately 50% of which are covered by Medicaid).

**Health Disparities Impact:** Significant benefits would accrue to racial and ethnic minorities who experience significant health disparities in birth outcomes including low birth weight and preterm births in New York State.

**Benefits of Recommendation:** Although New York has made tremendous strides in improving birth outcomes, key perinatal indicators have remained stagnant or have worsened. These poor outcomes result from complex medical, psychological, social and environmental factors that can present significant public health challenges to a state as diverse as New York. Some of the most significant factors that influence birth outcomes occur before pregnancy, such as nutritional status and other health behaviors.

In 2008, the percent of women giving birth in NYS who received early prenatal care was 66.5%, significantly below the Healthy People 2020 goal of 90%. There has also been little change in low birth weight rates for the past decade. In 2008, the prevalence of low birth weight was 8.2% of all births, higher than the Healthy People 2020 goal of 7.8 % of all births. Data also show that disparities in birth outcomes are often significant. For example, in 2008, 12.5% of black infants were born low birth weight, and black women were more likely to have preterm births than white and Hispanic women.

The 2008 NYS Minority Health Surveillance Report indicated that NYS' infant mortality rate for black babies was 11.3 and 4.4 white deaths for every 1000 live births. African American women are also more likely to experience a miscarriage or an early term delivery than white women. In 2006, 16.8 % of black women went into pre-term labor compared to 10.8% of white women. Observed disparities are not simply the result of differences in income and education: experts note that "black women are more than twice as likely to deliver a baby prematurely." Poverty, chronic diseases, and poor access to health care contribute to the high mortality rates, as well as stress. (**Sources:** New Jersey's Black Infant Mortality Reduction Resource Center (BIMRRC) and The Kaiser Family Foundation).

**Specific benefits of the recommendations offered are as follows:**

1. **Ensure access to effective contraception and other family planning services for all women of reproductive age.** Access to family planning services including funding for contraceptive services and supplies is one of the most fundamentally cost-effective public health investments. Multiple studies have demonstrated that providing coverage for family planning services results in cost savings, as the cost of providing pregnancy-related care greatly outstrips the cost of providing contraceptive services.



It is estimated that 51% of all pregnancies nationally are unintended and over 50% of women whose pregnancies were unintended were not using contraception at the time they became pregnant. Over 50% of births in NYS are covered by MA.

2. Inter-conceptional Care Coverage. Women who experience high-risk pregnancies and/or poor birth outcomes are more likely to experience the same problems in subsequent pregnancies. Effective management of chronic health problems (such as obesity, diabetes, and hypertension) between pregnancies, along with prevention of unintended pregnancies/adequate spacing of repeat pregnancies, has significant potential to reduce the costs of repeated adverse birth outcomes for both mothers and infants. Mothers, who are overweight or obese during pregnancy, as measured by body mass index, are known to be at risk for significant complications. These can include but are not limited to miscarriage, birth defects, hypertension, macrosomia, gestational diabetes, increased rates of Cesarean sections, and in general the morbidity and mortality of these women and children is higher. Many women who become MA eligible as a result of pregnancy status subsequently lose MA eligibility/coverage after birth, thereby increasing the likelihood that chronic health problems will not be optimally managed prior to another pregnancy. Perinatal health outcomes are directly impacted by the health of the woman prior to her pregnancy. Over 50% of pregnancies are unintended, diminishing the opportunity to foster optimal health at the time of conception.

3. Breastfeeding Education and Lactation Counseling. Provide Medicaid coverage of breastfeeding education and lactation counseling during pregnancy and in the postpartum period and financial incentives to hospitals that provide breastfeeding support (as recommended by the World Health Organization; i.e. have been certified by “Baby Friendly USA, Inc.”). These two initiatives are anticipated to result in increased rates of breastfeeding, exclusivity and duration and in turn reduced infant healthcare costs, reduced risk of childhood obesity and asthma, reduced perinatal bleeding and anemia and reduced risk of breast or ovarian cancer (mother). The Workgroup recommends Medicaid reimbursement for breastfeeding support services conducted by a specially trained lactation counselor. Analogous to coverage currently authorized for diabetes education and asthma counseling, this service conducted by a specially trained lactation counselor would be billed to Medicaid under the license of a professional (MD, DO, NP, PA, NMW, RD, RN, other) in New York State. Coverage of breastfeeding support and counseling will be required by insurance exchanges by January 1, 2013.

Increasing the rate of breastfeeding is a cost-effective public health strategy to reduce health care costs associated with infant and childhood illnesses and achieve better health outcomes later in life. Breastfed babies have been found to have fewer episodes of acute respiratory illnesses, ear infections and stomach viruses, as well as reduced incidence of Sudden Infant Death Syndrome, and a decreased risk of asthma later in life. Breastfeeding also benefits mothers by reducing postpartum bleeding and anemia, and decreasing the risk for breast and ovarian cancers. In recognition of the well-documented, scientific evidence of the benefits of breastfeeding, the Surgeon General recently issued a Call to Action<sup>25</sup> to Support Breastfeeding, describing in detail how people and organizations can contribute to the health of mothers and their children in a profound and lasting way.

