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Undocumented Immigrants and Access to Health Care in New York City

*Identifying Fair, Effective, and Sustainable
Local Policy Solutions*

*Report and Recommendations to
The Office of the Mayor of New York City*

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About this report

This independent report is based on a meeting convened by the New York Immigration Coalition and the Undocumented Patients Project of The Hastings Center, which was hosted by the Vera Institute of Justice in New York City on December 11-12, 2014. The goals of this meeting were to sharpen local stakeholders' understanding of gaps in access to health care for populations left out of the Patient Protection and Affordable Care Act of 2010 (ACA)—in particular, New York City residents who are both undocumented and uninsured—and to identify proven or promising local solutions to closing these gaps in other cities, counties, and states. Although this report and its recommendations focus on challenges and solutions in New York City, it may also be useful to other New York State municipalities, and to other cities and counties in the United States.

This document describes New York City's undocumented uninsured population, the City's safety-net health care system, and the specific gaps in coverage and financing that impede access to health care for this population. It also describes special opportunities and challenges for health care system improvement in the City and compares models that are proven or promising as sustainable ways to improve access to health care for undocumented immigrants and other uninsured populations. It concludes with six actionable recommendations for City stakeholders, supported by guidance for ongoing planning, program development, and system improvement. The final draft of this report was provided to the Office of the Mayor of New York City, Task Force on Immigrant Health Access, Care & Coverage Subgroup, on February 28, 2015.

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INTRODUCTION

New York City's undocumented uninsured population: current and projected access to health insurance coverage

This report is based on working estimates of the local undocumented population and summarized as follows:¹

- Approximately 500,000 immigrants who live in New York City are undocumented. Of these, about half (250,000) are insured through employer sponsored coverage, private insurance purchased outside of the ACA marketplace, or Child Health Plus.
- The other half (250,000) are currently uninsured. Of these, 155,000 will be eligible for Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) or Deferred Action for Childhood Arrivals (DACA). This total includes 121,000 newly eligible as of the Obama Administration's Executive Action of November 2014 and 34,000 who have been DACA-eligible since the June 2012 Executive Action but remain unenrolled. (See note 1.) Of these, 40-50 percent will be income-eligible for Medicaid after enrollment in DAPA or DACA.²
- 200,000 or more of the currently uninsured are likely to remain uninsured. In this report, "undocumented uninsured" refers to this remaining uninsured population, which includes undocumented immigrants who are ineligible for DACA or DAPA; eligible for but unenrolled in DACA or DAPA, or enrolled in DACA or DAPA but income-ineligible for Medicaid.

SECTION 1.

What is available and where are the gaps when a patient is undocumented and uninsured?

A. Safety-net health care systems in New York City

Like other City residents who lack health insurance, New Yorkers who are undocumented and uninsured rely on local safety-net health care systems, defined by the Institute of Medicine (IOM) as those that “organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients.”³ The City’s two major safety-net systems are the New York City Health and Hospitals Corporation (HHC), the nation’s largest local public hospital system, and Federally Qualified Health Centers (FQHCs, also known as community health centers), which are nonprofits that offer primary and preventive health care. Both systems rely on Medicaid (and to a lesser extent, Medicare) reimbursements. They also depend on federal Disproportionate Share Hospital (DSH) funding and other sources of state Indigent Care Pool (ICP) funding. Both systems have explicit provisions for uninsured patients who cannot afford to pay for needed care. Although patients are not asked directly about immigration status, both HHC and the Community Health Care Association of New York State (CHCA-NYS), whose members include FQHCs and migrant health programs, presume that many of their patients who are low income and are not enrolled in Medicaid are undocumented. Health care professionals may confirm that a patient is undocumented during the process of enrolling a patient in Emergency Medicaid (described in Section 1B) or determining whether a patient meets the requirements for Permanently Residing Under Color Of Law (PRUCOL; see note 2).

HHC receives funding from the City and operates with a structural budget deficit to accommodate services to uninsured patients. When an uninsured person presents at an HHC ambulatory center, a Certified Application Counselor (CAC) evaluates possible coverage options, which include Medicaid and Child Health Plus.⁴ For those determined to be ineligible for coverage, HHC offers a fee scale for patients with incomes up to 400 percent of the Federal Poverty Level (FPL).⁵ In addition to primary and preventive health care, HHC ambulatory centers offer uninsured

patients access to on-site pharmacies and referrals to medical specialists and diagnostic and other services located in HHC medical centers.

FQHCs, which are federally designated by the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA), receive federal grant funding to support care to the uninsured on a sliding scale. Their service delivery model is the medical home, which aims to include care coordination with providers outside of the FQHC.⁶ Because an FQHC does not have access to the range of specialists and services available in HHC hospitals, finding affordable care is a significant problem when an FQHC patient is uninsured and needs specialty services. In many cases, these FQHC patients are referred to HHC facilities. Some FQHCs in the City have begun to offer more services in-house in response to this problem.

