

Separate and Unequal: Medical Apartheid in New York City



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Making Health Equality a Reality

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Separate and Unequal: Medical Apartheid in New York City

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Separate and Unequal Care: Medical Apartheid in New York City

Executive Summary

Widespread racial and ethnic disparities in health care and health outcomes in our communities and across the nation prompted Bronx Health REACH, a coalition of 40 community and faith-based organizations, to examine the causes of these disparities and develop strategies to eliminate them. **What we found includes pervasive segregation of care, based on the link between race, ethnicity and insurance status, resulting in the systematic separation of whites and people of color into different systems of care. We call it Medical Apartheid.**

In this report, we outline specific findings of system-wide policies and practices contributing to the segregation of care, as well as a set of recommendations to address these issues.

Findings:

Differences in Health Insurance Coverage by Race

Black and Latino New Yorkers are more than twice as likely as whites to be uninsured, or to receive Medicaid or other public insurance. As a result, people of color face more barriers to accessing high quality care, leading to disparities in health outcomes.

Segregation of the Poor and Uninsured into Different Institutions

The uninsured and publicly insured are far more likely to receive care in public hospitals, while the privately insured go to private hospitals, regardless of geographic location. Within the private (voluntary) hospital community, there are extreme variations in the extent to which they make themselves available to treat uninsured and publicly insured people.

Segregation into Different Care Systems within Institutions

A Bronx Health REACH survey of New York hospitals found that even within the same institutions, the uninsured, people covered by Medicaid, and sometimes, even those enrolled in Medicaid Managed Care, Family Health Plus and Child Health Plus, receive poorer quality care in different locations, at different times, and by less trained physicians than those who are privately insured — a practice that is prohibited by the Patient Bill of Rights and Medicaid Managed Care contracts.

Inequities in Payment by Public Insurance Programs

Medicaid, for the poor, pays physicians far less than Medicare, for the elderly and disabled, for the same services. Medicaid also spends more per person per year for whites than it does for people of color. Different payment policies contribute to different systems of care.

Failure of Medicaid Managed Care to Eliminate Disparities in Care

Though designed to expand access to care, Medicaid managed care in New York often limits care for Medicaid patients. Since many hospitals participate in only a few managed care networks, patients no longer have a full range of options.

Institutional Subsidies for Care of the Poor and Uninsured

Public funds provided to New York State hospitals for care of the poor and uninsured are distributed without regard to the volume of charity care provided. Uninsured individuals are often charged a hospital's highest rates, yet these individuals are unable to access the charity funds that hospitals receive to pay their hospital bills.

Recommendations:

Structure Medicaid Fee Schedules to Create Equal Access to Quality Care

Clarify New York State policy to allow care provided in faculty practices to be reimbursed by Medicaid at the same rate as at the clinics located in the same hospital. This approach would promote a single model of care for all patients and remove financial incentives for two-tiered systems. This would have no impact on the State's budget.

Enforce Non-Discrimination Requirements

Create enforcement mechanisms that include significant penalties to ensure that discrimination based on source of payment, as regulated by New York State's Patient Bill of Rights and Medicaid, Child Health Plus, and Family Health Plus contracts, are not tolerated.

Mandate the Collection of Patient Race Data

Add the mandatory collection of race information to the data already collected in health facilities statewide to identify disparities in health care utilization and outcomes. This is a critical step in targeting efforts to eliminate health disparities.

Require Greater Accountability for Indigent Care Funds

Ensure that subsidies to hospitals reflect the amount of charitable care they provide, and create mechanisms that enable uninsured and underinsured patients to apply such funds to their medical bills.

Summary:

In addition to these recommendations, Bronx Health REACH has established a statewide advocacy agenda to address additional factors that contribute to health disparities. First among these is support for comprehensive, universal health insurance. Additional recommendations address the need for a more diverse health workforce, culturally and linguistically competent care, 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.

The Bronx Health REACH coalition includes 40 community and faith-based organizations dedicated to understanding and eliminating racial and ethnic health disparities in health outcomes in the southwest Bronx. The group was established in 1999, and in addition to its advocacy efforts, sponsors a host of community health promotion and disease prevention programs, funded by the Centers for Disease Control and Prevention and the New York State Department of Health.



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Separate and Unequal: Medical Apartheid in New York City

Along with stunning breakthroughs in medical science, racial and ethnic disparities in health are now a well-known product of the U.S. health care system. Federal reports, medical journals, and local data all provide evidence of pervasive differences in health care and health status among different groups of Americans. Less well known and understood are the factors that create and sustain these health disparities.

Our examination into the causes of racial and ethnic health disparities in our own community—the southwest Bronx—has identified separate and unequal systems of medical care. One is for patients who are uninsured or receive publicly funded insurance such as Medicaid, who are predominantly people of color. The other is for those with private insurance, who are more likely to be white. We found evidence of patients sorting into segregated pathways of care, a system of medical apartheid in health care which leads to disparities in health outcomes.

In this paper we present the findings of surveys, data analyses, and literature reviews undertaken by our Bronx-based community coalition that document a system of separate and unequal care in New York City. We also present the coalition’s recommendations for addressing health system policies that contribute to racial and ethnic disparities in health.

Bronx Health REACH

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 a coalition, Bronx Health REACH, to examine racial and ethnic health disparities in the southwest Bronx and work to eliminate them. Over the past five years, Bronx Health REACH has grown to include 40 community and faith-based organizations that have each played a role in the coalition’s multiple research projects, community health promotion efforts, and disease prevention programs. The coalition produced a 22-minute documentary, entitled *Voices for Health Equality*, to provide multiple perspectives on

Our primary goal is to explore... the link between race, ethnicity and insurance status that results in the systematic separation of whites and people of color into differential systems of care.

health disparities. It also has developed a statewide legislative agenda highlighting specific steps that can be taken in New York State to address health disparities.¹

This monograph identifies specific factors that lead to health disparities in our community, focusing on one factor that is rarely discussed in the health disparities literature: the link between race, ethnicity and insurance status that results in the systematic separation of whites and people of color into differential systems of care within New York's health care system. These systems of care, which are separate and unequal, maintain and exacerbate the disparities in health outcomes that result from them.

Racial and Ethnic Disparities in Health Outcome: What We Know

The members of the Bronx Health REACH coalition have learned from our own experiences that people of color in general and residents of the southwest Bronx in particular suffer from poorer health status than others. A review of the literature provides evidence of widespread racial and ethnic disparities in health care and health outcomes for people of color across the country. In 2002, the Institute of Medicine's groundbreaking study, *Unequal Treatment*, concluded that, "Racial and ethnic minorities tend to receive a lower quality of care than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled".²

From birth to death, health data illustrate inferior health outcomes for people of color. For example,

- A black male baby born in the U.S. today will live for seven fewer years than a white male baby born today,³ and is far less likely to collect social security than his or her white counterpart.
- An African-American with diabetes is 1.5 to 2.5 times more likely to lose a limb than other diabetics, and is 2.5 to 6.5 times more likely than other diabetics to develop kidney disease.⁴
- Black, Latina, and Asian American women wait twice as long as white women for diagnostics tests following an abnormal mammogram to determine if they have breast cancer.⁵

While all Americans benefit from advances in medical treatment, health data show that white Americans benefit sooner than others.