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<sup>25</sup> U.S. Department of Health and Human Services. *The Surgeon General’s Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011.





The Call to Action includes recommendations for insurance coverage for breastfeeding counseling and support.<sup>26</sup> In addition, recently issued HHS guidelines pertaining to insurance plans offered under the Patient Protection and Affordability Care Act require breastfeeding counseling and support to be covered without a co-pay.

4. Using HIT to coordinate service delivery among and between community-based social health and clinical care providers to enhance the quality of care to underserved populations and to increase the effectiveness of service navigation is recommended to improve overall health outcomes. This proposal recommends beginning with funding for community pilots with hospital and health care systems and community-based health organizations to demonstrate the effectiveness and efficiencies of using HIT technology to coordinate services, reduce fragmentation and redundancy and the associated costs; increase patient's access to health records and care engagement, improve quality and reduce costs. Use of a HealthSmart ID card will assure compliance with several health reform requirements for electronic health records and portability and increase the timely availability of data for community assessments and health planning to more effectively address health disparities.

Use of this technology will virtually eliminate redundant tests and procedures as well as medical errors, greatly reduce patient admission times and insure that all caregivers are aware of patient encounters with other caregivers and outcomes. Most of the current demonstration projects in New York, like the Health Homes, are targeted to special populations that do not necessarily include pregnant and parenting women and their families. Yet it has been well-documented that low-income and immigrant women, and particularly those of color, have particular health needs that when ignored/addressed too late create significant health care treatment costs, some covered by Medicaid others borne by service providers as uncompensated care.

Poor perinatal health outcomes are major cost drivers for health care institutions and Medicaid. When high risk perinatal women receive early and comprehensive screening, and timely social and medical interventions to mitigate identified risks, birth and health outcomes are greatly improved. (Stankaitis et. al., 2005) The majority of infant and maternal morbidity and mortality and associated costs are related to women's/ maternal health and prematurity factors, so it is wise for prevention efforts to focus on maternal health supports and early identification and treatment of risks. (Mittal, 2005). This underscores the need for early screening and continuous primary/prenatal care, referral of those at high-risk for poor pregnancy outcomes, good management of chronic conditions such as diabetes, and comprehensive obstetric care and perinatal depression / behavioral health risks, among them.

Two examples of systems that work include the New Jersey State Health Department which has mandated the use of increased screening criteria and data collection processes that have in turn resulted in improved birth outcomes and reduced costs and in Upstate New York, Monroe County (the Monroe Plan for Health (MPH)) which has demonstrated savings on perinatal costs (\$2) saved for every dollar of enhancement spent. (Stankaitis et. al., 2005)

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<sup>26</sup> U.S. Department of Health and Human Services. *The Surgeon General's Call to Action to Support Breastfeeding*. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2011.



**Concerns with Recommendation:** Overall the recommendations suggest significant system changes to enhance initial and ongoing Medicaid coverage to promote maternal and child health. Specific concerns include a limited number of CLC health care professionals to support breastfeeding recommendations. Time will be needed to institute statewide training and certification. With regard to the health IT proposal it will be necessary to engage all parties for effective implementation. With regard to uterine fibroids, because of the sizeable population with uterine fibroids, initial outlay of preventive treatment may show an upsurge in medical costs as they relate to OBGYN care. Long term costs will likely decrease due to averting the need for more extensive surgery in the future.

#### **Impacted Stakeholders:**

- Female Medicaid recipients of child bearing age
- OBGYN Health personnel
- Primary Care Providers
- Hospitals
- Medical societies
- Breastfeeding advocates
- Health care Funders



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Address Disparities through Targeted Training for NYS' Health Care Workforce

**Program Area:** Health Disparities

**Implementation Complexity:** Medium

**Implementation Timeline:**

**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Health Disparities Workgroup recommends that New York mandate training to promote care and reduce disparities experienced by people with disabilities, for Lesbian, Gay, Bisexual and Transgender (LGBT) persons and for persons at risk of suicide. More specifically the workgroup recommends the following:

- Mandated annual training of staff working within OASAS and OMH licensed programs on Sexual Orientation and Gender Identity and Expression to address cultural sensitivity as well as clinical issues that relate to the LGBT experience; such training should not only take place in multiple settings including OASAS and OMH licensed programs but should target multiple provider specialties including pediatricians, family medicine and internal medicine providers as well as front line staff, family members and social networks to assure comprehensive community-based understanding and support.
- That the State apply for funding under ACA § 5307 Cultural Competency, Prevention, Public Health Proficiency, and Individuals with Disabilities Training for the purpose of developing curricula to address training in cultural competency, prevention, public health proficiency, reducing health disparities, and training for working with disabled individuals. In addition, Section 5403 of the ACA allows for certain health professions training dollars to be used to prepare health professionals for placement in underserved areas and with health disparities populations.
- Provide suicide prevention training material that is germane to various ethnic populations that are at highest risk of suicide attempts.
- That Disability Competency Training for NYS' Health Care Workforce be required to increase access to care and reduce disparities experienced by people with disabilities.