Other parts of the local safety-net include non-profit (also known as “voluntary”) hospitals that have emergency departments (EDs) where uninsured patients may seek or be referred for health care. These hospitals also provide inpatient care to uninsured patients admitted to the hospital through the ED, with the cost of this care covered by Medicaid for the Treatment of an Emergency Medical Condition, often known as “Emergency Medicaid” (described in the next section) and/or a hospital’s charity care funds.⁷ Voluntary hospitals, including specialty hospitals that do not have EDs, may also have provisions for treating uninsured patients other than through ED admissions.⁸ One-stop facilities such as free clinics, urgent care centers, and walk-in clinics in chain drug stores are part of the informal safety-net for uninsured patients. These facilities usually do not work in coordination with HHC, FQHCs, or voluntary hospitals, but may offer shorter wait times or hours that are convenient for undocumented uninsured patients.

B. Emergency Medicaid and its limits in New York State

Undocumented immigrants who are not PRUCOL (see note 2) are ineligible for Medicaid apart from

Emergency Medicaid, which covers “emergency” services to treat conditions that seriously jeopardize a patient’s health, put the patient at risk of bodily dysfunction of a major organ, or cause severe pain. In New York State, Emergency Medicaid reimburses hospitals for the costs of providing inpatient care to uninsured patients who earn up to 138 percent of the FPL. Emergency Medicaid also functions as a limited form of insurance coverage. Once a condition defined as an “emergency” is documented, coverage can be authorized for a maximum of 15 months to cover certain treatments, such as some types of cancer treatment.⁹ With the implementation of the ACA in New York State, undocumented immigrants can be pre-qualified for Emergency Medicaid through the New York State of Health web portal; pre-qualified individuals are issued a card confirming that they have this limited coverage should a medical emergency arise. Unfortunately, there are many gaps in Emergency Medicaid, which often does not cover the long-term consequences of initiating life-saving or life-sustaining treatment and excludes some treatments that would typically constitute appropriate medical care for specific life-threatening conditions. For example, Emergency Medicaid covers chemotherapy and radiation but does not cover many usual services associated with the delivery of these treatments, and does not cover bone marrow transplants, which would be standard treatment for some forms of cancer.

C. Gaps in the New York City safety-net

Safety-net clinicians and administrators familiar with the undocumented uninsured population in New York City describe a range of problems that typically arise when a patient’s medical needs exceed the resources of an HHC or FQHC primary care setting or the temporary coverage provided by Emergency Medicaid. For example:

1. Effective management of chronic conditions

HHC ambulatory centers and FQHCs care for many patients with common chronic conditions such as diabetes. Treatments for some of these conditions are covered under Emergency Medicaid, while others are excluded or only partially covered. A particular problem is that Emergency Medicaid does not cover medical supplies, such as glucose test strips that diabetic patients use to manage their condition. If a primary care provider lacks a payment mechanism for the needed supplies and the patient cannot afford to pay for the supplies out of pocket, the patient lacks a re-

source needed for effective control of this disease. As a consequence, the patient’s health may deteriorate, requiring expensive and preventable ED and possibly inpatient treatment. Also, some chronic conditions require regular consultation with a medical specialist, such as an oncologist, nephrologist, or ophthalmologist, to be managed effectively. As noted, access to specialty care may not be readily available in HHC ambulatory centers or in FQHCs, and wait times for uninsured patients to see specialists (who may be concentrated at HHC medical centers such as Bellevue) are typically long. Preliminary data from FQHCs suggest that uninsured patients with a diabetes diagnosis have a higher volume of charges compared to insured patients with the same diagnosis, which suggests unmet medical needs.¹⁰ Behavioral health services, including treatment for chronic and persistent mental illness, are especially difficult for the undocumented uninsured population to obtain, due to long wait times for appointments with qualified providers in primary care settings, licensure restrictions on potentially qualified providers, and uneven geographic distribution of qualified providers who have the linguistic skills and cultural knowledge needed to serve the City’s diverse undocumented community.

2. Effective treatment and management of life-threatening conditions

It is difficult to treat certain life-threatening conditions, such as Hepatitis C, advanced kidney disease, or cancer, when a patient is undocumented and uninsured. Emergency Medicaid does not cover the expensive but effective drug therapy for Hepatitis C. Emergency Medicaid covers dialysis but access to scheduled outpatient dialysis is difficult due to Emergency Medicaid’s low reimbursement rate as compared to Medicare, the usual source of reimbursement for this treatment. Emergency Medicaid also does not cover medications associated with dialysis. Hospitals sometimes resort to admitting patients who need dialysis to ensure that they receive treatment and medications on schedule, although inpatient dialysis is much more expensive for the Medicaid system. While organ transplantation is a treatment option for conditions such as Hepatitis C or advanced kidney disease, it is extremely difficult for an undocumented immigrant to receive an organ transplant, even when a family member is willing to be a living donor, due to the lack of ongoing insurance coverage for post-transplant medical care.¹¹ Uninsured patients who have cancer may try to re-

duce their out of pocket costs by spacing out their treatments (therefore taking longer to complete treatment), or reducing their use of medications that are not covered by Emergency Medicaid.¹²

