

SEPARATE AND UNEQUAL CARE IN NEW YORK CITY

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Bronx Health REACH, a coalition of community- and faith-based groups, health care providers, and an academic institution, recently examined the causes of racial and ethnic health disparities in the southwest Bronx and identified separate systems of care for uninsured and publicly insured patients, who are predominantly people of color, and those with private insurance. We found evidence that patients are sorted into segregated pathways of care, a system of medical apartheid in which differential care contributes to disparities in health care and health outcomes.

I. BACKGROUND

In 1999, the Institute for Urban Family Health, in collaboration with three community organizations and an academic partner, received a grant from the Centers for Disease Control and Prevention (CDC) to develop Bronx Health REACH, a coalition that would examine racial and ethnic health disparities in the southwest Bronx and work to eliminate them.¹ The members of the coalition were aware that people of color in general and residents of the southwest Bronx in particular suffered from poorer health status than other residents of New York City. An extensive review of the literature provides evidence of widespread racial and ethnic disparities in health care and health outcomes for people of color nationally.²

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1. At its foundation, Bronx Health REACH comprised The Institute for Urban Family Health, St. Edmund Episcopal Church, Mount Hope Housing Company, the Women's Housing and Economic Development Corporation (WHEDCO), and the Center for Health and Public Service Research at New York University. Spring Gombe, *Ending Racial Disparities in Health Outcomes*, METRO EXCHANGE (Mar. 2000), <http://www.institute2000.org/cdc/metro.htm>; see also Bronx Health REACH, <http://www.institute2000.org/cdc/reach.htm> (last visited Feb. 28, 2006) (articulating the organization's mission statement). The southwest Bronx neighborhoods that were examined encompassed zip codes 10452, 10453, 10456, and 10457.

2. INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE* 38-79 (Brian D. Smedley et al. eds., 2003).

Closer to home, health data illustrates the poor health status of residents in the southwest Bronx compared to all residents of New York City:³

- Death rates from all causes are 50% higher than the death rate for all New Yorkers.⁴
- Death rates from AIDS are three-and-a-half times higher than those in New York City as a whole.⁵
- Hospitalization rates for diabetes and asthma (generally controllable with proper care) are twice and two-and-a-half times as high as the rates for all New Yorkers, respectively.⁶
- A greater proportion of community residents are without a personal physician.⁷

The CDC grant assisted Bronx Health REACH, now comprised of over forty organizations, to undertake a wide-ranging examination of health disparities and their causes. In an initial series of focus groups in which community residents were asked to provide their views on the causes of racial and ethnic disparities in health, responses centered on themes of distrust, feelings of disrespect, poor communication with health care providers, and the need for self-advocacy.⁸ Using several publicly available data sources, Bronx Health REACH analyzed aspects of the health care system with respect to race and ethnicity. We found pervasive segregation of care between and within New York City hospitals—care that was not only separate but unequal.

II. MALDISTRIBUTION OF HEALTH INSURANCE COVERAGE BY RACE

Health insurance is a major factor in access to medical care, and studies link lack of insurance to delayed care and poorer health outcomes.⁹ In New York City,

3. N.Y. CITY DEP'T OF HEALTH & MENTAL HYGIENE, COMMUNITY HEALTH PROFILES: THE HEALTH OF HIGHBRIDGE AND MORRISANIA 4-5, 10 (2003), available at <http://www.nyc.gov/html/doh/downloads/pdf/data/2003nhp-bronxc.pdf>.

4. *Id.* at 4.

5. *Id.* at 4-5.

6. *Id.* at 5.

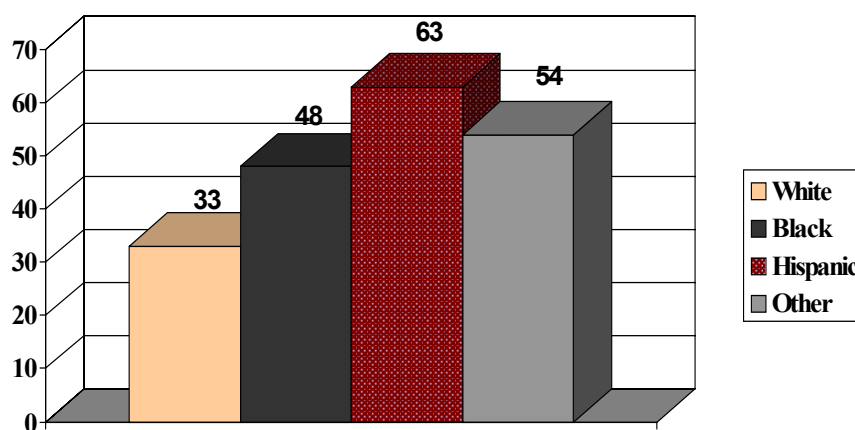
7. *Id.* at 10.