**Financial Impact:** Costs of implementation would be training costs and could be partially offset by ACA funding (is available to NYS).

**Health Disparities Impact:** The impact of health disparities will be significant as appropriate training will facilitate enhanced utilization of services by identified populations and more effective engagement and retention in appropriate care and treatment.

**Benefits of Recommendation:** The purpose of this proposal is to reduce barriers to health services for Lesbian, Gay, Bisexual and Transgender persons, persons with disabilities and persons at risk of suicide and in turn result in better engagement and retention of these individuals in health care and treatment services as appropriate.

Persons of LGBT experience have higher levels of addiction and certain mental health problems than the population at large which may be related to the prejudice they experience because of their sexual orientation and/or gender identity and expression. They experience other mental health issues at the same rates as the larger population, but their identification as LGBT makes access to treatment sometimes difficult. Often, even professional staff in mental health services and drug treatment services are uneducated with regard to non-normative sexual orientation and gender identity and expression. This frequently causes insensitivity and even outright discrimination that become barriers to care for people of LGBT experience. This proposal would mandate annual training of staff working within OASAS and OMH licensed facilities on LGBT issues that would address cultural sensitivity as well as clinical issues that relate to LGBT experience.

A potential model is training now required by NYC HHC that is mandatory for all staff and is designed to improve access to healthcare for lesbian, gay, bisexual and transgender (LGBT) New Yorkers. The training focuses on the importance of showing openness, using inclusive language, welcoming and normalizing individuals' disclosure of their sexual orientation and is intended to address the fact that many LGBT individuals are totally turned off by the healthcare system and avoid getting the help they need out of fear of stigma and discrimination. There are serious health disparities in this community, like late cancer diagnoses, high rates of depression, and higher rates of smoking and alcohol use. To help patients to feel welcome and respected HHC now mandates cultural competency for providers as a first step to help providers understand issues of sexual orientation and gender identity.

With regard to persons with Disabilities, a survey of primary care physicians found that almost 20% were unaware of the Americans with Disabilities Act and 45% were not aware of its architectural requirements. Physicians receiving training on disability issues were in the minority. Lack of knowledge or disability-related education is consistent with other reports finding inadequate preparedness to provide health services to people with disabilities. (Michelle A. Larson McNeal, Ph.D.; LeeAnne Carrothers, Ph.D.; Brenda Premo, MA; "Providing



Primary Health Care for People with Physical Disabilities: A Survey of California Physicians,” Center for Disability Issues and the Health Professions, Fall 2002.) Studies related to lack of disability knowledge or education are too numerous to catalogue here.

Various sections of the Affordable care Act promote and support training particularly for persons with disabilities as follows:

- ACA § 5307 Cultural Competency, Prevention, Public Health Proficiency, and Individuals with Disabilities Training: Secretary has the authority to award grants, contracts, or cooperative agreements to public and non-profit entities to develop curricula to be used in health professions training programs. The curricula should provide training in cultural competency, prevention, public health proficiency, reducing health disparities, and training for working with disabled individuals.
- Section 5403 of the ACA allows for certain health professions training dollars to be used to prepare health professionals for placement in underserved areas and with health disparities populations.

A potential model is the Kansas “Healthcare Access for Persons with Disabilities” continuing education course which addresses strategies for offering “high quality care to adults and children with physical and sensory disabilities, along with solutions to problems in serving patients with disabilities. By the end of this course providers will: gain a better understanding of health, wellness and care issues concerning people with physical and sensory disabilities, recognize the four barriers to quality healthcare as addressed in the (ADA), identify a minimum of five skills to increase effective communication and problem solving to enhance quality care for people with disabilities. The course should be offered for CME/CNE credit. Another model is the Disability and Public Health Curriculum co-authored by Charles Drum, Gloria Krahn and Hank Bersani – published by APHA 2009.

**Concerns with Recommendation:** Would require the cost of committing staff time to training. New York would have to apply for funding pursuant to Section 5403 of the ACA.

**Impacted Stakeholders:** The LGBT community, persons who have disabilities and persons at risk of suicide and the providers who serve these individuals.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Enhance Services for Youth in Transition with Psychiatric Disabilities

**Program Area:** Health Disparities

**Implementation Complexity:** Medium

**Implementation Timeline:**

**Required Approvals:**

Administrative Action

Statutory Change

State Plan Amendment

Federal Waiver

**Proposal Description:** The workgroup recommends that comprehensive programs to serve youth in transition to adulthood with psychiatric disabilities be developed across all systems of care including foster care, school populations that have youth with serious emotional diagnoses (SED) and the juvenile justice population to ensure that youth with psychiatric disabilities who are aging out of these programs do not end up homeless or in the criminal justice system.

More specifically the workgroup recommends that Medicaid (the Medicaid Rehab Option - MRO<sup>27</sup>) be used to support the provision of rehabilitative, community-based services to transitioning youth (ages 16-24 years) with psychiatric and co-occurring psychiatric-substance abuse diagnosis. The MRO services have the advantages of reimbursing services delivered in clients' natural settings as well as in offices. They can be used to ensure coverage of points of intervention for transitioning youth including youth in the educational system with SED that require intervention. Medicaid coverage of services and programs that will assist these youth with successful development through education, employment and community integration will in turn reduce overall health system expenditures. Points of intervention should include youth drop in centers run by peers that integrate employment, education, vocational services, General Educational Development education and other necessary skills that will provide links to the community.