3. Discharge planning and post-hospital care

Undocumented uninsured patients face immense difficulties securing needed post-hospital medical and nursing care, again due to their ineligibility for Medicaid and Medicare. In addition to the gaps noted above, hospital social workers and other staff responsible for meeting the “safe and effective” discharge planning standard describe nursing home care, home care, physical therapy, durable medical equipment, and medical transportation (to scheduled outpatient dialysis, for example) as major barriers to discharge. HHC is the City’s largest provider of skilled nursing and long-term acute care, and also provides short-term skilled nursing, but even when the needed services are available within the HHC system, the absence of a financing mechanism for appropriate post-discharge care creates barriers to discharge.

4. Efficiency and cost effectiveness

The efficient and cost effective use of limited resources, include staff time and expertise, is stymied by these coverage problems. A hospital discharge planner who is highly knowledgeable about the limited care and coverage options available to the undocumented uninsured will still need to plead for medi-

cally appropriate resources that would otherwise be funded by public insurance. If these resources cannot be secured and the patient cannot be discharged safely, the hospital will retain the patient at high cost to the facility, which may no longer be able to use Emergency Medicaid as a source of reimbursement if the patient no longer requires this level of treatment. This situation also creates an equity problem when a patient who needs inpatient care cannot be admitted because a bed is being occupied by a patient who cannot be discharged. Other problems of efficiency and cost effectiveness arise when health care professionals have insufficient or inaccurate knowledge about care and coverage options for the undocumented uninsured. When health care professionals are misinformed about Emergency Medicaid eligibility, patients may delay initiating treatment that is covered or be billed erroneously for covered conditions. Also, chronically ill undocumented uninsured patients may present at HHC ambulatory centers or FQHCs after hospitalization with discharge plans that do not realistically reflect their ability to pay for the ongoing health care services they need. This burdens the primary care provider with the unresolved coverage problem. A coordinated approach, in which the discharge planner and the patient’s primary care provider confer prior to discharge, would be more effective.

SECTION 2.

Opportunities and challenges in improving access to health care for the undocumented uninsured in New York City¹³

A. Opportunities presented by health system reform initiatives, specifically the Medicaid Delivery System Reform Payment Incentive Program (DSRIP), to improve access to health care for “residually uninsured” populations

In addition to expanding access to health care, an important goal of most state and local programs for the undocumented and other uninsured populations is to achieve the “triple aim” of access, cost, and quality through better care coordination. As part of New York State’s Medicaid Redesign, there are several initiatives underway to improve care coordination for safety-net patients. For example, New York State is participating in the CMS-sponsored Comprehensive Primary Care Initiative (CPCI), a multi-payer demonstration project that supports the development of medical homes.¹⁴ New York State has also created a Delivery System Reform Incentive Payment (DSRIP) program as part of a larger Section 1115 Medicaid waiver. DSRIP waivers provide Medicaid funds to hospitals and certain other providers if they pursue delivery system reform leading to measurable performance gains. The goal of the program is to achieve greater vertical integration in the health care safety-net and to improve care coordination. Under this program, New York State has established 25 Performing Provider Systems (PPSs), led by public or other safety-net hospitals (including HHC) that serve selected geographic areas. Providers are eligible to participate in a PPS if at least 35 percent of their patients are Medicaid beneficiaries, dually eligible for Medicaid and Medicare, or uninsured.¹⁵ PPS participants in addition to hospitals include community health centers, behavioral health providers, and skilled nursing facilities, among others. At stake is over \$8 billion in federal money—each PPS is at risk of losing DSRIP funds associated with improving care for safety-net patients in its geographic region—so any effort by New York City to improve care coordination for the undocumented uninsured should both build on and contribute to this broader effort.¹⁶

B. Opportunities and challenges concerning the role of voluntary hospitals in improving ac-

cess to health care for the residually uninsured

The City’s voluntary hospitals are part of the local safety-net through their ED services and the care they provide to acutely ill uninsured patients who are admitted through the ED or who gain access to hospital services in other ways. Like their colleagues in public hospitals, physicians, nurses, and social workers in these institutions face ethical and practical challenges in providing undocumented uninsured patients with medically appropriate care, especially when patients are approaching discharge.¹⁷ Although voluntary hospitals are required by state law to provide charity care and financial assistance to low-income patients regardless of immigration status, the extent of their involvement in efforts to close gaps in care and coverage in New York City and elsewhere in the state is not fully understood.¹⁸ Solutions or promising practices concerning frequently occurring problems that arise in this sector may not be shared broadly with public safety-net systems. When explicit discussion of these problems is discouraged within the voluntary hospital sector out of leaders’ concern that to describe successes will make a hospital a magnet for undocumented uninsured patients, this hampers local efforts to understand the extent of the challenges hospitals face and how they are managing them. To overcome the problem of siloed problem-solving and promote sharing of knowledge and promising practices, the City should have a strategy to engage voluntary hospitals at all levels to ensure that their knowledge, experience, and resources are part of local policy solutions.