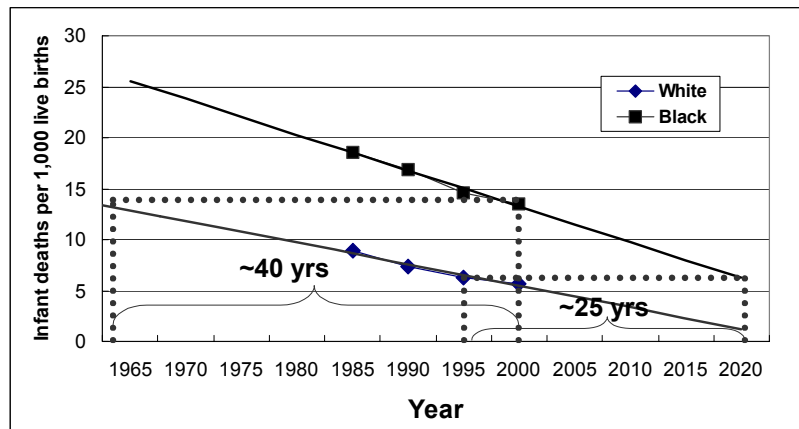
These examples illustrate the effects of a health system that provides different care to people of different races. While all Americans benefit from advances in medical treatment, health data show that white Americans benefit sooner than others. Various studies have found delays in the implementation of new treatment protocols and medical technologies at facilities serving primarily people of color.⁶ One of the most disturbing results of these delays is the disparity between whites and blacks in improved survival rates and complications from various conditions.

The following figures show that, while the survival rates for both blacks and whites increased over time, the gap continues between the two groups.* Blacks are able to achieve the same survival rates as whites, but this happens many years later—at a point where whites have already advanced to the next milestone in survival rates. Recent studies indicate that the same disparities in mortality rates exist for Latinos.⁷

We call this “lag time.” What we see in these figures is that in spite of increased survival rates for both whites and blacks, it takes many years for blacks to achieve the level of health outcomes achieved by whites years before. This tells us that access to healthcare, whether defined as exposure to health education, prevention, diagnosis or treatment, is different for blacks and whites. In addition, these data confirm that the increased death rate for these diseases and conditions is not genetic in origin. If it were, blacks would not achieve the same rates as whites in subsequent years. As a result, as shown below, minority populations lag behind whites in infant mortality, life expectancy, cancer survival rates, death rates for heart disease and HIV/AIDS. In sum, “Minority populations continue to lag behind the white population on many important indicators. Despite the overwhelming sophistication of our health care system, minority Americans...often do not fully benefit from what it can offer.”⁸

* Data for Latinos has been collected more recently and is not available for historical trend analysis. This is especially important to note given the language barriers that many Latinos face.

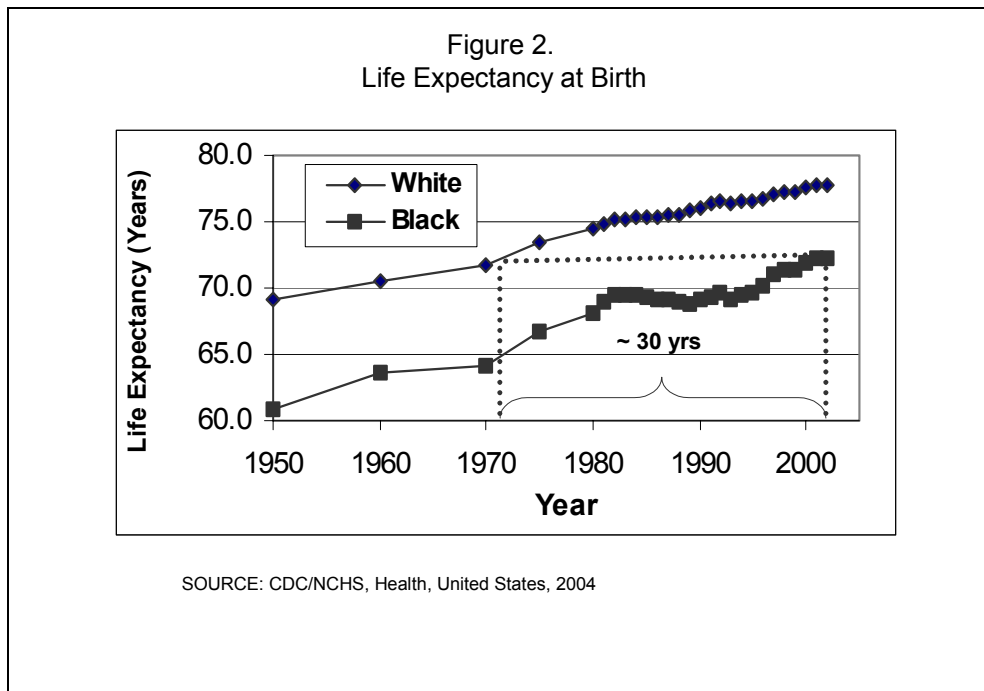
Figure 1.
Infant Mortality Rates



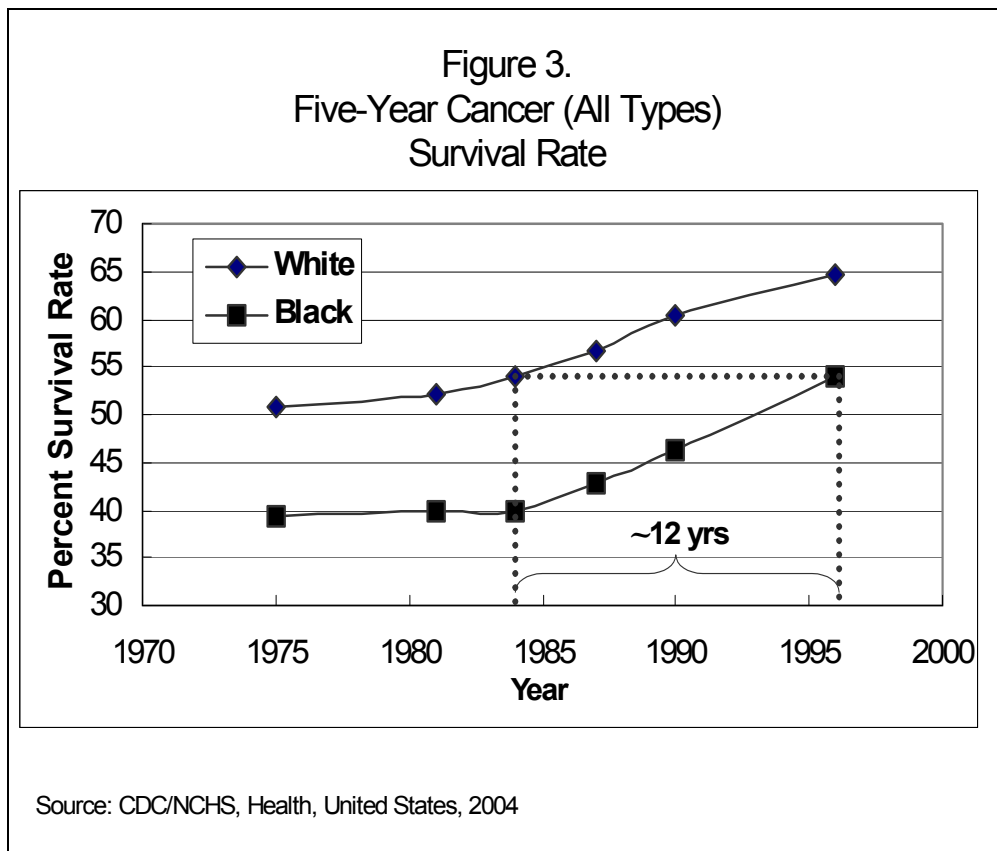
SOURCE: CDC/NCHS, Health, United States, 2004

Figure 1 shows the infant mortality rates for blacks and whites over a 40-year period. Both groups experienced decreases in infant mortality rates. However, the rate for whites was below 15 deaths per 1,000 births in 1962 and blacks did not reach that rate until 2000. This is a gap, or “lag time,” of almost 40 years. Given the current patterns, blacks can be expected to wait until 2020 to experience the infant mortality rates that whites had in 2000—a twenty-five year lag time.