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<sup>27</sup> The Medicaid Rehab Option incorporates rehabilitative, community-based services to persons with psychiatric and co-occurring psychiatric-substance abuse diagnosis. The MRO services have the advantages of being reimbursed for delivery in clients' natural settings as well as in offices. They focus specifically on assisting clients with gaining skills and resources that allow them to live and function as independently as possible.



Provision of these programs will assist clients with gaining skills and resources that allow them to live and function as independently as possible and will pay for supported education, pre-employment training and ADL skill training. It is also recommended that New York better utilize and publicize the Medicaid Buy-In program which offers Medicaid coverage to people with disabilities who are working, and earning more than the allowable limits for regular Medicaid, to insure that when these youth transition to an adult home and are employed, they do not lose benefits.

**Financial Impact: TBD**

**Health Disparities Impact:** Youth with serious emotional diagnoses are at increased risk of homelessness, poor health, being uninsured and in the criminal justice system. Only 35% of young disabled people are employed full- or part-time, compared to 78% of individuals without disabilities, and they are three times as likely to live in poverty,” Funded interventions will assist these youth and promote health and well being.

**Benefits of Recommendation:** Youth in transition with psychiatric disabilities cross all systems of care including the school system, foster care and juvenile justice. Over 40% of these transitional age youth drop out of high school and end up homeless, in the criminal justice system or in emergency rooms. Points of intervention to insure that these youth receive the services and programs that will assist them in successful development through education, employment and community integration will promote health and reduce overall health costs.

It is estimated that nationally at least 2.4 million young adults aged 18 through 26—or 6.5 percent of the 37 million non-institutionalized young adults in that age range—had a serious mental illness in 2006, and they had lower levels of education on average than other young adults. This estimate of 2.4 million is likely to be low because certain groups that may have high rates of mental illness, such as the institutionalized, were not included in the NCS-R. Nearly 90 percent of young adults with serious mental illness had more than one type of disorder. For example, 32 percent of these young adults had a drug or alcohol-related disorder in addition to another type of mental disorder. In addition, compared to young adults with no mental illness, those with serious mental illness have significantly lower rates of high school graduation (64 versus 83 percent) and continuation into postsecondary education (32 versus 51 percent)

Young adults with serious mental illness face several challenges, including finding services tailored to their specific needs, qualifying for adult programs that provide access to mental health services, and navigating multiple programs and delivery systems. Existing public mental health, employment, and housing programs are not necessarily tailored to their mental disability or age range, which may discourage these young adults from participating.

Three states, Maryland, Massachusetts and Mississippi use the Medicaid rehab option to pay for services related to community living, psych rehab programs, symptom management, and counseling and ACT. In Massachusetts rehab option used in Medicaid has helped to fund recovery oriented services for adults with psychiatric disabilities including the acquisition of skills essential for everyday functioning.



A report issued by the State (Massachusetts) recommends that there be better use of the rehab option to pay for services for youth in transition. With appropriate and timely transition planning to connect youth with employment, post-secondary education, and support services, these programs and services will make a positive difference in hundreds of young lives.

**Concerns with Recommendation:** Pending Federal guidance regarding use of this benefit.

**Impacted Stakeholders:** Juveniles with serious emotional diagnoses; schools, juvenile justice and foster care providers.





## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Promote Effective Use of Charity Care Funds

**Program Area:** Health Disparities

**Implementation Complexity:** High

**Implementation Timeline:**

**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Medicaid Redesign Team Health Disparities Workgroup recommends that the charity care reimbursement system be revised to ensure that charity care funding is transparent and is used to pay for the care of the uninsured. New federal law under the Affordable Care Act (ACA) will use some of the current federal funding under DSH (Disproportionate Share Hospitals) to pay for care of the newly insured. Remaining DSH funding will be distributed to states based on the remaining number of uninsured and that use the money to pay for care of the uninsured and target to hospitals with high Medicaid patients. To continue to receive New York will be required to change the current way that federal matching funds for charity care are distributed to hospitals.

The Workgroup specifically recommends that two principles guide the distribution of charity care funds: (1) Funding should follow the patient – hospitals should be paid from the charity care pool for providing care to uninsured patients; and (2) Payments to hospitals should be progressively increased based on providing a larger proportion of care for the uninsured.

Based on these principles, specific changes in the way the State distributes Charity Care funding were developed and are offered for consideration:

- The first step is to start with a uniform reimbursement, the median statewide Medicaid reimbursement rate, as a leveler for all hospitals in the state.
- The second step is to add to this median rate the regional costs for things like salaries and then to add more for the care of sicker patients.
- The third step is to add more dollars on a progressive scale for hospitals that treat a higher percentage of uninsured patients.