C. Opportunities and challenges presented by the municipal ID card (IDNYC) and associated outreach and enrollment strategies

The 2015 launch of IDNYC, a City-issued identification card available to all New York City residents over the age of 14, offers lessons for successful outreach to immigrant populations.¹⁹ It also offers the opportunity to adapt lessons from other direct-access models and explore the potential for using IDNYC as an enrollee card. A frequent feature of programs to expand access to health care for the uninsured (see next section) is the use of an enrollment card that

provides information about enrollee benefits, the name of the enrollee's primary care medical home, and for programs that allow participating providers to charge fees, relevant information about fee scaling. In San Francisco, the use of the card is supported by a handbook and newsletters. In Nevada, the card identifies the enrollee as a member of a non-profit that provides access to low-cost services at pre-negotiated rates. Houston has also used an enrollee card that entitles income-eligible county residents to sharply discounted rates for services in public hospitals and clinics. Cards that identify the holder to participating providers as an enrollee in a program with transparent, predictable costs can function as a key to unlocking safety-net services across institutions that are available to uninsured individuals.

D. Challenges that require policy solutions above the local level

Three opportunities and challenges related to the specific context of New York State:

1. Improving existing state programs and closing remaining gaps

The number of uninsured immigrants in New York State would be higher were it not for important protections guaranteed by the state Constitution and affirmed by the 2001 *Aliessa v. Novello* decision, which requires New York State to "provide aid, care and concern" for lawfully admitted permanent residents and individuals who are "permanently residing under color of law" (PRUCOL).²⁰ This case law makes lawful permanent residents who have received green cards within the past five years and undocumented immigrants who are PRUCOL (see note 2) eligible for state funded Medicaid provided they meet income eligibility (138 percent of the FPL), even though these immigrant populations are excluded from federally funded Medicaid.²¹ President Obama's Executive Actions in 2012 and 2014 granting deferred action for certain populations also offer important but prescribed coverage opportunities in New York State. Because they are considered to be PRUCOL, immigrants granted administrative relief through DACA and DAPA will be eligible for state funded Medicaid if they meet income eligibility. (See note 2.) Under the ACA, New York State legislatively approved and is now implementing a Basic Health Plan (BHP) to cover individuals whose incomes are too high for Medicaid and who cannot afford to buy private health insurance through the marketplace. Applicants who earn

up to 200 percent of the FPL will be eligible for BHP coverage. This arrangement is projected to save the state \$500 million annually because New York State will be able to draw down federal dollars for coverage rather than using state dollars.²² However, despite the efforts of immigration and health care consumer advocates, the state is not currently contemplating the creation of a parallel state funded BHP that would cover undocumented immigrants who remain Medicaid-ineligible. Individuals who make more than the income limits for Medicaid will have no subsidized or public coverage options, as they are prohibited by CMS from purchasing marketplace coverage or being covered through BHP. In short, the state-level policy patchwork includes some promising developments for Medicaid-eligible immigrants. Undocumented and uninsured immigrants need a City mechanism to increase their access to health care, because there is no plan, at present, to guarantee them coverage through equivalent state-level reforms.

2. Expanding the primary care workforce

As demand for primary care increases due to the formerly uninsured entering the health care system as the result of the ACA, FQHCs are struggling to recruit sufficient numbers of primary care physicians and dentists. Experts in community health centers have identified 16 neighborhoods in the City as already in high need of expanded primary care, with potential for sustainable growth by local FQHCs.²³ Current state regulations defining scope of practice for nurse practitioners (NPs) and other non-physicians may prevent these clinicians from practicing at the "top of their license" so their skills can be applied to fill primary care gaps. Reforms to update scope of practice regulations to meet the current and projected primary care needs of low-income communities have been proposed by community health advocates in many states. These proposals could also be taken up by the City with reference to the need to strengthen the primary care workforce in FQHCs serving immigrant neighborhoods.

3. Indigent Care Pool (ICP) and Disproportionate Share Hospital (DSH) payments

In contrast to Massachusetts (see next section), where uninsured individuals apply for support from the state's ICP, payments from the comparable fund in New York State are directed in lump sums to health care institutions. The City's plan to improve access to health care for the remaining uninsured could include a proposal to restructure this state's ICP so

these dollars fund specific care and coverage gaps, or follow individual patients.²⁴ A related issue is the potential impact of scheduled reductions under the ACA of DSH payments to safety-net institutions and the effect of these reductions on the ICP.