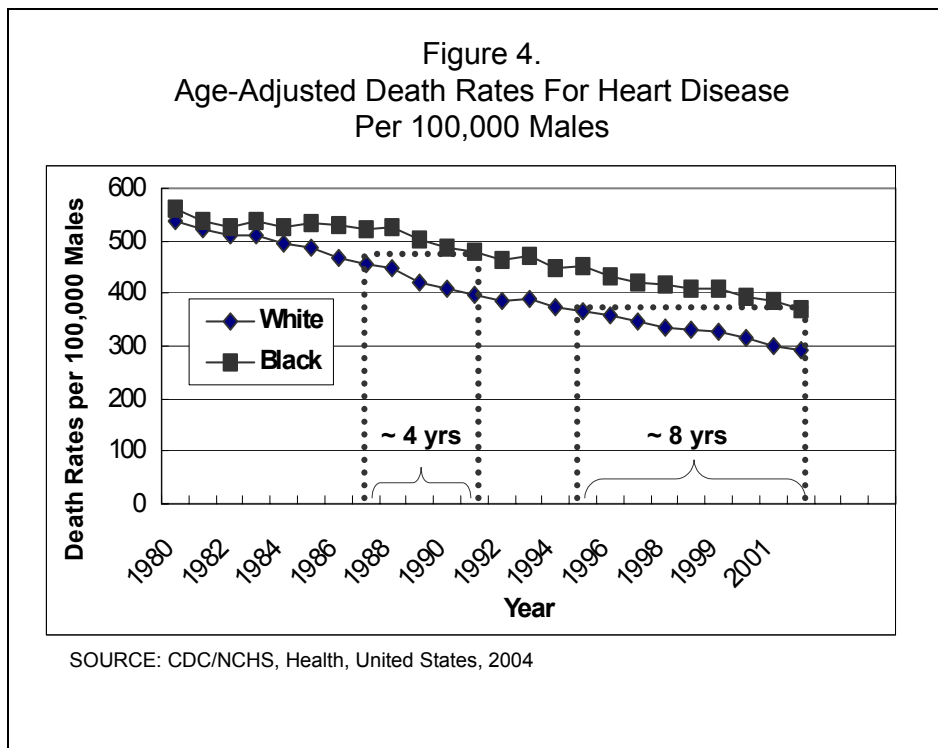
Once a black child is born, he or she can expect to live fewer years than a white baby. In 2002, black babies had an average life expectancy of 73.2 years (see Figure 2). This was the life expectancy that a white baby had in 1970, a lag time of over 30 years.



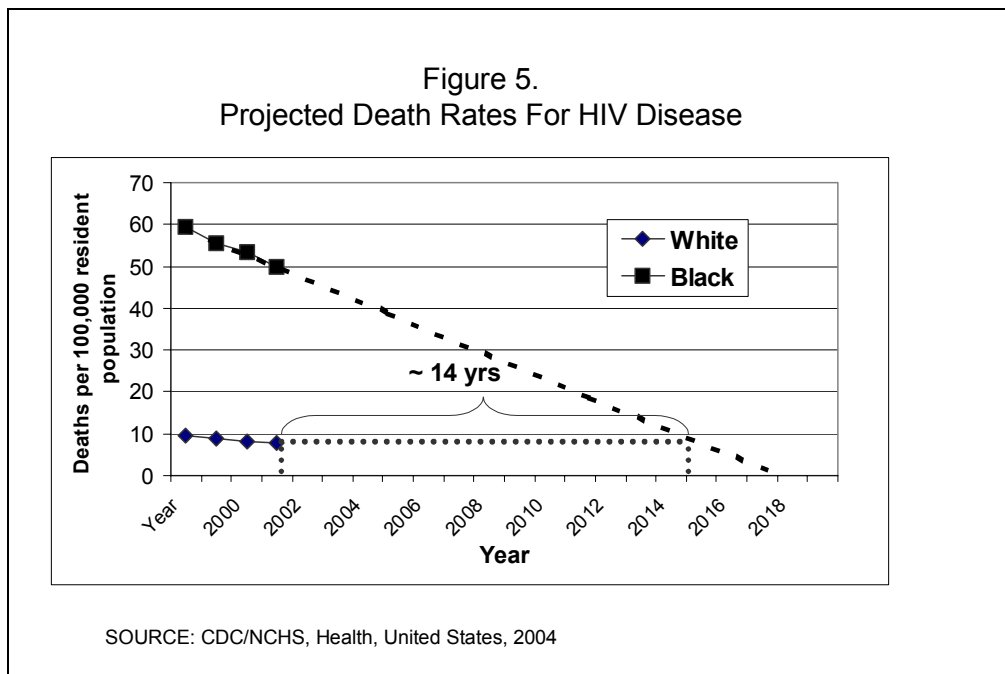
In 1984, whites had a five-year cancer survival rate of 54% and blacks had a rate of only 40%. Twelve years later, in 1996, blacks had reached a 54% cancer survival rate but white rates had improved even higher—to 65% (see Figure 3). Advances in cancer treatment and survival rates for blacks lag 12 years behind those achieved for whites.



Deaths from heart disease are another example of this lag time (see Figure 4). Death rates from heart disease were nearly equal for blacks and whites in the late 1970s. These rates have decreased over time, but the death rate for whites has decreased faster than the death rates for blacks. The death rate for blacks in 1991 was the same as the death rate for whites in 1987, a four-year lag. More recently, it has taken longer for blacks to achieve equity with whites. In 2002, blacks had a death rate from heart disease that whites experienced in 1994, an eight-year lag time. As new technologies emerge and heart disease treatments continue to develop, blacks are experiencing increasing delays in access to these benefits.



Those with access to state-of-the-art treatments for HIV/AIDS can now expect to live with this as a chronic condition, rather than die from a terminal disease. However, for HIV/AIDS, as with other conditions, blacks experience higher death rates than whites. In 2002, the white death rate from HIV/AIDS was 7.7 per 100,000, while blacks had a death rate nearly seven times higher—49.9 per 100,000 (see Figure 5). Prevention programs and state-of-the-art treatments clearly are not reaching the black community. How many lives will be lost in the fourteen years it is likely to take for blacks to reach the most recently documented HIV/AIDS death rates for whites? Will this ever be achieved?



