Summary of Comments by Proposal
(only those proposals for which comments were submitted are listed below)

DATA COLLECTION/METRICS TO MEASURE DISPARITIES

1 MTM. Improving Data Collection to Reduce Health Disparities. b) Improvements to Data Collection and Reporting on Race/Ethnicity in Medicaid

- This is THE issue in this area and short term investment fundamental to long term quality and disparities related savings
- 1 and 5 MTM should be merged
- Very important to be able to assess disparities and the impact of other proposals on outcomes. Required by HRSA programs and Meaningful Use so we should support and require this
- No cost and dramatically improves the ability to identify health disparities so that they can be more effectively addressed.

2 MTM. Review existing disparity and cultural competence measures (HEDIS, QUARR CON, National Quality Forum, PQI and Ambulatory Sensitive Conditions data) for appropriateness.

- For Medicaid program, short term costs trivial and long term returns potentially significant

4 MTM. Provide funding to support the integration and analysis of child health data (Medicaid and public health) to better identify, understand and address health disparities among children.

- Limited information on cost; proposal does not seem expensive and seems directly tied to improve quality and effective utilization.
- Minority children face major disparities and proposed data system could both reveal causes and track progress

5 MTM. **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.**

- Integrate with 1 MTM

6 MTM. Add housing Status to data collection tools.

- Data on association of poor/no housing with high utilization could be relatively no cost-high return
- Housing status is a key indicator of health outcomes, but the information is rarely collected except in the context of special studies. Having this data routinely collection would dramatically demonstrate the importance and cost effectiveness of stable housing in improving health outcomes.

SYSTEMIC REFORM AND ACCESS TO HEALTH SERVICES

7/8 SR. Charity Care in New York State – Pool distribution must be more equitable and charity care dollars must clearly follow uninsured patients.

- Under current system, safety net disadvantaged; appropriate distribution adds resources to these key institutions which care for more minorities
- This is the most important of all the proposals we discussed.
- This proposal largely bolsters hospitals irrespective of the quality of care and the use of funds just because they serve a low-income constituency. While an improvement over the present formula, it does nothing to ensure that uninsured consumers are getting cost-effective preventive and primary care.

9 **SR. Integrate Medicaid enrollment in correctional discharge planning by submitting applications prior to release through a statewide enrollment center.**

- Highly vulnerable population with potential for high cost to system on release and health risk to community at large from untreated ID
- Effective linkage from incarceration not only improves health outcomes but decreases recidivism.

10 SR. Disparities in Treatment: Improving Access to Care.

- THE issue viz disparities in national studies/priorities; implementation strategy challenge, but should not be lost

11 SR. Implement community-based pay for performance to create incentives to providers to reduce unnecessary hospital admissions and readmissions. (87)

- This is the most important of all the proposals we discussed.

12 SR. Eliminate co-pays and expand access for preventative services. (65)

- Requirement in ACA; implementation key; priority for addressing disparities

13 SR. Educate and Incentivize Beneficiaries to appropriately use ERs/Urgent Care Centers. (108)

- Could occur in ER, would probably save money but specific disparities impact unclear
- Education may not be the solution. Effective accessible primary care is what is needed.

14 SR. Flexibility to Convert/Establish Urgent Care Centers. (135)

- We need to replace this concept with the establishment of primary care centers that operate on greatly expanded hours. People need primary care on evenings and weekends not just urgent care.

LANGUAGE ACCESS

17 LA. Medicaid Reimbursement for Language Assistance Service.

- Another critical priority for this group; opportunities for savings and quality clear

LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND QUEER/QUESTIONING

19 LGBT. Mandated Training on Sexual Orientation and Gender Identity and Expression in OASAS and OMH Licensed Programs.

- Should be done, but may not guarantee changes in behavior of providers

20 LGBT. Training for pediatricians, family medicine and other providers on transgender sexual health issues – tie to training for other cultural compliance issues (e.g. GME, continuing education). Include front line staff in graining (model after HHC mandates for new staff training)

- Recommendation complex--main target educational system not Medicaid

CHEMICALLY DEPENDENT INDIVIDUALS

22 CDI. Expanded Access to Syringes and Harm Reduction Therapy.

- Might generate early savings; need data from previous efforts re: current obstacles.

HOMELESS PERSONS

25 HP. Improve Access to care by Utilizing Mobile Health Clinics. (205)

- Could do more harm than good as a result of lack of continuity and breaking links to existing provider--perhaps in rural areas
- This is not a real solution. Need more community based primary care with continuity of care available

PERSONS WITH HIV (SEXUAL HEALTH)

28 PH. Allow local health department billing of Medicaid for STD services and unbundling of SBIRT services.

- STDs are of higher incidence in minorities according to state data so increased access/care could have higher impact

PERSONS LIVING WITH MENTAL ILLNESS

30 PLM. Develop comprehensive community health teams, combining case management, medical care and mental health services. (15)

- Assume this is envisioned in behavioral /medical home plans
- This may be one of the most important approaches to improving quality reducing disparities-developing infrastructure to help patients manage their medical conditions
- Not enough information to assess this proposal. It seems to replicate what health home is intended to do.

31 PLM. Develop comprehensive programs to serve youth in transition with psychiatric disabilities across all systems of care including foster care, school populations that have youth with SED diagnosis and the juvenile justice population.

- Expansive and non-specific proposal, though excellent conceptually

36 PLM. Provide a wide variety of housing options for individuals with psychiatric disabilities that are inclusive of the culturally diverse needs of these individuals.

- Not role of Medicaid as currently structured

37 PLM. Provide suicide prevention training material that is germane to various ethnic populations that are at highest risk of suicide attempts.

- Disproportionate issue for minority youth--marginal cost

39 PLM. Access to Mental Health Medication.

- Access alone will help but also requires psychotherapy and counseling and assurance of medication adherence
- Overall, would save costs; critical variable in management and access

PERSONS WITH DISABILITIES

44 PWB. Reform CON, contracts and award process to ensure ADA compliance.

- Could be explicitly required re: data submitted for CON etc.,

46 PWB. Rigorous review of ADA compliance in public health initiatives.

- Since this is disease focused, not clear how ADA compliance assurance would add value in dx and Rx.

MATERNAL, INFANT and CHILD HEALTH

51 MICH. Medicaid Eligibility/Coverage for Medical and Contraceptive Services for Child Bearing Age Women. (1, 260, 180, and 63)

- Critical area of disparities; proposal very expansive but deserved attention as pre-pregnancy health critical to maternal and neonatal outcomes

53 MICH. Medicaid Reimbursement of Nurse Family Partnership Services.

- Good data on overall cost savings and quality improvement even in short/medium term

59 MICH. Medical Coverage of Home-Based Environmental Assessments and Care Coordination for Children with, or at Risk for Lead Poisoning and Asthma.

- Environmental action not just assessment but clear evidence of reduced cost to health care system

DISEASE-SPECIFIC PROPOSALS TO ADDRESS IDENTIFIED DISPARITIES

63 DSP. Medicaid Coverage of Community Health Workers for Chronic Disease Prevention and Control. (179)

- Good data on overall cost savings and quality improvement even in short/medium term

65 DSP. Require Medicaid Managed Care plans to cover automated home blood pressure monitors for patients with uncontrolled hypertension

- Access to home blood pressures devices is helpful but also education for medication adherence is also needed
- inclusion would accelerate higher accuracy and self management