SECTION 3.

Similarities and differences among solutions to closing gaps in systems outside of New York City

Overview of state and local programs for the uninsured

Five prominent state and local programs for undocumented and other uninsured patients offer useful lessons for New York City. These include city-county programs for the uninsured in Los Angeles, Houston, and San Francisco, as well as state programs for the uninsured in Massachusetts and Nevada.

My Health LA (MHLA) is a no-cost health care program launched in October 2014 that offers comprehensive health care for low-income (at or below 138 percent of the FPL), uninsured county residents, regardless of immigration status or medical condition.²⁵ MHLA relies on a budget of \$61 million per year and does not require out-of-pocket payments or user fees. It offers care through 164 community clinic medical home sites, where patients receive primary and preventive health care services and some diagnostic services. Los Angeles County Department of Health Services facilities also provide County clinic medical home sites, plus emergency, diagnostic, specialty, inpatient services, and pharmacy services. Of the estimated 400,000 remaining uninsured in Los Angeles County, 135,000 are now receiving services through County clinic medical homes, and approximately 145,000 additional patients could be served by MHLA through the community clinic medical homes, for a total of 280,000 potentially served.

Healthy San Francisco (HSF) is a low-income program for San Francisco County residents with incomes up to 500 percent of the FPL regardless of employment status, immigration status, or medical condition.²⁶ Unlike MHLA, HSF charges a participation fee and point-of-service fee to all patients except for those under 100 percent of the FPL and those who are homeless. (Since 1993, the San Francisco Department of Public Health has provided subsidized/sliding scale services to persons with incomes at or below 500 percent the FPL.) Point-of-service fees vary by medical home; there is one set of fees for all public clinics, while non-public clinics can set their own fees. Point-of-service fee information is provided at the time of enrollment to help applicants make decisions about selecting a medical home. As noted, HSF partici-

pants receive a card with the name of their medical home, plus informational materials. HSF includes a mix of public, nonprofit (voluntary), and for-profit providers, creating a large, interconnected care network. Participating hospitals are asked to document the level of charity care provided, although HSF is not a reimbursement source for hospitals. HSF was launched with the help of major investments by the managed care consortium Kaiser Permanente and other non-public sources. Investment by Kaiser in fiscal year 2013-14 totaled \$12 million, for which they were reimbursed \$4 million by HSF, contributing \$8 million. Kaiser also paid for an actuarial analysis to help determine how to further expand access.

Access Care is the financial assistance program of the Harris Health System, the hospital district that includes the city of Houston.²⁷ It is open to uninsured Harris County residents and provides access to discounted health care at more than 20 community clinics, a dental clinic, and surgical and other sub-specialty clinics. (A separate, no-cost program provides health care for the homeless.) This scope of services exceeds that of most FQHCs in the area, although wait times for sub-specialty clinic appointments and for elective surgeries can be long. Harris Health System has also invested in a scheduled dialysis clinic for uninsured patients; because a Medicare entitlement covers this diagnosis and treatment for most patients, patients who lack Medicare coverage for dialysis tend to be undocumented. The system also includes one long-term care facility.

In Massachusetts, all immigrants are eligible for some form of health coverage. There is one application for all available programs, including the insurance marketplace. **Mass Health Limited** is the state version of Emergency Medicaid.²⁸ It is available to undocumented immigrants and some immigrants who are PRUCOL. The **Children's Medical Security Plan**, created by statute in 1996, is financed by the state and offers primary care and preventive services to low income children. The program includes premiums if a patient has an income greater than 200 percent of the FPL. The **Health Safety Net (HSN)** grew out of the state's ICP and was created in 1985

under hospital rate setting to pay for care at acute care hospitals and community health centers. Massachusetts residents earning less than 400 percent of the FPL are eligible for HSN funds, which follow individuals rather than institutions. Patients with incomes between 200-400 percent of the FPL can apply once they incur a health care cost; HSN's Medical Hardship Program can be applied up to a year retroactively to cover medical debts.

In Nevada, the nonprofit **Access to Healthcare Network (AHN)** offers medical discount programs, specialty care coordination, a health insurance program, non-emergency medical transportation services, a pediatric hematology/oncology practice, and a toll free statewide call center.²⁹ AHN has 35,000 members, more than half of whom are presumed to be undocumented. To be eligible, members must be at 100-325 percent of the FPL, live and/or work in Nevada, and be ineligible for public insurance such as Medicaid or Medicare. Members pay \$35 a month for deeply discounted medical services plus care coordination.