These illustrations of lag times in health improvements tell us that all groups can achieve the same health status if they are given access to the same quality of health care at the same time. The gaps between blacks and whites in health improvements, historical and projected, tell us that separate systems of care exist and that given adequate health education, as well as preventive, diagnostic and treatment interventions, health equality can become a reality.

A recent report out of the New York City Department of Health and Mental Hygiene provides evidence of unacceptable gaps in infant mortality rates within New York City. In the Brownsville neighborhood, there were 12.2 infant deaths per 1,000 live births in 2004, while in Yorkville the infant mortality rate was 1.9 per 1,000 live births.⁹ In our own community, health data illustrate the poor health status of residents in the southwest Bronx compared to all residents of New York City:¹⁰

- Death rates from all causes are 50 percent higher than the death rate for all New Yorkers.
- Death rates from AIDS are 3½ times higher than in New York City as a whole.
- Hospitalization rates for asthma and diabetes (generally controllable with proper care) are over twice that for all New Yorkers.
- A greater proportion of community residents are without a personal physician.

The healthcare system **can** do more and **must** do more for the residents of New York City.

Causes of Health Disparities: Separate and Unequal Care

The Institute of Medicine's (IOM) *Unequal Treatment* report cast a strong national spotlight on the complex causes of racial and ethnic disparities in health. In our review of the evidence, we found that aspects of the clinical encounter, such as provider stereotyping, biases, and language barriers all contribute to disparities, and that the conditions in which care takes place is also a critically important factor. Barriers involving culture, geography, and certainly insurance, also contribute.

Most relevant to this paper is the IOM's finding that "financial and institutional arrangements of health systems, as well as the legal, regulatory, and policy environment in which they operate, may have disparate and negative effects on minorities' ability to attain quality care." Further, the report states that even when studies control for differences due to insurance coverage, health status, age, gender, education, and other socioeconomic factors, the gap in health outcomes between people of color and whites remains.²

"financial and institutional arrangements of health systems... may have disparate and negative effects on minorities' ability to attain quality care."
IOM Report

In a series of focus groups conducted by Bronx Health REACH, residents of our community relayed numerous encounters with the health care system in which they were treated disrespectfully, had difficulty communicating with their health care provider, and felt they were treated differently because of the type of insurance they had or because they were a person of color. These feelings are reflected in comments such as this one made by a focus group participant: "For a black man and a white man with the same symptoms, they send the black man home and they put the white guy in the hospital for observation." Another participant stated, "Just the way I was treated with that job coverage as opposed to Medicaid. It felt really good. I felt like I had money!"¹¹

Discriminatory treatment during a medical visit is one factor in health disparities, but what about the health system itself? Bronx Health REACH decided to examine the health systems that provide care to community residents. Using several publicly available data sources and a separately conducted survey, Bronx Health REACH analyzed aspects of the New York City health care system with respect to race and ethnicity.

What we found was pervasive segregation of care between and within New York City's hospitals; care that was not only separate, but was also unequal. We call this medical apartheid because it separates people by race and has the same deadly effect as apartheid in other settings. Although the systems of separate care are not always visible, discrimination occurs daily, often under the guise of segregation by insurance status. Since insurance status is so closely linked to race in New York City, where 52% of blacks, and 63% of Latinos, compared to 24% of whites, are uninsured or publicly insured,¹² this creates a de facto sorting of patients by race.

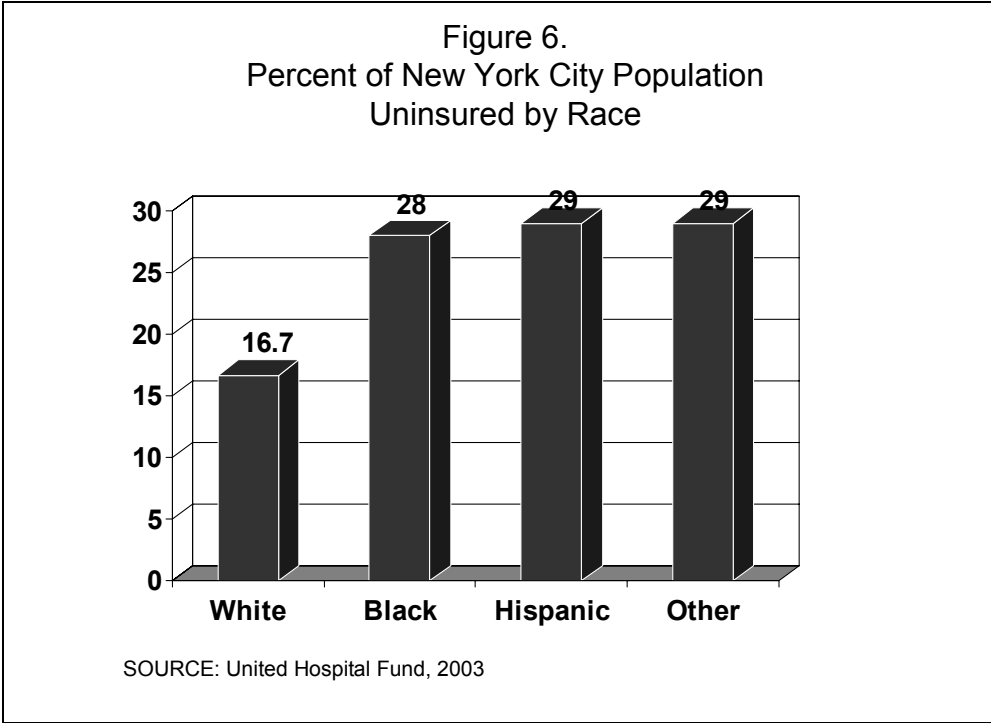
Discrimination is built into the way institutions organize and deliver health care, the way government legislation and regulation controls the delivery and financing of health care, and the way health care providers make clinical decisions about people of color. This discrimination is a major contributing factor in the ongoing gap in health outcomes between whites and people of color.

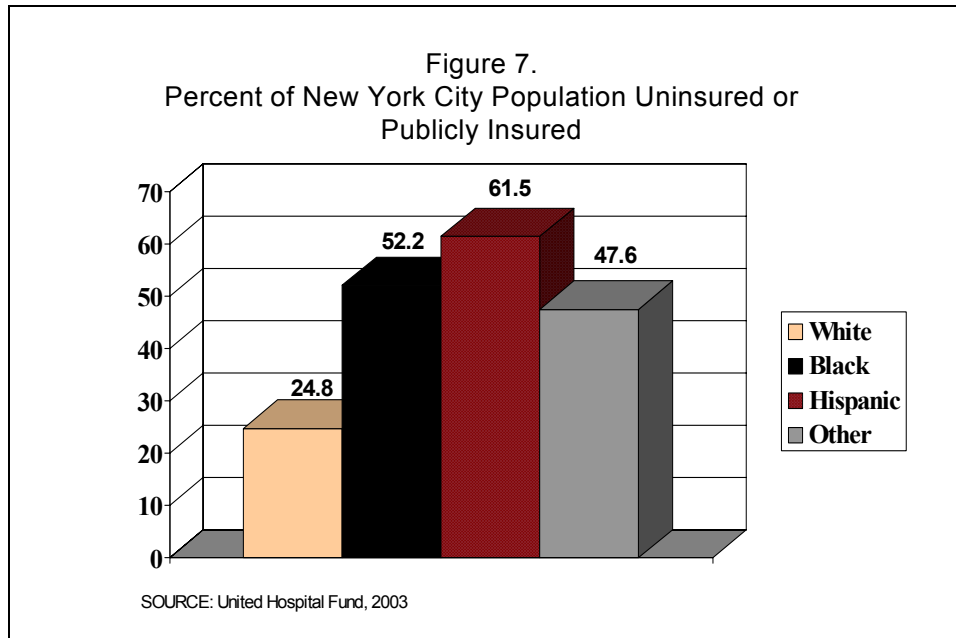
1. Differences in Health Insurance Coverage by Race