- The final step only occurs if the federal DSH dollars are reduced; in this instance it is proposed that the current pools be combined to fund public and private hospitals. This is very important because the 21 public hospitals in the state provide the lions' share of services for the uninsured.

To ensure that safety-net hospitals that provide a high proportion of care for Medicaid patients but do not provide as much care for the uninsured do not lose money as a result of the charity care recommendations, it is proposed that there be a special increase in the Medicaid reimbursement rate to cover potential funding shortfall. It is also recommended that there be an increase in the dollar amount of the Charity Care pool which funds community health centers for the care of the uninsured.

### **Background:**

New York has a long history of using public financing to help hospitals provide care to uninsured and underinsured patients. The State remains committed to supporting those institutions that provide this care. However the formulas that allocate bad debt and charity care funds are not transparent and it is difficult to trace the allocation of fund back to care delivered.

The Commission on the Public's Health System (CPHS), and others, has long advocated for a more transparent system, where money indeed follows the patient.

Over a period of years, the CPHS documented the allocation of public dollars from the State's \$847 million Hospital Indigent Care Pool intended to compensate hospitals for the indigent care they provided. As a result of this effort, CPHS published two reports that showed little or no relationship between the actual dollars received by the hospitals from the hospital Charity Care pool and the amount of health care services they provided to the uninsured. It is interesting to note that there is a separate community health center pool to pay for the care of the uninsured. This pool of dollars is much smaller than the hospital pool and is funding allocated to health centers based on their reporting care that they provide to the uninsured.

Despite recent efforts to change the allocation of charity care dollars, provider resistance has maintained the system almost untouched. There has, however, been movement over the last several years to ensure that they uninsured have access to health services regardless of their ability to pay. The first change was passage of the Hospital Financial Assistance Law (Subdivision 9-a of Section 2807-k of the New York State Public Health Law) – also called Manny's Law. For the first time, the State required that all hospitals develop a charity care sliding scale fee policy for New York residents with incomes at or below 300% of the federal poverty level, post these policies, and notify patients of their right to a sliding fee scale for payments based on income and family size.

The second important change came as the result of a 2008 State Task Force which reviewed the hospital charity care system, and resulted in the requirement that 10% of the total \$847 million in the hospital Charity Care pool be distributed on the strength of the hospital showing it had cared for numbers of uninsured patients. The benefit of this very small movement is that in order to receive a share of the



10%, hospitals have to report all of the care they delivered to people with no health insurance. The reporting has enabled a more in-depth look at what hospitals are doing to provide care and to match that care to the dollars being distributed to these institutions.

**Financial Impact:** The Hospital Indigent Care (Charity Care) Pool has \$847 million annually for distribution to hospitals. The concept here is for redistribution of these funds to ensure that those hospitals providing care for the uninsured are paid for providing this care. This is also a way for encouraging hospitals to meet their obligations under Manny's Law to post and inform patients of a sliding fee scale for uninsured patients with family income under 300% of the federal poverty level. Although this is currently a requirement, it is not at all clear how many hospitals are actually informing patients about charity care at the time that they arrive for services. Funding that would follow the uninsured patient could serve as an important stimulus for hospitals to follow the Manny's Law requirement, and it could result in preventive and primary care patients who now use the Emergency Room. Use of primary and preventive care could mean a reduction in overall cost of care. Another very important consideration is that in the not too distant future there will be a reduction in federal Disproportionate Share Hospital dollars to pay for newly insured patients under the Affordable Care Act (ACA). Federal DSH dollars will be reduced by \$500 million in 2014.

"The HHS Secretary will develop the DSH allotment reduction methodology to apply funding reductions to states. The methodology will be structured to ensure that states using DSH funding appropriately are able to retain such funding. Specifically, the methodology will:

\*apply the largest reductions to states that (i) have the lowest uninsured rates (based on Census data), (ii) have the lowest levels of uncompensated care (excluding bad debts), and (iii) do not target DSH payments to hospitals with high volumes of Medicaid inpatient care..."<sup>28</sup>

If New York State does not make changes in the hospital charity care distribution formula this year, the state stands to lose millions of federal dollars.

**Health Disparities Impact: High.** Assuring the Charity Care funding is appropriately used to support care and services for the uninsured will primarily benefit New Yorkers who currently experience significant health disparities.

**Benefits of Recommendation:** Reduction in disparities in treatment and improved clinical outcomes

**Concerns with Recommendation:** Implementation would require New York State to revise its payment methodology. There is the potential for unintended consequences for providers who will lose significant funding as a result of the proposal.

**Impacted Stakeholders:** All hospitals and Community Health Centers, Consumers, and the Department of Health.

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<sup>28</sup> *Implementing Federal Health Care Reform: A Roadmap for New York State.* Boozang, Patricia, Dutton, Melinda, Lam, Alice and Bachrach, Deborah. August 2010. New York State Health Foundation.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Promote Hepatitis C Care and Treatment through Service Integration

**Program Area:** Health Disparities

**Implementation Complexity:** Medium

**Implementation Timeline:**

**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Health Disparities workgroup recommends that steps be taken to integrate Hepatitis C (HCV) care, treatment and supportive services into primary care settings including community health centers, HIV primary care clinics and substance use treatment programs.