Similarities and differences

Eligibility: All of these programs are targeted to low-income, uninsured residents. HSF stands out as the most generous, with subsidies for people with incomes up to 500 percent of the FPL. (Most local programs for the uninsured are designed for people with incomes within 200 percent of the FPL.) None of the programs target undocumented immigrants explicitly but all are designed to cover uninsured patients who are not eligible for public insurance programs. Program eligibility is structured so it does not crowd out the use of other programs. Individuals must present proof of residence and income but in most cases are not required to provide information about their immigration status.³⁰

Financing: All of these programs rely on multiple sources of revenue. The three local programs (MHLA, Access Care, and HSF) are supported by county taxes. HSF is unique because it draws on a fee imposed on businesses that do not provide health insurance

to their employees. The programs in Los Angeles, Houston, San Francisco, and Massachusetts all rely, to varying degrees, on DSH payments scheduled to be reduced under the ACA; this is a potential source of instability for all of these programs. All but one of the programs involves cost sharing, co-payments, and fees. MHLA does not require cost sharing, but is limited to those within 138 percent of the FPL.

Provider networks: All of these programs were launched using existing capital facilities. HSF expanded the public safety-net to establish a public-private partnership that includes private hospitals and physicians.³¹ (Past efforts in Los Angeles to create public-private partnerships to care for the uninsured had been politically controversial because organized labor objected to expanding county contracts with private providers.) MHLA and Access Care rely exclusively on public safety-net systems. Nevada is distinctive as a discount program with a broader range of providers.

Care coordination: All of these programs emphasize care coordination. Most programs use some form of primary care medical home to accomplish this. MHLA, as noted, assigns enrollees to a medical home at one of the participating clinics. HSF uses eReferral, a web-based system developed at San Francisco General Hospital, to respond to primary care providers' requests for specialty consultation and identify when a patient should be referred to a specialist and when the issue can be resolved in the primary care setting. This prevents medically unnecessary appointments and as a result reduces wait times at specialty clinics.

Political support: Political support was crucial to creating and sustaining all of these programs. The creation of these programs depended on support from local political champions. In San Francisco, for example, a member of the Board of Supervisors, labor unions, and a host of community organizations formed a coalition that overcame opposition to HSF from the restaurant association and other employer groups.³²

SECTION 4. Recommendations

Based on our review, in collaboration with City stakeholders, of proven or promising models for improving access to health care, with attention to relevant opportunities and challenges, we offer the following recommendations.

The City's plan to improve access to health care for the undocumented uninsured and for other remaining uninsured populations in a fair, effective, and sustainable way should:

Recommendation 1 Improve access to primary and preventive health care, and to specialty care and other services, through primary care medical homes in FQHCs and HHC ambulatory centers networked with specialists and services available in HHC medical centers.

A plan featuring primary care medical homes with points of access in targeted neighborhoods throughout the City, offering linguistically and culturally competent health care and robust care coordination within and across these safety-net systems, will significantly support access to primary care and to some forms of chronic care and post-hospital care. Care coordination, including explicit attention to outreach, enrollment, logistics, and cost, is a shared feature of all proven or promising direct-access models we have reviewed.

Recommendation 2 Explore the potential for the City's municipal ID card to function as an enrollee card for a primary care medical home network for uninsured New Yorkers.

Other direct-access models use cards to link a patient to his or her medical home or to support access to health care in other ways. In view of the popularity of IDNYC among immigrants and the lessons already learned about successful local outreach to this population, taking advantage of the card's popularity and adapting lessons from other systems about the effective use of enrollee cards to promote access can be part of the City's plan.

Recommendation 3 Acknowledge that a primary care oriented medical home solution, while important, will not resolve health care access for undocumented immigrants and other uninsured populations who have

medical and related social service needs that significantly exceed the scope of a primary care medical home and that further efforts are needed to close these gaps.

The United States lacks federal policy solutions for affordable access to long-term care and other forms of health care that are needed by people who are aging, disabled, or living with chronic progressive conditions in New York City and throughout the nation. The consequences of ACA-mandated cuts in DSH funding to safety-net providers is another example of a federal policy issue with serious local consequences for access to health care. Mindful of these realities, a City plan to improve access to health care for the undocumented uninsured, and for other uninsured populations, should include attention to transitions from hospital to non-hospital care for patients with chronic conditions who are enrolled in primary care medical homes. This effort could also aim to restructure available safety-net funds to cover certain medical supplies and equipment that are used in chronic care, or on a short-term basis, and for which no payment mechanism exists when a patient is uninsured. This would support the ability of primary care medical home providers and patients to collaborate in the aftermath of hospitalization to support the self-management of chronic conditions and potentially prevent re-hospitalization. It would also support the development of hospital discharge plans that are medically and financially feasible, and contribute to the statewide goal of reducing avoidable hospitalizations.

Recommendation 4 Describe explicitly the potential role of the City's major voluntary hospitals in supporting access to health care for the undocumented uninsured and other uninsured populations, with attention to

their current role in emergency and inpatient care and to access problems that exist at the hospital/post-hospital transition.