Health insurance is a major determinant of access to medical care. Studies have shown that lack of insurance has been linked to delayed care and poorer health outcomes.^{13,14} In New York City, more than in the U.S. as a whole, insurance status is closely tied to race and ethnicity. While nearly 30 percent of black, Latino, and “other” New Yorkers are uninsured, just under 17 percent of white New Yorkers are uninsured.¹² As illustrated in

...black and Latino New Yorkers are more than twice as likely as whites to be uninsured or publicly insured.

Figures 6 and 7, black and Latino New Yorkers are more than twice as likely as whites to be uninsured or publicly insured. While there are many other causes of racial and ethnic disparities in health outcomes, the link between race, ethnicity and insurance status restricts access to care for people of color, and is one major cause of health disparities.





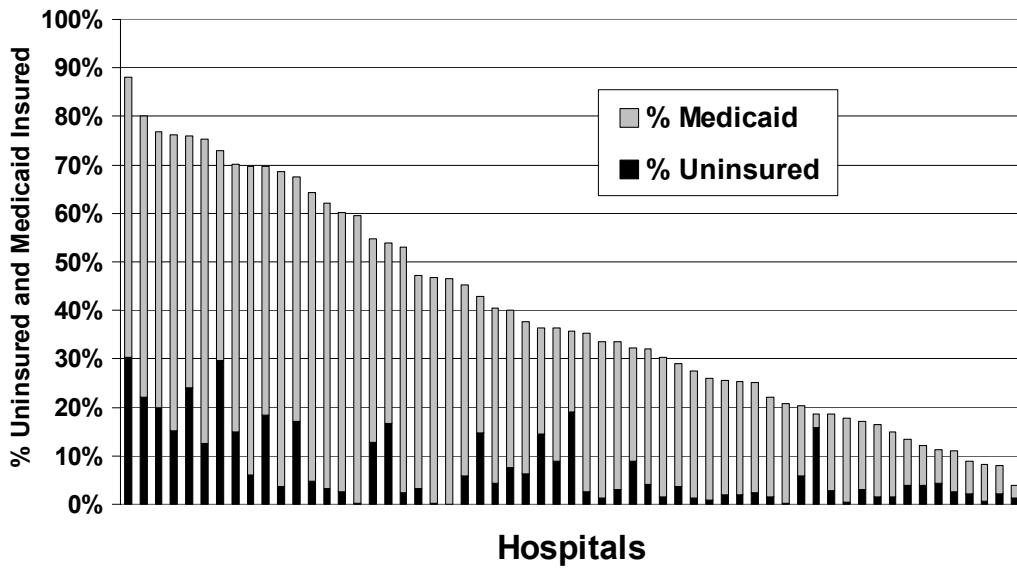
Because the rates of those who are uninsured and publicly insured are so high among blacks, Latinos, and other people of color relative to whites in New York City, these patients are disproportionately affected when health systems sort patients based on insurance, a practice that is widely found in New York City hospitals as well as elsewhere in the state and country.

2. Segregation of the Poor and Uninsured into Different Institutions

A health care system that segregates the poor and uninsured from those who are privately insured practices medical apartheid. Why the term “medical apartheid?” Because apartheid separates people by race and that is exactly what happens in New York City. While there are no longer signs that say “Coloreds” and “Whites” hanging over the doors of our institutions, nearly the same thing occurs when we discriminate based on insurance. A look at the differences in insurance status of patients at different institutions confirms that this is so.

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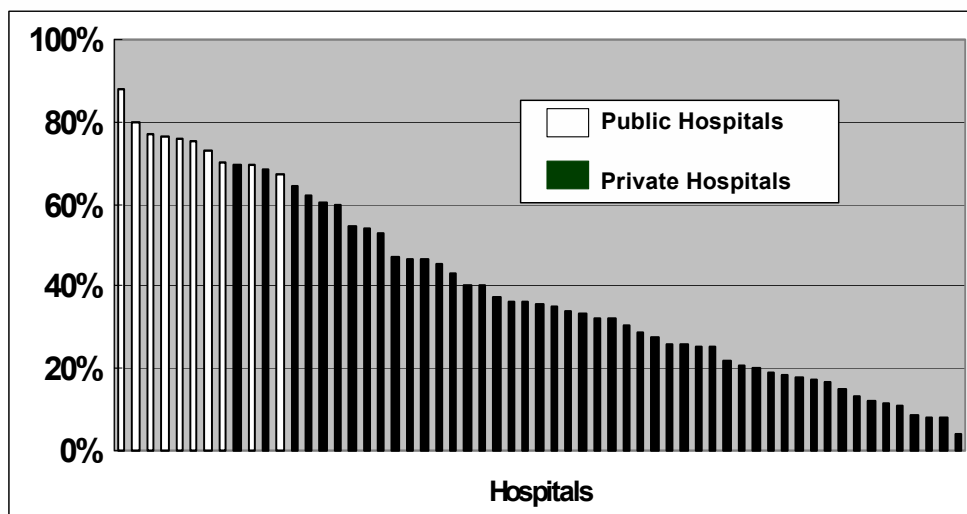
Figure 8.
 NYS Hospital Discharges By Expected
 Source of Payment



SOURCE: SPARCS, Table IX, 2001

There is wide variation in the number of poor and uninsured patients cared for by hospitals in New York City (see Figure 8). Uninsured and Medicaid-insured patients account for less than four percent of hospital discharges at the low end, and up to nearly ninety percent of hospital discharges at the high end. Almost all of the hospitals in the top quartile of those caring for poor and uninsured patients are public hospitals (see Figure 9).

Figure 9.
 Percentage of Uninsured and Medicaid Discharges at New York City Hospitals



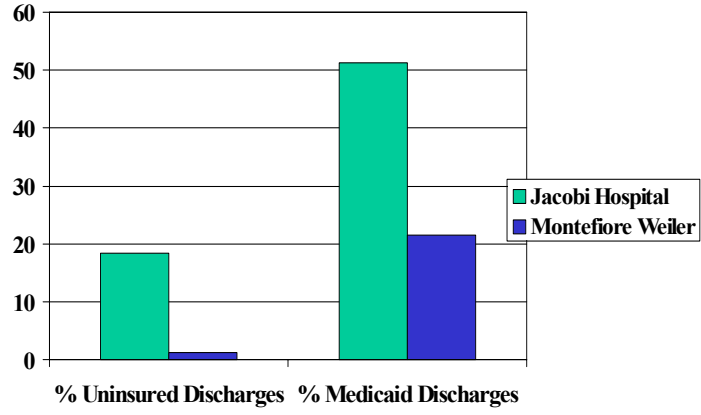
SOURCE: SPARCS 2001, Table IX

These variations are not related to hospital location. New York City operates a number of its public hospitals in the immediate vicinity of a private hospital, often adjacent or at distances of one or two blocks. In the absence of patient sorting by insurance, the insurance mix of patients at two hospitals located so close to each other would be expected to be similar. A Bronx Health REACH review of New York State SPARCS* data showed that, in fact, they are quite different. Public hospitals care for a much higher proportion of uninsured and publicly insured patients than the private hospitals located near them.