8. S.A. Kaplan et al., *Racial and Ethnic Health Disparities: A View From the South Bronx*, 17 J. HEALTH CARE FOR POOR & UNDERSERVED 116, 116-27 (2006).

9. E.g., Stuart H. Altman et al., *Healthcare for the Poor and Uninsured: An Uncertain Future*, in THE FUTURE U.S. HEALTHCARE SYSTEM: WHO WILL CARE FOR THE POOR AND UNINSURED? 2-7 (Stuart H. Altman et al. eds., 1998); Jack Hadley, *Sicker and Poorer—The Consequences of Being Uninsured: A Review of the Research on the Relationship Between Health Insurance, Medical Care Use, Health, Work, and Income*, 60 MED. CARE RES. & REV. 3S, 5S-65S (2003); Joel S. Weissman et al., *Limits to the Safety Net: Teaching Hospital Faculty Report on Their Patients' Access to Care*, 22 HEALTH AFF. 156-62 (2003).

insurance status is closely tied to race and ethnicity. While nearly 26% of black, 32% of Hispanic, and 38% of “other” New Yorkers are uninsured, only 19% of white New Yorkers are uninsured.¹⁰ Black and Hispanic New Yorkers are significantly more likely than whites to be uninsured or publicly insured.¹¹

Figure 1.
Percent of New York City Population Uninsured or Publicly Insured



Source: United Hospital Fund, 2003

Because the rates of those who are uninsured and publicly insured are so high among blacks, Hispanics, and other people of color compared to rates among whites in New York City, these patients are disproportionately affected when health systems sort patients based on insurance, as described below.

III. SEGREGATION OF THE POOR AND UNINSURED INTO DIFFERENT INSTITUTIONS

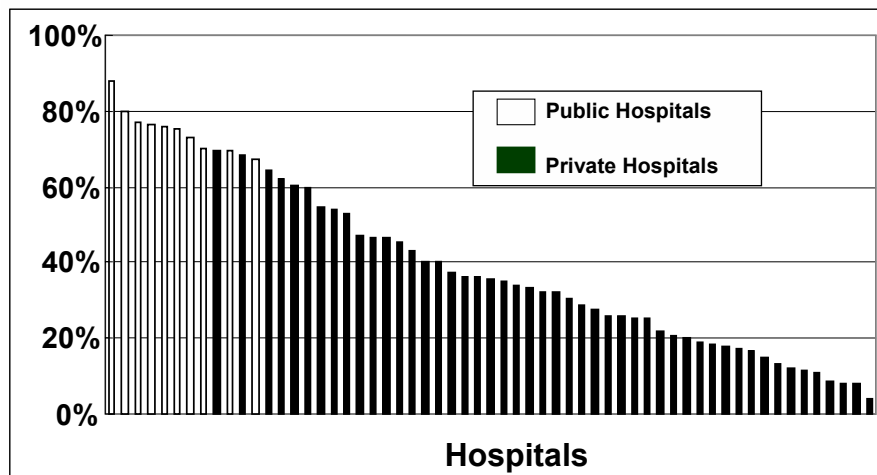
There is wide variation among New York City hospitals in the number of poor and uninsured patients treated at each facility. Uninsured and Medicaid-insured patients account for less than 4% of hospital discharges at some hospitals,

10. UNITED HOSP. FUND, HEALTH INSURANCE COVERAGE IN NEW YORK, 2001, at 18 (June 2003), http://www.uhfnyc.org/usr_doc/chartbook2003.pdf (presenting data collected by the U.S. Census Bureau's 2001-2002 *Annual Demographic Survey Current Population Survey*).

11. *Id.*

while amounting to nearly 90% of hospital discharges at others.¹² This disparity is closely linked to the public or private nature of the hospital—almost all of the hospitals in the top quartile of those caring for poor and uninsured patients are public (see Figure 2).¹³

Figure 2.
Percentage of Uninsured and Medicaid Discharges at
New York City Hospitals



Source: SPARCS 2001, Table IX

These variations in treatment of uninsured and Medicaid patients may not be attributed simply to hospital location. New York City operates a number of its public hospitals in the immediate vicinity of a private hospital, often adjacent or within one or two blocks. In the absence of patients' being sorted by insurance, the insurance mix of patients at two hospitals located in the same neighborhood would be expected to be similar. A Bronx Health REACH review of New York State Statewide Planning and Research Cooperative System (SPARCS) Data¹⁴ showed