The purpose of this proposal is to create an integrated hepatitis C care model that will ensure comprehensive and coordinated quality care for HCV mono-infected and HIV/HCV co-infected persons, by providing HCV medical management and treatment, mental health and substance use services, care coordination and peer education/support services within primary care environments. While Health Homes are not disease specific, each Health Home will have COBRA providers in their network and those members with Hepatitis C who are eligible for Health Home services will be expected to receive appropriate care management around their needs (physical, behavioral, social).

The integration of such services is designed to: 1) improve the identification of HCV mono-infected individuals; 2) increase their access to and engagement in care; and 3) support adherence to care and improve treatment outcomes while also addressing other health conditions of the client. With recent advances in HCV testing, the number of individuals knowing their HCV status is increasing; at the same time more effective treatments aimed at curing more people with HCV are becoming available. Therefore, the need for timely access to medical care and treatment is crucial. Unlike HIV, HCV can be cured in some cases and treatment is short term. Studies have shown that earlier diagnosis and earlier treatment lead to better treatment outcomes.

**Financial Impact:** Savings associated with reduced health care needs and thus expenditures resulting from enhance care coordination, access and treatment adherence will result. Most of these services are independently covered by Medicaid. Grant funding currently supports infrastructure costs (staff, peer counselors).



**Health Disparities Impact:** High

**Benefits of Recommendation:** Reduction in HCV-related Medicaid expenditures through enhanced coordination, access to and adherence in treatment.

**Concerns with Recommendation:**

- There may be an inadequate number of primary care providers willing and able to treat HCV. However, this proposal could lead to an increase in the number of providers.

**Impacted Stakeholders:**

- Community health centers,
- HIV primary care providers,
- Drug treatment programs.
- Medical providers (health care facilities and practitioners), NYSDOH-authorized syringe exchange programs, addiction treatment providers, pharmacies.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Promote Full Access to the Mental Health Medication on the Medicaid Formulary

**Program Area:** Health Disparities

**Implementation Complexity:** Low

**Implementation Timeline:**

**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Health Disparities Workgroup recommends that all Medicaid recipients who are in managed care plans where the pharmacy benefit is no longer carved out continue to have full access to mental health medications under the Medicaid formulary. To assure continued access to ongoing medications the Workgroup recommends that the State Health Department provide written notification to health plans urging that all individuals on existing mental health medications remain on that medication (unless changed by their physician) whether or not the medication is subject to pre-authorization. In addition it is recommended that the Department of Health send a letter to Medicaid recipients that identify medication resources available to them through the State and recourse should they have difficulty accessing medications.

**Financial Impact:** None.

**Health Disparities Impact:** Significant benefits would accrue to persons living with mental illness.

**Benefits of Recommendation:** Recent Medicaid changes eliminated the carve out of all mental health medications. Prior to these changes, there was access to the full array of mental health medications for anti-depressants and atypical antipsychotics. Given the variability in individualized reaction to medications, it is essential to recovery to continue to assure individuals access to the full array of mental health medications.

The Department of Health has encouraged health plans to cover the full array of mental health medication in their formularies; most plans have agreed to 'grandfather in' all mental health medications. The Health Disparities Workgroup urges the Department to follow up with a statement (in



writing) to providers and consumers indicating that all individuals on existing mental health medications may remain on that medication (unless changed by their physician) whether or not the medication is subject to pre-authorization. Communication with consumers should also note available recourse if they perceive that a medication has been denied or discontinued. The recent changes and the letters sent to Medicaid recipients have led to a great deal of anxiety regarding mental health medication coverage in each health plan – additional communication should help to relieve that anxiety and assure continued access to needed medications.

**Concerns with Recommendation:** Costs associated with mailings to consumers.

**Impacted Stakeholders:** Health Plans and Medicaid enrollees with mental illness.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name: Medicaid Support of Water Fluoridation**

**Program Area: Health Disparities**

**Implementation Complexity:**

**Implementation Timeline: SFY 2012**

**Required Approvals:**

Administrative Action

Statutory Change

State Plan Amendment

Federal Waiver

**Proposal Description:** Medicaid funds will be used to support costs of community water fluoridation equipment and chemical additives. With this waiver New York proposes to utilize Medicaid dollars to support community water fluoridation equipment, supplies and staff time in population centers (cities of over 50,000) where the majority of Medicaid eligible children reside.

**Financial Impact:** Studies comparing the cost-effectiveness of water fluoridation compared with other strategies for reducing tooth decay always conclude that water fluoridation is the most cost-effective approach. Analysis of dental procedures in predominantly fluoridated community water versus non-fluoridated drinking water communities in New York State suggests savings of \$24 per child<sup>29</sup>. Out of the approximately 2 million children on Medicaid in New York State, about 500,000 live in less fluoridated counties and another 1.5 million live in mostly fluoridated counties. With \$1 million investment, we estimate that the number of children on fluoridated drinking water will increase by 200,000 to 1.7 million children. At a savings of \$24 per child, and a utilization of 35%, we estimate the annual savings to be \$14million. Thus an investment of \$10 million is likely to yield savings of \$140 million to the Medicaid program. This is a conservative estimate, as claims for adjunctive services such as examinations; radiographs and complex treatments; and costs related to transportation, emergency room visits, and lost productivity are not included. Such annual decreases in claims per recipient when applied to lifetime exposure of the whole population have large societal benefits. Barriers to fluoridation of public drinking water include lack of resources for community water systems to purchase equipment and chemical additives to institute fluoridation or to upgrade old equipment.