Figures 10-14 provide examples of patient discharges by insurance status for pairs of public and private hospitals. In Manhattan, for example, (see Figure 11) 67 percent of discharges from the public Bellevue Hospital are for uninsured or publicly insured patients, compared to less than nine percent at New York University Hospital which is one block away. Such data provide evidence of separate care within the New York City health care system.

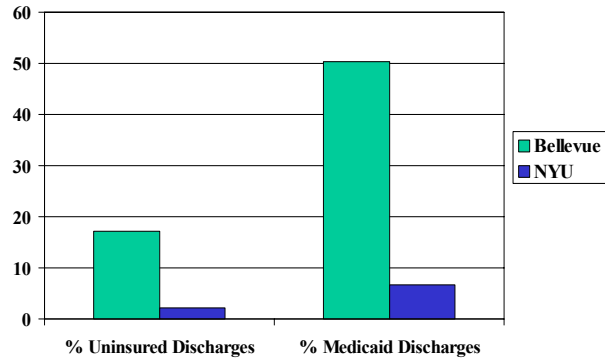
* New York State Planning and Research Cooperative System

Figure 10.
 Jacobi Hospital (Public) v. Montefiore Weiler (Private)
 (Distance: 2 Blocks)



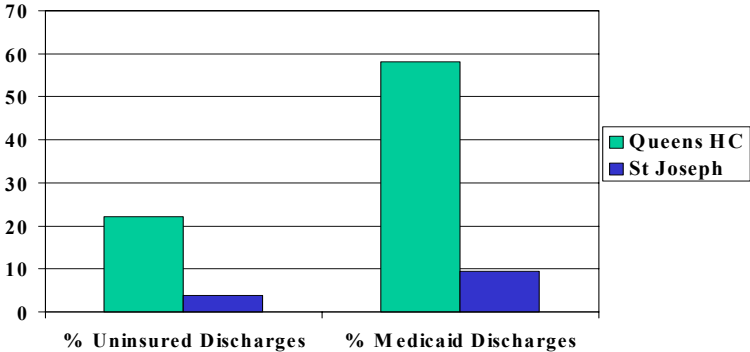
SOURCE: SPARCS 2001, Table IX

Figure 11.
 Bellevue Hospital (Public) v. New York
 University Hospital (Private)
 (Distance: 1 Block)



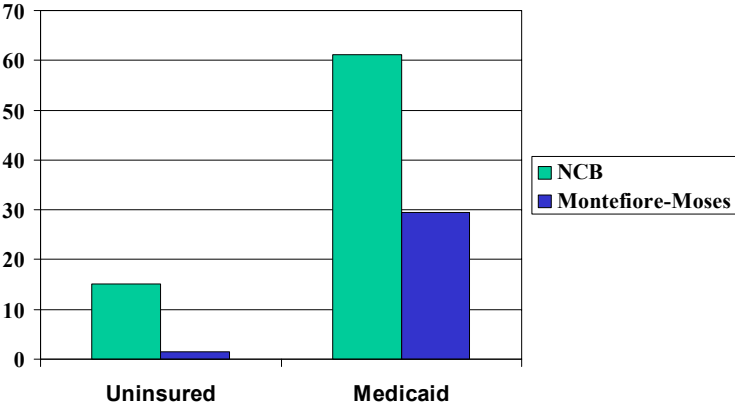
SOURCE: SPARCS 2001, Table IX

Figure 12.
 Queens Hospital Center (Public) v.
 St Joseph's Hospital (Private – Closed Aug. 2004)
 (Distance: 4 Blocks)

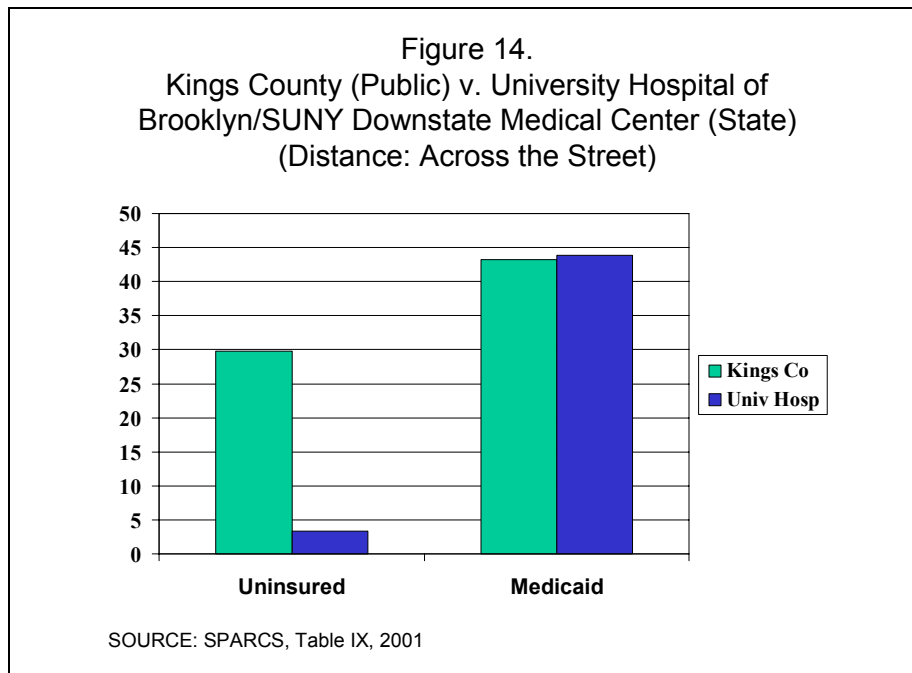


SOURCE: SPARCS 2001, Table IX

Figure 13.
 North Central Bronx (Public) v. Montefiore Moses (Private)
 (Distance: Contiguous)



SOURCE: SPARCS, Table IX, 2001



3. Segregation into Different Care Systems within Institutions

Even when the uninsured and Medicaid recipients are seen in the same voluntary hospital as privately insured patients, the ambulatory care systems for specialty care (ie: cardiology, urology) are often structured as if there were two institutions operating in one facility. Generally speaking, there are faculty practices for the privately insured, and clinics for the publicly insured or uninsured. Sometimes they operate in the same physical space at different times or on different days, and sometimes they are housed at different locations. In either case, they have different models of care. This is especially true at large academic medical centers.

Bronx Health REACH examined this issue by conducting a telephone survey of several medical centers in New York that are important providers of specialty care to community residents.¹⁵ Four different specialty services at each hospital were surveyed. At one hospital, surveyors were told that Medicaid is accepted at all of the hospital's specialty clinics, but not at any of its faculty practices. In another hospital, this was the case at two out of four specialty services.