New York City's highest-volume emergency departments include both HHC hospitals and voluntary hospitals, which means that the provision of health care to uninsured patients, and the challenge of financing this care when a patient's needs exceed the provisions of Emergency Medicaid, is a challenge for hospitals in both sectors. It is also a challenge for voluntary hospitals offering specialized services, such as cancer treatment, to uninsured patients under Emergency Medicaid provisions. Cases involving undocumented uninsured patients are frequently complex cases for hospitals to manage, and the City's plan to improve access to health care for this patient population should include ongoing, focused efforts to better understand how voluntary hospitals manage these cases and whether there are lessons that can be more broadly shared or adapted for a Citywide solution. Further suggestions on integrating these efforts into planning are included in the next section.

Recommendation 5
Integrate new efforts to improve access to primary care for uninsured New Yorkers into current efforts of New York City Performing Provider Systems to meet their DSRIP goals.

A City plan to expand access to health care for the undocumented uninsured should aim to be integrated with safety-net institutions' efforts to meet time-sensitive DSRIP goals. As a first step, New York

City PPS governance committees and advisory structures should include representatives from any new program created by the City. The IT infrastructure and online platforms that PPSs will put into place are potential resources for improving care coordination for the undocumented uninsured. The City's primary care medical home plan, once implemented, may serve an important function as a consumer-friendly facet of a PPS, helping the public to better understand how this new structure helps people who are uninsured.

Recommendation 6
Advocate for state-level policymakers to identify a mechanism that will provide health coverage to immigrant populations who remain uninsured.

This report describes how Emergency Medicaid is necessary but not sufficient as a financing mechanism to support health care for uninsured populations, including undocumented immigrants and also other low-income immigrants who are currently ineligible for Medicaid. In the absence of universal coverage, restructuring ICP payments to follow individual patients, as in Massachusetts, is one option for using available safety-net dollars to provide coverage to the remaining uninsured, including those who will not benefit from a local solution because they live outside the City. Another option is to create better incentives for hospitals to account for the charity care they provide. Either option could encourage voluntary hospitals to expand access to health care for the remaining uninsured.

SECTION 5.

Guidance for effective local planning during national health care system change

To support the implementation of a City plan during a time of continuing changes in the financing and delivery of safety-net health care, we offer these further observations and suggestions to City stakeholders responsible for program planning, evaluation, and improvement:

Improving public systems

The de Blasio Administration has recognized the need to rethink and reform how public institutions and public dollars are used with respect to legally marginalized populations with complex medical and social needs, such as the chronically mentally ill and the homeless. These ongoing efforts to redesign public systems can also inform the City's new efforts on behalf of undocumented immigrants, another legally marginalized population in need of access to the right systems for their needs.

Anticipating emerging issues in organizational collaboration

The City's plan to improve access to health care for the undocumented uninsured and other uninsured populations will include provisions for data collection, data analysis, and programmatic adjustments, aimed at understanding the effects of this initiative on access, health outcomes, and the cost of care. This plan involves new or deeper collaborations among currently distinct parts of the safety-net system and also involves outreach to a population whose access-related problems are related to factors such as language, culture, and work schedules as well as to lack of insurance. There will be continuing need for expert insight into this emerging model of care and its responsiveness to the population it aims to serve. An interdisciplinary advisory group, including immigrant community representatives and experts in areas such as immigrant health, safety-net health care and health policy, clinical and organizational eth-

ics, and health care advocacy may be helpful to City planners as a mechanism for identifying, discussing, and making recommendations concerning issues as they emerge.

Promoting knowledge sharing and problem solving among public and voluntary hospitals

Recruiting voluntary hospitals in New York City—in particular, academic medical centers with concentrations of specialties and services—as part of the local solution to the unmet health care needs of undocumented uninsured New Yorkers involves encouraging clinicians, administrators, and leaders in these institutions to discuss these challenges openly, so that the scope of the problems different institutions are confronting is better understood by City stakeholders. An invited facilitated meeting could start this process, by providing a forum for discussion of how individual hospitals manage typical and rarer problems in the care of undocumented uninsured patients and whether there are more efficient and/or cost-effective ways of managing these problems collaboratively. Issues that would benefit from discussion among a range of voluntary and public hospitals would include: negotiating discounts on medical equipment from suppliers; negotiating with home care agencies and hospice programs to offer charity-care services to undocumented patients; paying nursing homes directly to accept uninsured patients with short-term needs when discharge to home is not possible; collaborating with legal services organizations and with foreign consulates to determine if an undocumented patient is PRUCOL or to clarify immigration status; and clinical and organizational decision-making concerning retaining patients in the hospital to meet sub-acute and chronic-care needs when discharge is feasible but the potential for deterioration and readmission are high.