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<sup>29</sup> Kumar JV, Adekugbe O, Melnik T. Geographic Variation in Medicaid Claims for Dental Procedures in New York State: Role of Fluoridation under Contemporary Conditions. Public Health Reports 2010;125 (Sept-Oct):647-654





**Annual Cost: \$ 1.0 million**

**Annual Net Savings: \$14.28 million**

**Health Disparities Impact:** Significant benefits would accrue to all children covered by Medicaid.

**Benefits of Recommendation:** Even though the Department of Health and Human Services and New York State Department of Health fully support drinking water fluoridation, approximately 30% of all children in New York receive community drinking water that is not fluoridated. Community water fluoridation at current levels results in a 20 to 40 percent reduction in **tooth decay** nationwide.

Assuring fluoride in community drinking water is especially important today because many people cannot afford dental care. Fluoridation of community drinking water helps people of all ages and income groups. Systematic reviews of the scientific evidence have concluded that community water fluoridation is effective in decreasing dental caries prevalence and severity (McDonagh MS, et al, 2000<sup>30</sup>, Truman BI, et al, 2002<sup>31</sup>, Griffin SO, et al, 2007<sup>32</sup>). Effects included significant increases in the proportion of children who were caries-free and significant reductions in the number of teeth or tooth surfaces with caries in both children and adults (McDonagh MS, et al, 2000b, Griffin SO, et al, 2007). When analyses were limited to studies conducted after the introduction of other sources of fluoride, especially fluoride toothpaste, beneficial effects across the lifespan from community water fluoridation were still apparent (McDonagh MS, et al, 2000b; Griffin SO, et al, 2007).

Tooth decay is the most common chronic disease in children accounting for about 30% of all health care expenditures in children. Although dental caries is preventable, many children unnecessarily suffer the consequences because of poor dental care and the inability to access preventive and treatment services in a timely manner. Untreated dental disease in children can lead to chronic pain, medical complications, early tooth loss, impaired speech development, poor nutrition and resultant failure to thrive or impaired growth, inability to concentrate in school and missed school days, and reduced self-esteem. The burden of oral disease is far worse for those who have restricted access to prevention and treatment services. Limited financial resources, lack of dental insurance coverage, and a limited availability of dental care providers all impact access to care and lead to widespread disparities in health.

**Concerns with Recommendation:** Some members of the public are opposed to fluoridation, in part due to concerns about excessive exposure to fluoride. Excessive intake of fluoride during the first 8 years of life leads to changes in the tooth enamel called dental fluorosis. It is a disturbance in the mineralization of enamel. Its manifestation ranges from barely noticeable fine lacy white markings to pitting of surface. A report released late last year by the Centers for Disease Control and Prevention linked fluoride to an increase among children in dental fluorosis. About 40 percent of children ages 12 to 15 had dental

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<sup>30</sup> McDonagh MS, Whiting PF, Wilson PM, et al. Systematic review of water fluoridation. *BMJ* 2000;321(7265):855–9.

<sup>31</sup> Truman BI, Gooch BF, Evans CA Jr, editors. The guide to community preventive services: interventions to prevent dental caries, oral and pharyngeal cancers, and sports-related craniofacial injuries. *Am J Prev Med* 2002;23(Suppl 1).

<sup>32</sup> Griffin SO, Regnier E, Griffin PM, Huntley V. Effectiveness of Fluoride in Preventing Cavities in Adults. *J Dent Res* 2007;86(5):410–415.



fluorosis, mostly very mild or mild cases, from 1999 to 2004<sup>33</sup>. That percentage was 22.6 in a 1986-87 study. In fluoridated areas, dental fluorosis is seen mostly in milder forms and therefore, considered as a cosmetic effect and not an adverse functional effect. In fact, studies show that teeth with enamel fluorosis are more resistant to tooth decay.

**Impacted Stakeholders:** All New Yorkers, most notably children will be affected by the lack of access to fluoride. Critical inadequacies in access to oral health care in the U.S., particularly in the low-income population, have been a focus of increasing concern in the health policy community in recent years. *Poor children suffer the most dental disease and are less likely to receive dental care.* The burden of dental disease and conditions is not distributed evenly in children. The Surgeon General's report documented that poor children suffer far more, and more extensive and severe, dental disease than other children; indeed, they are about twice as likely to have untreated caries<sup>34</sup>. Another federal report, by the U.S. General Accountability Office, indicates that 80% of untreated caries in permanent teeth are found in roughly 25% of children who are 5 to 17 years old – mostly from low-income and other vulnerable groups<sup>35</sup>. That report also estimates that poor children suffer nearly 12 times more restricted-activity days, such as missing school, as a result of dental problems, than higher-income children. Because poverty is more prevalent among minority children than among whites, income-related disparities in oral health status can translate also into racial/ethnic disparities. At the same time that poor children have more dental disease than other children, they are less likely to receive dental care.<sup>910</sup> In 2006, nearly a quarter of all children age 2-17 had not had a dental visit in the past year, but poor and low-income children were more likely to lack a recent visit than higher-income children (31% and 33% versus 18%).<sup>36</sup>

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<sup>33</sup> Beltrán-Aguilar ED, Barker L, Dye BA. Prevalence and Severity of Dental Fluorosis in the United States, 1999–2004. NCHS Data Brief No. 53. November 2010.