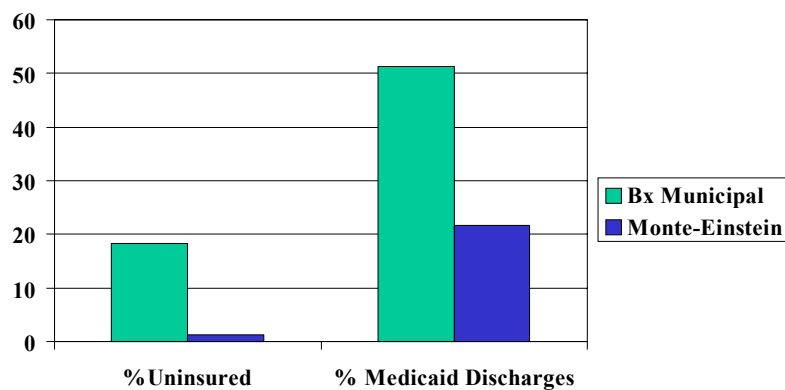
12. N.Y. STATE DEP'T OF HEALTH, STATEWIDE PLANNING AND RESEARCH COOPERATIVE SYSTEM (SPARCS): ANNUAL REPORT 2001 TABLE 9(I) (2003) [hereinafter SPARCS 2001], <http://www.health.state.ny.us/statistics/sparcs/annual/ars2001.htm>.

13. *Id.*

14. SPARCS is a comprehensive patient data system enacted through a collaboration of health care providers and government, under which hospitals are required to submit 95% of their data within sixty

that, in fact, mixes of patients between two hospitals in the same vicinity are often quite different. The data showed that public hospitals care for a much higher proportion of uninsured and publicly insured patients than do the private hospitals located near them.¹⁵ Figures 3-5 compare patient discharges by insurance status for pairs of public and private hospitals within walking distance of each other. For example, over 75% of discharges from the public Queens Hospital Center were uninsured or publicly insured patients, compared to only 15% at St. Joseph's Hospital, a private hospital just four blocks away.¹⁶ Such data provides evidence of separate care within the New York City health care system.

Figure 3.
Jacobi Hospital (Public) v. Montefiore Weiler (Private)
Distance: 2 Blocks



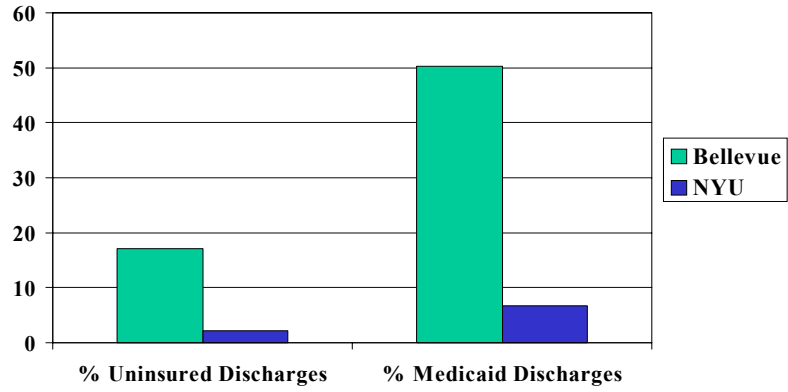
Source: SPARCS 2001, Table IX

days following the month of the patient's discharge. N.Y. STATE DEP'T OF HEALTH, STATEWIDE PLANNING AND RESEARCH COOPERATIVE SYSTEM (SPARCS): OPERATIONS GUIDE 2-4 (2005).

15. SPARCS 2001, *supra* note 12, at Table 9(I); *see infra* Figures 3-5.

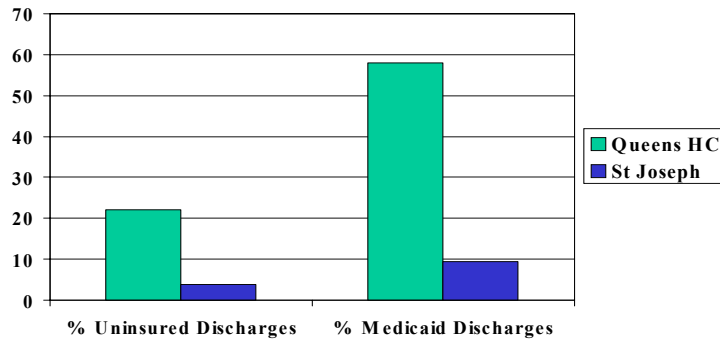
16. SPARCS 2001, *supra* note 12, at 17-18.