...surveyors were told that Medicaid is accepted at all of the hospital's specialty clinics, but not at any of its faculty practices.

Faculty practices, as described in Figure 15, are characterized by more highly trained providers, greater communication between providers, 24-hour phone access, continuity of care, and accountability to both the patient and the referring primary care provider. Patients at specialty clinics, on the other hand, are far more likely to receive care from residents who are rotating in and out of clinics, and are less able to provide the continuity of care that is critical to patients with chronic illnesses. These physicians-in-

training learn that uninsured and Medicaid-insured patients, who are predominantly people of color at these hospitals, are “teaching patients,” while privately insured patients are cared for by fully-trained physicians.

Figure 15.
Separate and Unequal Models of Care

	FACULTY PRACTICE	SPECIALTY 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 do not know the patient

New York State’s Medicaid payment system contributes to this sorting of patients by insurance through its payment methods. Hospital-based faculty practices are considered private practices, and the payments they receive for the care of Medicaid patients are lower than the rates paid to the same hospital’s clinics even when they operate in the same space on different days. Hospitals have an incentive to direct Medicaid patients to their clinics, where they receive a higher, cost-based institutional rate for that care.

But this type of differential care based on insurance coverage is a violation of multiple laws and regulations.

- Every contract between New York State and managed care companies that serve Medicaid, Child Health Plus, and Family Health Plus enrollees contain 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.”¹⁶

“...patients have a right to receive treatment without discrimination as to race, color, religion, sex, national origin and source of payment.”
NYS Patient Bill of Rights

- 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*.”¹⁷
- Two-tiered systems of care are also prohibited by the federal Hill-Burton Act, which authorizes funding for hospital construction. Many New York hospitals have received such funding.^{18,19}

While segregation of patients by insurance in an **inpatient** hospital setting has resulted in government intervention,²⁰ patient segregation in hospital **outpatient** facilities has failed to attract attention from regulatory agencies. Although there are provisions in place to prevent discriminatory care, there is no clear mechanism for enforcing these requirements.

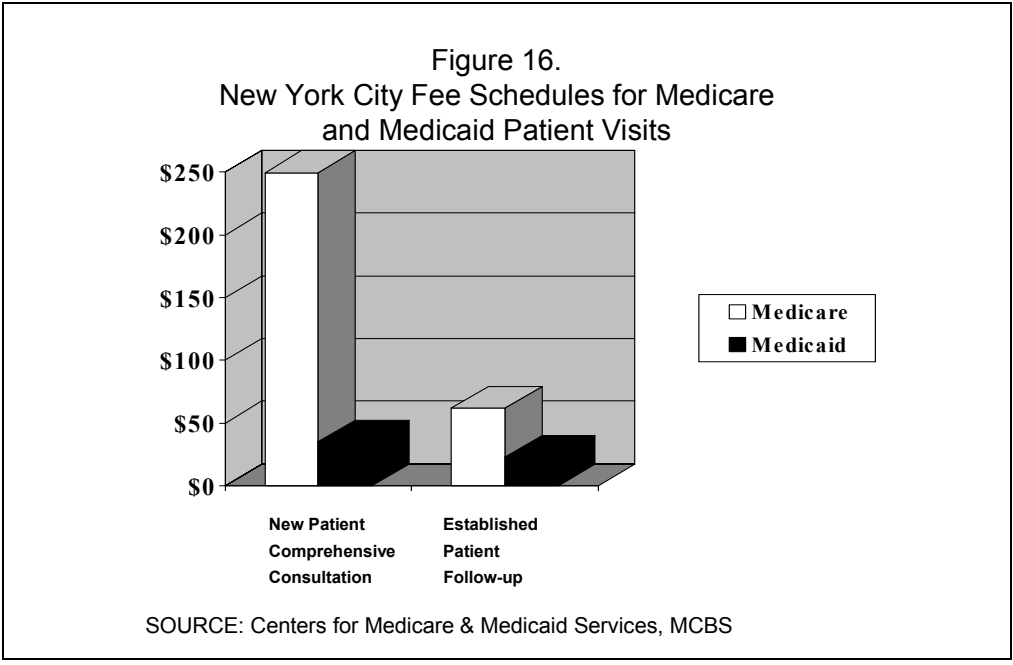
We have little reason to believe that our findings are limited to New York City. In many other places where Bronx Health REACH staff present these data, we are told about similar discriminatory treatment of uninsured and publicly insured patients in hospital facilities.

4. Inequities in Payment by Public Insurance Programs

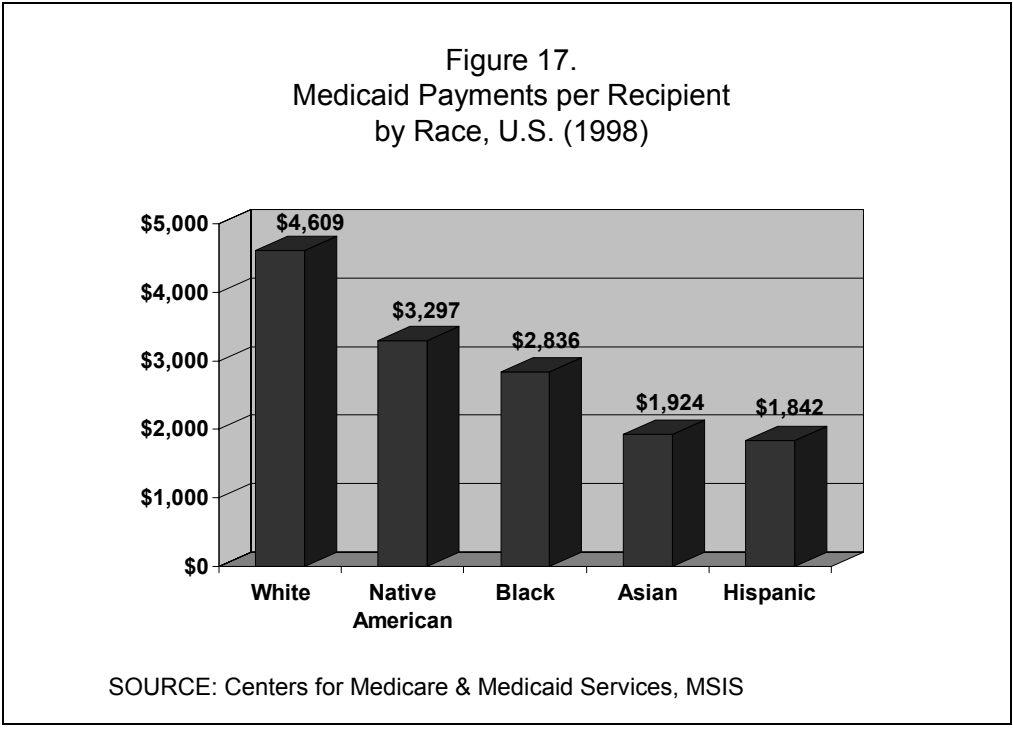
The Federal government operates the two largest public health insurance programs covering New York residents: Medicare for the elderly and disabled, and Medicaid for the poor. While both programs have undoubtedly expanded access to health care for the populations they serve, differences in program administration have led to 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. Medicaid rates are typically set at levels below Medicare rates and, in some states like New York, are set at levels that are so low they almost preclude access to care at private physicians’ offices. For those enrolled in Medicaid, institutional care settings are often the only option as institutions are paid at a significantly higher rate.