<sup>34</sup> US Department of Health and Human Services. Oral health in America: A Report of the Surgeon General. Rockville (MD): National Institute of Health; 2000.

<sup>35</sup> GAO, MEDICAID: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay, GAO-08-1121 (Washington, D.C.: Sept. 23, 2008).

<sup>36</sup> Bloom B and Cohen RA. Summary Health Statistics for U.S. Children: National Health Interview Survey, 2006. National Center for Health Statistics. Vital Health Stat 10(234). 2007.



## Medicaid Redesign Team Health Disparities Work Group Final Recommendations – October 20, 2011

**Recommendation Number:**

**Recommendation Short Name:** Medicaid Coverage of Syringe Access and Harm Reduction Activities

**Program Area:** Health Disparities

**Implementation Complexity:** High

**Implementation Timeline:**

**Required Approvals:**  Administrative Action  Statutory Change  
 State Plan Amendment  Federal Waiver

**Proposal Description:** The Health Disparities Workgroup recommends the following three actions to promote and address health care needs of persons with chemical dependency:

- Clarify regulations to allow any medical provider to prescribe syringes to an injection drug used for prevention of disease transmission, paid for by Medicaid. (Currently payment for syringes is only available with ESAP funding).
- Allow OASAS licensed drug treatment providers to be reimbursed for harm reduction counseling.
- Authorize NYS DOH AIDS Institute Syringe Exchange providers (community-based organizations) to be reimbursed by Medicaid for harm reduction/syringe exchange program services provided to Medicaid eligible individuals.

**Financial Impact:** Overall Medicaid costs would be reduced through enhanced engagement and retention of persons with chemical dependency in drug treatment, primary health and mental health services resulting in reduced inpatient hospital, detoxification and rehabilitation costs as well as Emergency Room visits.

**Health Disparities Impact:** Significant. The services afforded under this proposal will reduce HIV/AIDS transmission. HIV/AIDS has had a devastating impact on minorities in the United States and in New York State. Racial and Ethnic minorities accounted for almost 71 percent of the newly diagnosed cases of HIV and AIDS in 2008. In 2008, 73 percent of babies born with HIV/AIDS belong to minority groups. For Hepatitis the story is largely the same with African American men are 80% more likely to have chronic



liver disease than non-Hispanic White men; Asian American women are 2.4 times more likely to die from chronic liver disease, as compared to non-Hispanic Whites; Native Hawaiian/Pacific Islanders are seven times more likely to be diagnosed with chronic liver disease, as compared to non-Hispanic Whites and both Hispanic men and women have a chronic liver disease rate that is twice that of the White population.

**Benefits of Recommendation:** Implementing these proposals would increase the number and availability of harm reduction providers to the state’s injection drug-using population. In addition to retaining current grant funding, a Medicaid reimbursed program would greatly complement the existing structures and support for syringe access. Once linked into this system of care, individuals could more easily be integrated into a range of health care as well as mental health and substance use services. Research has shown that harm reduction and access to sterile syringes promotes entry to and retention in drug treatment, health care, and other social services and leads to reductions in and even cessation of injecting behaviors among program participants. Addiction treatment results in other outcomes such as reductions in use of and expenditures for emergency departments and outpatient and inpatient detoxification services, and also results in a reduction in transmission of HIV, hepatitis, and other blood-borne infections. (Addiction treatment has also been shown to result in reduced crime and increased employment.) Evidence of the benefits of harm reduction has supported the lifting of the ban on the use of federal funds to support programs such as syringe exchange. In addition, the Surgeon-General has determined that syringe services are effective in reducing drug abuse and HIV transmission, thus meeting the statutory requirement permitting the expenditure of Substance Abuse Prevention and Treatment (SAPT) block grant to pay for such services.

#### **Concerns with Recommendation:**

- Would require a redirection of OASAS resources.
- For clinicians who are not currently registered as providers in the Department’s Expanded Syringe Access Program (ESAP), writing prescriptions for syringes for purposes of injecting drugs may not be a common practice. Implementation will require an educational effort.
- The Federal Government may ban the use of federal funds for syringe exchange.

#### **Impacted Stakeholders:**

- Persons who are chemically dependent,
- Syringe Exchange and Harm Reduction Programs,
- OASAS-licensed drug treatment providers.
- Medical providers (health care facilities and practitioners), NYSDOH-authorized syringe exchange programs, addiction treatment providers, pharmacies