Figure 4.
 Bellevue Hospital (Public) v. New York
 University Hospital (Private)
 Distance: 1 Block



Source: SPARCS 2001, Table IX

Figure 5.
 Queens Hospital Center (Public) v.
 St. Joseph's Hospital (Private)
 Distance: 4 Blocks



Source: SPARCS 2001, Table IX

IV. SEGREGATION INTO DIFFERENT CARE SYSTEMS WITHIN INSTITUTIONS

Even within institutions, disparate systems of care exist for patients who have private insurance and those who are uninsured and publicly insured. Bronx Health REACH examined this issue by conducting a telephone survey of several Bronx medical centers that are important providers of specialty care to community residents.¹⁷ We surveyed four different specialty services at each hospital. One hospital told surveyors that fee-for-service Medicaid is accepted at all of the hospital's specialty clinics, but not at any of its faculty practices.¹⁸ At another hospital, this was the case for two out of four specialty services.¹⁹ Medicaid fee schedules contribute to this sorting of patients by insurance, because payments are far less for the care of Medicaid patients seen in faculty practices than when these same patients are seen at hospital clinics, which are paid a higher, cost-based rate.²⁰

How do these differences in treatment contribute to disparities in care? The Bronx Health REACH survey found that the models of care at the hospital specialty clinics and faculty practices differ in important ways (see Figure 6). Patients at specialty clinics are far more likely to receive care from residents, while patients at the faculty practices are more likely to receive care from attending physicians.²¹ Residents rotating in and out of clinics are less able to provide the continuity of care that is critical to patients with chronic illnesses, because patients are less likely to be treated by the same doctor at each visit. These physicians-in-training also learn that uninsured and Medicaid-insured patients are "teaching" patients, while privately insured patients should be treated by fully-trained physicians.²² We also found that patients at the surveyed faculty practices have access to their physicians through evening and weekend office hours or telephone coverage for emergencies, while patients at most of the clinics are referred to the emergency room by a telephone recording after office hours.²³

17. Neil Calman, *From the Field: Making Health Equality a Reality: The Bronx Takes Action*, 24 HEALTH AFF. 491, 494 (2005) (citing BRONX HEALTH REACH & INST. FOR URBAN FAMILY HEALTH, ACCESS TO SPECIALTY CARE: A TELEPHONE SURVEY OF SPECIALTY SERVICES IN THREE HOSPITALS (Apr. 2004) (unpublished report, on file with authors)).

18. *Id.*

19. *Id.* at 493.

20. EMPIRE MEDICARE SERVS., 2004 Fee Schedule (2004), <http://www.empiremedicare.com/fees/ny/ny04pfs01.pdf> (Jan. 21, 2005).

21. Calman, *supra* note 17, at 494.

22. *Id.* Medicaid and uninsured patients are predominantly people of color at these hospitals.

23. *Id.*

Figure 6.
Separate and Unequal Models of Care

	FACULTY PRACTICE	CLINIC
Who gets seen there	Privately insured patients	Uninsured and Medicaid patients
Providers	Board-certified faculty physicians	Students, residents and fellows
Continuity	Each patient has their own private doctor	Rotating group of doctors in training
Coordination of Care	Good reports – doctors want referrals	No coordination or communication
Night Coverage	Doctors are on call for their practice	Go to the Emergency Room
If the person needs hospital care	Doctors take care of their own patients	Another group of doctors takes over who don't know the patient

New York State Medicaid, Child Health Plus, and Family Health Plus contracts prohibit this type of differential care based on insurance coverage. Every contract between New York State and managed care companies that serve Medicaid, Child Health Plus, and Family Health Plus enrollees contains language that states, “All training sites must deliver the same standard of care to all patients irrespective of payor. Training sites must integrate the care of Medicaid, uninsured and private patients in the same settings.”²⁴ Further, New York State’s Patient Bill of Rights, which must be publicly posted in every hospital and handed to every patient upon admission, states that patients have a right to “receive treatment without discrimination as to race, color, religion, sex, national origin and *source of payment*.”²⁵ Two-tiered systems of care also are prohibited by the federal Hill-Burton Act, which authorizes funding for hospital construction.²⁶ Several Bronx hospitals have received such federal funding.²⁷

24. N.Y. STATE DEP’T OF HEALTH, MEDICAID MANAGED CARE MODEL CONTRACT app. I, at I-5 (2005), http://www.health.state.ny.us/health_care/managed_care/macont0105.pdf.

25. N.Y. PUB. HEALTH LAW § 2803(g) (McKinney 2005); Patients’ Bill of Rights, N.Y. COMP. CODES R. & REGS. tit.10, § 405.7(c)(2) (2005) (emphasis added).

26. 42 U.S.C. §§ 291-291o-1, 291c(e) (2000).

27. HEALTH RES. & SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUM. SERVS., HEALTH CARE FACILITIES OBLIGATED TO PROVIDE HILL-BURTON FREE & REDUCED COST CARE (2005).