In New York, a private physician providing a comprehensive visit to a new Medicare (elderly) patient is paid six times as much as when he provides the same service to a Medicaid (poor) patient (see Figure 16). Such discrepancies virtually ensure unequal access to care.



Medicaid expenditures per recipient, when stratified by race and ethnicity, reveal further inequities. Data from the Centers for Medicare and Medicaid Services show that total Medicaid payments per white recipient per year are 60 percent higher than those for blacks, 140 percent higher than for Asians, and 150 percent higher than for Latinos (see Figure 17). More detailed analyses of these data are urgently needed in order to understand these disparities and their relationship to health services and health care outcomes.



5. Failure of Medicaid Managed Care to Eliminate Disparities in Care

The transition from traditional fee-for-service Medicaid to managed care in New York State was promoted in part as a way to increase access to care, particularly private specialty care, for Medicaid recipients.²¹ Our research indicates that this has not always 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. 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.

Parents choosing a managed care plan have no idea that this choice may result in denying their children access to facilities they may need in the future.

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 region, accepts less than half of the licensed Medicaid managed care plans in the Bronx. Children covered by the other plans do not have access to this state-of-the-art facility nor to many of its world-class specialists. Parents choosing a managed care plan have no idea that this choice may result in denying their children access to facilities they may need in the future.

We also learned that many Medicaid managed care patients are seen in the same clinic setting where they previously received care, rather than having expanded access to private specialty care. Despite extensive reviews of Medicaid managed care plans by state and city authorities, there is totally inadequate monitoring of compliance with anti-discrimination provisions by teaching hospitals.

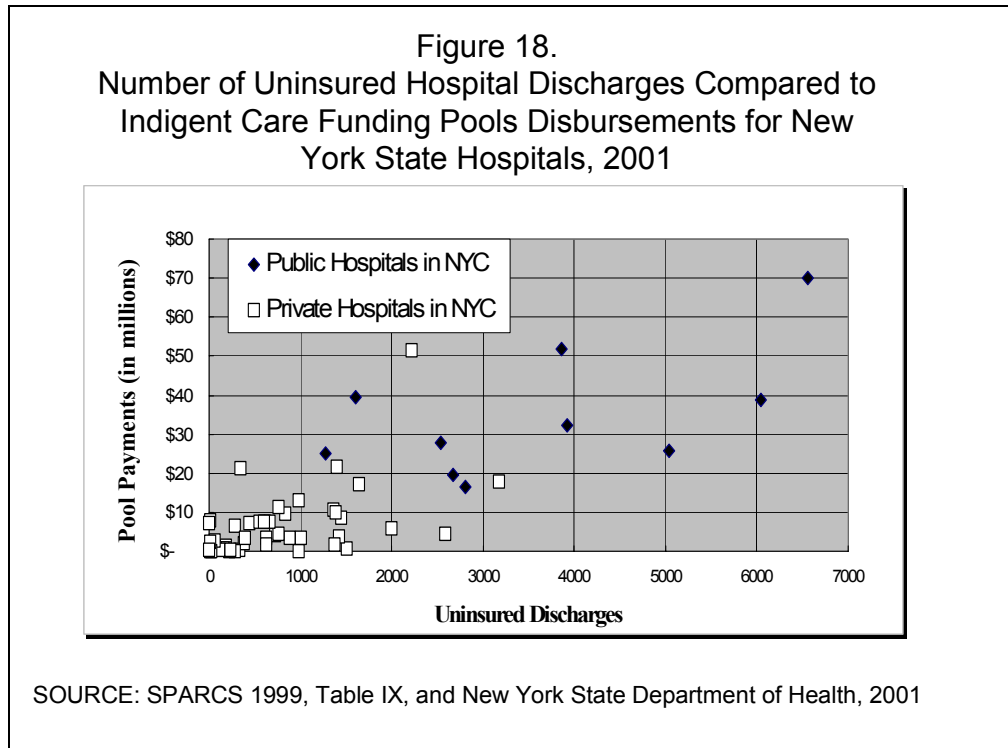
6. Institutional Subsidies for Care of the Poor and Uninsured

New York State provides financial assistance to hospitals to cover the cost of uncompensated care. In 2003, 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 Fund. Studies of policies related to these pools found that uninsured and underinsured individuals are unlikely to directly benefit from these funds.^{22, 23}

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.²⁴ The government does not regulate the fees hospitals charge to the uninsured. Hospitals that receive payments from the pools are not required to make patients aware of the availability of funds to cover the cost of care, and typically they do not. Hospitals are not required to report the number of patients who received charity care

in order to receive funds. Further, hospitals that receive payments from the pools are not required to apply these amounts to the accounts of uninsured or underinsured patients.

Payments from the pools are calculated using a complex funding formula that does not adequately reflect the volume of charity care hospitals provide. The distribution of these funds among hospitals, as illustrated in Figure 18, has little relationship to the number of uninsured discharges.



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. New York's Indigent Care and High Need Indigent Care Adjustment Pools fail to expand equitable access to care for uninsured individuals.

Eliminating Segregated Care

1. Conclusions

The Bronx Health REACH examination of the health care system has led us to the following conclusions:

- In New York City, to a greater extent than in the U.S. 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.
- Inequalities in insurance coverage are associated with inequalities in health care and health outcomes.
- People who are uninsured or publicly insured are often cared for in separate institutions from those who are privately insured.
- 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.

2. Recommendations

The coalition has formulated a set of recommendations to begin to address the issue of segregated and inequitable care in New York that leads to health disparities.

A. Structure Medicaid Fees to Create Equal Access to Quality Care

In hospital outpatient facilities, Medicaid and uninsured patients are more likely to be seen in the clinics, while privately insured patients are seen in the faculty practice. The differences in these two models of care have been discussed above. Some hospitals use the fact that Medicaid reimbursement rates are higher in the clinic setting than in the faculty practice setting as a reason to continue to segregate care, while others bill at the clinic rate for patients seen anywhere in their system.

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 the clinics located 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 any financial rationale for maintaining 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 already reimbursed at the higher rate—even though it does not merit the same standards as care in the faculty practices.

B. Enforce Non-Discrimination Requirements

New York State's Patient Bill of Rights and Medicaid, Child Health Plus, and Family Health Plus contracts prohibit hospitals from discriminating based on source of payment. 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. 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.

D. Require 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 the state of 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. Similar legislation is needed at the state and national levels. New York State must also ensure that payments from the Indigent Care Pools reflect the amount of charitable care provided by hospitals.

3. Next Steps: Addressing Health Disparities on Multiple Fronts

These Bronx Health REACH recommendations reflect short-term, specific actions that can be taken to address separate and unequal care that contributes to health disparities. The coalition has also established a broader advocacy agenda to address health disparities.¹ First among these is support for comprehensive, universal health insurance. People of color are less likely to have health insurance, including those who work full-time. New York State has been in 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 those who are eligible for enrollment.

Additional recommendations address the need for a more diverse health workforce, culturally and linguistically competent care, 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 remain, Bronx Health REACH believes that many solutions are already within reach.

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