While segregation of patients by insurance in an inpatient hospital setting has resulted in government intervention,²⁸ patient segregation continues in hospital outpatient facilities, unaddressed by regulatory agencies.²⁹ Although provisions are currently in place to prevent discriminatory care, there is no clear mechanism for enforcing such requirements. We have little reason to believe that our findings are limited to the Bronx. Wherever Bronx REACH staff present this data, we are told of similar discriminatory treatment of uninsured and publicly insured patients in hospital facilities.

V. PAYMENT INEQUITIES IN PUBLIC INSURANCE PROGRAMS

The federal government operates the two largest public health insurance programs covering Bronx residents: Medicare for the elderly and disabled and Medicaid for the poor. While both programs have undoubtedly expanded access to health care for the populations they serve, differences in program administration create disparities in access for participants in the two programs. Medicare establishes its fee schedule through a national methodology that has by and large provided excellent access to care for the nation's elderly. In the Medicaid program for the poor, individual states set rates and benefit schedules.³⁰ States typically set Medicaid rates at levels below Medicare's, and some states like New York set rates at levels so low that they almost preclude access to care at private physicians' offices.³¹ For those enrolled in Medicaid, institutional care settings are often the only option. Data from New York provides a striking example of the differences between the Medicaid and Medicare systems. In New York, a private physician providing a comprehensive visit with a new Medicare patient is paid six times as much as she would be for the same visit with a Medicaid patient (Figure 7).³² Such discrepancies virtually ensure unequal access to care.

28. Press Release, U.S. Dep't of Health & Hum. Servs., HHS Office for Civil Rights Signs Agreement with Mt. Sinai Medical Center (Mar. 9, 1994), *available at* <http://www.hhs.gov/news/press/pre1995pres/940309.txt> (last visited Feb. 28, 2006).

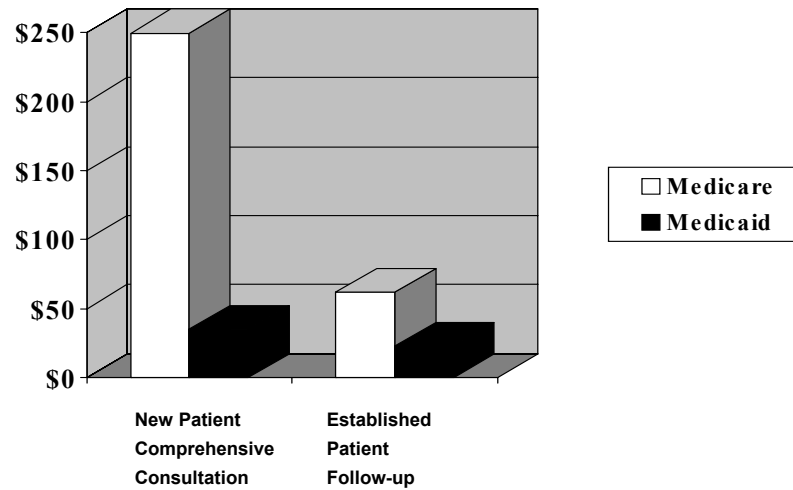
29. Calman, *supra* note 17, at 494.

30. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID PROGRAM: TECHNICAL SUMMARY (2005), http://www.cms.hhs.gov/MedicaidGenInfo/03_TechnicalSummary.asp#TopOfPage ("Within federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services.") (last visited Feb. 28, 2006).

31. PHYSICIAN PAYMENT REVIEW COMM'N, ANNUAL REPORT TO CONGRESS 352-53 (1994) (reporting that New York's Medicaid expenditures are a mere 31% of the amount spent on Medicare).

32. EMPIRE MEDICARE SERVS., *supra* note 20.

Figure 7.
New York City Fee Schedules for
Medicare and Medicaid Patient Visits

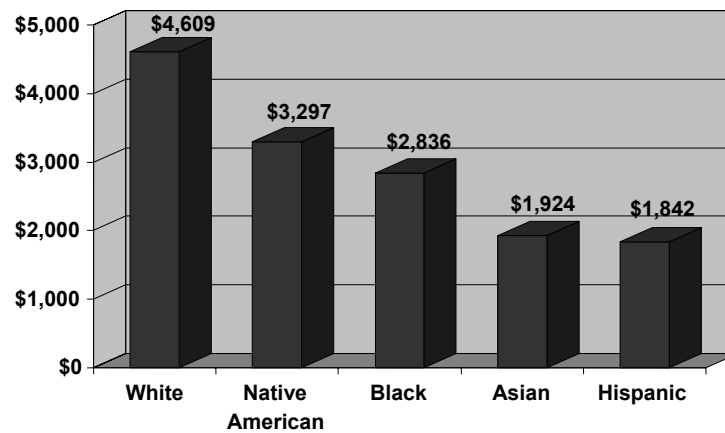


Source: Centers for Medicare & Medicaid Services, MCBS

Medicaid expenditures per recipient, when stratified by race and ethnicity, reveal further inequities. Data from the Centers for Medicare and Medicaid Services shows that nationally, Medicaid payments per white recipient are about 60% higher than those for blacks, 140% higher than those for Asians, and 150% higher than those for Hispanics (see Figure 8).³³ More detailed analyses of this data is urgently needed in order to understand the reasons for these disparities and their impact on health.

33. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID STATISTICAL INFORMATION SYSTEM, TABLES 24, 27 (1998), <http://www.cms.hhs.gov/medicaid/msis/mstats.asp>.

Figure 8.
Medicaid Payments per Recipient
by Race, U.S. (1998)



Source: Centers for Medicare & Medicaid Services, MSIS

VI. FAILURE OF MEDICAID MANAGED CARE TO EXPAND ACCESS

City and state policy-makers promoted the transition from traditional fee-for-service Medicaid to managed care in New York State as a way to increase access to care, particularly private specialty care, for Medicaid recipients.³⁴ Our research indicates that this has not been the case. Hospitals typically choose to participate in a few Medicaid managed care plans, frequently focusing on plans they own and from which they derive the most financial benefit.³⁵ Medicaid recipients in the Bronx have access to over a dozen managed care plans. However, they can only receive non-emergency specialty care at a hospital in their neighborhood if they belong to one of the few managed care plans that has a contract with that hospital.³⁶

34. KATHRYN HASLANGER, UNITED HOSP. FUND, *MEDICAID MANAGED CARE IN NEW YORK: A WORK IN PROGRESS* 7 (2003); see U.S. GEN. ACCOUNTING OFFICE, *MEDICAID: STATES TURN TO MANAGED CARE TO IMPROVE ACCESS AND CONTROL COSTS* 76-81 (1993).

35. HASLANGER, *supra* note 34, at 6-7.

36. BRONX HEALTH REACH & INST. FOR URBAN FAMILY HEALTH, *ACCESS TO SPECIALTY CARE: A TELEPHONE SURVEY OF SPECIALTY SERVICES IN THREE HOSPITALS* (Apr. 2004) (unpublished report, on file with authors).

In one striking example, the Bronx Health REACH survey of Bronx hospitals found that the newly built Children's Hospital at Montefiore Medical Center, which has been promoted as the premier center for children in the world,³⁷ accepts fewer than half of the licensed Medicaid managed care plans available in the Bronx.³⁸ Children covered by the other plans do not have access to this state-of-the-art facility. Parents choosing a managed care plan have no idea that this choice might result in denying their children access to facilities they may need in the future. We also learned that many Medicaid managed care patients in New York City teaching hospitals are still seen in the same clinic setting where they previously received care, rather than having expanded access to private specialty care.

This data shows that Medicaid patients continue to face barriers, even with the advent of the Medicaid Managed Care system. Despite extensive reviews of Medicaid Managed Care plans by state and city authorities, there does not appear to be adequate monitoring of compliance with anti-discrimination prohibitions under either New York State or federal law.

VII. INSTITUTIONAL SUBSIDIES FOR CARE OF POOR AND UNINSURED

New York State provides substantial financial assistance to hospitals to cover the cost of unpaid patient medical bills. In 2003, New York hospitals received \$847 million in payments from the State's Indigent Care and High Need Indigent Care Adjustment Pools, also known as the "Bad Debt and Charity Care Pool."³⁹ Studies of policies related to these pools found that the uninsured and underinsured individuals are unlikely to directly benefit from the funds.⁴⁰ Hospitals that receive payments from the Indigent Care Adjustment Pool are not required to make patients aware of the availability of funds to cover the cost of care, and often they

37. About the Children's Hospital at Montefiore, <http://montekids.org/about/> (last visited Feb. 28, 2006).

38. See N.Y. STATE OFFICE OF MANAGED CARE, 2003 MANAGED CARE ENROLLMENT TREND REPORT § II, 26-27 (2004), http://www.health.state.ny.us/health_care/managed_care/report/2003/2003complete.pdf (listing the thirty-one available Medicaid plans); *What Health Plan is Best for Your Family?*, MonteKIDS News 1 Montefiore Med. Ctr., Summer 2004, http://montekids.org/library/download/MKN.Sum.04.pdf?item_id=204266 (listing five Medicaid Managed Care plans that are acceptable at the hospital).

39. PUB. POLICY & EDUC. FUND OF N.Y., HOSPITAL FREE CARE: CAN NEW YORKERS ACCESS HOSPITAL SERVICES PAID FOR BY OUR TAX DOLLARS?, at ii (2003), http://www.communitycatalyst.org/resource.php?doc_id=177. The fund was created by the New York State legislature under the Health Care Reform Act and is paid for by taxes placed on patient services. *Id.*

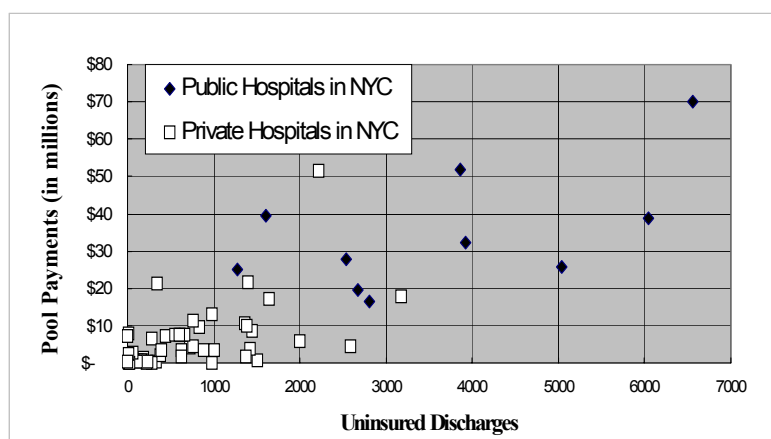
40. THE LEGAL AID SOC'Y, STATE SECRET: HOW GOVERNMENT FAILS TO ENSURE THAT UNINSURED AND UNDERINSURED PATIENTS HAVE ACCESS TO STATE CHARITY FUNDS 1-4 (2003), http://www.communitycatalyst.org/resource.php?doc_id=240 (reporting that New York requires no accountability, uniformity, or regulation in administration of the Indigent Care Adjustment Pools); see also PUB. POLICY & EDUC. FUND OF N.Y., *supra* note 39, at iii-v.

do not.⁴¹ Thus, patients who may benefit the most from such programs may not even know of their existence.

Uninsured patients are generally charged the hospitals' highest fees, while insurance companies routinely negotiate discounted hospital rates on behalf of those covered by their plans.⁴² The government offers no regulation of the fees hospitals charge to the uninsured. Hospitals are not required to report the number of patients who received charity care in order to receive funds.⁴³ Further, hospitals that receive payments from the pools are not required to apply these amounts to the accounts of uninsured or underinsured patients.⁴⁴

Payments from the pools are calculated using a complex funding formula that does not reflect the volume of charity care hospitals provide.⁴⁵ The distribution of these funds among hospitals, as illustrated in Figure 9, has little relationship to the number of uninsured discharges.⁴⁶

Figure 9.
Number of Uninsured Hospital Discharges Compared to
Indigent Care Funding Pools Disbursements for New York
State Hospitals, 2001



Sources: SPARCS 1999, Table IX, and New York State Department of Health, 2001

41. See LEGAL AID SOC'Y, *supra* note 40, at iv.

42. *Id.* at 6, 14; PUB. POLICY & EDUC. FUND OF N.Y., *supra* note 39, at 3 (citing THE COMMONWEALTH FUND, UNINTENDED CONSEQUENCES: HOW FEDERAL REGULATIONS AND HOSPITAL POLICIES CAN LEAVE PATIENTS IN DEBT 10-11 (2003), at http://www.cmwf.org/usr_doc/pryor_unintendedconsequences_653.pdf).

43. LEGAL AID SOC'Y, *supra* note 40, at 2 (citing N.Y. PUB. HEALTH L. § 2807 (McKinney 2005)).

44. *Id.* at 9.

45. *Id.* at 20.

46. N.Y. STATE DEP'T OF HEALTH, *supra* note 12, at 56-83.

People of color are more likely to be uninsured and are therefore more likely to incur large medical debt or to delay needed medical care that they cannot afford.⁴⁷ New York's Indigent Care and High Need Indigent Care Adjustment Pools fail to expand equitable access to care for uninsured individuals.

VIII. ELIMINATING SEGREGATED CARE

The Bronx Health REACH examinations of the health care system lead us to the following conclusions:

- In New York City to a greater extent than in the United States as a whole, race and ethnicity are closely linked to insurance status, with people of color far more likely to be uninsured or publicly insured than whites.⁴⁸
- Inequalities in insurance coverage are associated with inequalities in health care.
- People who are uninsured or publicly insured are often cared for in institutions separate from those who are privately insured.⁴⁹
- Even within health care institutions, separate and unequal systems of care exist.
- When patients are sorted according to their insurance status, this segregated care, or medical apartheid, leads to different health outcomes.⁵⁰

Consequently, the Coalition has formulated a set of recommendations to begin addressing the issue of segregated and inequitable care in New York that leads to health disparities.

A. Mandate Collection of Patient Race Data

The Coalition seeks an expansion of the current New York State SPARCS hospital reporting system to include mandated reporting of patient race and ethnicity by hospitals for both inpatient and outpatient services. The SPARCS system is an important tool for improving health care quality in the State. The addition of patient race and ethnicity data will permit analyses of primary, specialty, and tertiary care in our institutions that can identify isolated and systemic disparities in health care utilization and outcomes. This is a critical step in targeting efforts to eliminate health disparities.

47. Calman, *supra* note 17, at 494.

48. UNITED HOSP. FUND, *supra* note 10, at 18.

49. Calman, *supra* note 17, at 494.

50. *See id.* (discussing how New York hospitals' sorting patients by insurance results in racial discrimination).

B. Enforce Non-Discrimination Requirements

New York State's Patients' Bill of Rights and Medicaid, Child Health Plus, and Family Health Plus contracts prohibit hospitals from discriminating based on source of payment.⁵¹ Despite such prohibitions, hospitals continue to operate two-tiered systems of care. Bronx Health REACH advocates the creation of enforcement mechanisms that include significant sanctions to ensure that discriminatory treatment is not tolerated.

C. Structure Medicaid Fee Schedules to Create Access to Equal Quality of Care

In hospital outpatient facilities, Medicaid and uninsured patients are more likely to be seen in the clinics, while privately insured patients are more likely to be seen in the faculty practice.⁵² The differences in these two models of care have been discussed above. Hospitals have an incentive to maintain this two-tiered approach, because Medicaid reimbursement rates are higher in the clinic setting than in the faculty practice setting.⁵³

Bronx Health REACH advocates clarification of New York State policy to allow care for patients seen in faculty practices to be reimbursed by Medicaid at the same rate as that of clinics in the same hospital. This approach would promote a "mixed model" of care that integrates hospital outpatient clinic services with faculty practice services at one site. Medicaid-insured and privately insured patients could be seen by the same physicians under the same model of care, eliminating a two-tiered system. Such a policy would not result in increased Medicaid costs, as Medicaid patients are almost always seen in the clinic now and the care is reimbursed at the higher rate.

D. Greater Accountability for Indigent Care Funds

New York State must create mechanisms through which uninsured and underinsured individuals have access to the Indigent Care and High Need Indigent Care Adjustment Pools. Nassau and Suffolk Counties in New York and Massachusetts have enacted legislation that requires hospitals to inform patients about the availability of the Indigent Care Pools to cover the cost of their care and relevant eligibility criteria.⁵⁴ Similar legislation is needed at the state and national

51. N.Y. COMP. CODES R. & REGS. tit. 10, § 405.7 (2005).

52. See Calman, *supra* note 17, at 494.

53. EMPIRE MEDICARE SERVS., *supra* note 20.

54. 114.6 MASS. CODE REGS. 10.08 (2004), available at http://www.mass.gov/Eeohhs2/docs/dhcfp/pdf/114_6_10.pdf; NASSAU COUNTY, N.Y., ADMIN. CODE § 9-23.0 (2005), available at http://www.nassaucountyny.gov/official/resources/file/ebfb88407a62211/NassauCountyAdCode_July-11-2005.pdf; SUFFOLK COUNTY, N.Y., ADMIN. CODE § A9-7 (2003), available at <http://www.co.suffolk.ny.us/legis/>.

levels. New York State must also ensure that payments from the Indigent Care Pools reflect the amount of charitable care provided by hospitals.

These Bronx Health REACH recommendations reflect short-term, specific actions to address separate and unequal care that contributes to health disparities. The Coalition has established a broader legislative agenda to address health disparities. First among these is establishing comprehensive, universal health insurance. People of color are less likely to have health insurance, a statistic that includes those who work full-time.⁵⁵ New York State has been at the forefront of efforts to expand public insurance programs to a wider range of residents, but coverage alone does not necessarily ensure access. It is important that these programs provide adequate reimbursement to health care providers and that they are accessible to all those who are eligible for enrollment.

Additional recommendations address the need for culturally competent care, a more diverse health workforce, increased funding for public health education targeted to communities of color, and ensuring that minority communities do not bear a disproportionate burden from environmental stressors. While the need for rigorous examination and better understanding of racial and ethnic health disparities remains, Bronx Health REACH believes that many solutions are already within reach.

55. Calman, *supra* note 17, at 493-94.