NOTES

1. These estimates reflect data provided by City officials to the New York Immigration Coalition (NYIC) and The Hastings Center/Undocumented Patients Project and included in the summary of the December 11-12, 2014 meeting convened by these organizations. These estimates have been cross-checked against the Preliminary Assessment Summary prepared by the Care & Coverage Subgroup of the Mayor's Task Force on Immigrant Health Access. They do not reflect the legal delay in implementing the November 2014 Executive Action; this delay creates a barrier to subsequent enrollment in Medicaid by immigrants who are eligible for DACA or DAPA, and so could increase the estimated number of remaining uninsured. Sources: Meeting Summary, "Undocumented Immigrants and Access to Health Care in New York City: Identifying Fair, Effective and Sustainable Local Policy Solutions," convened by the New York Immigration Coalition (NYIC) and The Hastings Center/Undocumented Patients Project, New York City, December 11-12, 2014 (unpublished working paper reflecting participants' corrections, January 27, 2015); Preliminary Assessment Summary, Care & Coverage Subgroup, Mayor's Task Force on Immigrant Health Access (unpublished draft, February 3, 2015). Estimates are based on previous estimates of the New York City undocumented population and the New York State uninsured population.
2. In New York State, people who are known to the immigration system, do not have status in that system, and meet the requirements for Permanently Residing under Color of Law (PRUCOL) are eligible for state-funded Medicaid.
3. Marion Lewin and Stuart Altman, US Institute of Medicine (IOM), *America's Health Care Safety Net: Intact But Endangered*. Washington, DC: Institute of Medicine, National Academy Press, 2000.
4. A certified application counselor (in HHC, and similarly in FQHCs) or a "navigator" in an organization that receives state funding to offer this service, are both "In-Person Assistors" (IPAs) who help people complete insurance applications. Certified application counselors can target low-income and other specific populations and are paid by the organization they work for. Navigators are required to serve all income levels and are compensated by the state/federal marketplaces.
5. For some procedures, there is a financial benefit to being uninsured in the HHC system versus having insurance with a high co-pay/deductible. For example, an uninsured patient will pay \$400 out of pocket for an MRI, while an insured patient will pay \$2000.
6. This report's use of the term "medical home" (sometimes known as a primary care medical home, a patient-centered medical home, or a PCMH) corresponds to this standard definition of a model designed to meet "the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care." See: Agency for Healthcare Research and Quality (AHRQ), "Defining the PCMH," Webpage: <http://pcmh.ahrq.gov/page/defining-pcmh> Accessed March 26, 2015. This report's use of the term "care coordination" corresponds to this standard definition: "Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care." See: Agency for Healthcare Research and Quality (AHRQ), "Care Coordination," Webpage: <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html> Accessed February 27, 2015.
7. Voluntary hospitals in New York State have also received Indigent Care Pool (ICP) funds, which they have used to cover uncompensated (charity) care and their losses from unpaid bills (bad debt). See discussion of Massachusetts approach (Section 3); see also Recommendations (Section 4).
8. For example, Memorial Sloan Kettering Cancer Center does not have an ED that is open to the public and so does not admit patients through an ED. It does have provisions for uninsured patients.
9. Emergency Medicaid is not available to individuals who exceed the income limit for Medicaid.
10. The NYS Center for Primary Care Informatics (CPCI) data warehouse, established by CHCANYS, supports the targeting, design, and implementation of improvements within FQHCs. It builds on FQHCs' electronic health record (EHR) systems and includes clinical, operational, and financial data from participating FQHCs. More than half of the state's FQHCs are part of this ongoing effort.
11. Undocumented immigrants are not explicitly ineligible for organ transplants due to their immigration status. Because there are limits on organ transplants to "foreigners" to discourage medical tourism, transplant centers often perceive that putting undocumented immigrants and other noncitizens on waiting lists for organs may expose centers to risk during audits. This is another barrier to organ transplantation for this population, in addition to their lack of coverage.
12. Memorial Sloan Kettering Cancer Center is documenting this problem.
13. This report reflects the scope of the Care & Coverage Options subgroup of the Mayor's Task Force on Immigrant Health Access. It does not address in detail the challenges of linguistic and cultural competency as these relate to access to health care for the undocumented uninsured, as these important issues were addressed by the subgroups on Barriers to Health Care for Immigrants and on Language Barriers to Health Care for Immigrants.
14. New York State Department of Health, *The Patient-Centered Medical Home Initiative in New York State Medicaid*. Report to the Legislature, April 2013. Available at https://www.health.ny.gov/health_care/medicaid/redesign/docs/pcmh_initiative.pdf Accessed February 15, 2015.
15. Of particular relevance to uninsured populations are the "11th Projects," which will support outreach to and engagement of Medicaid enrollees and uninsured individuals who are infrequent users of health care. Public hospitals are offered the first right of refusal for implementing an 11th Project.
16. The 11th Project was the most significant addition to the DSRIP project list, and was announced in August 2014. See: Greater New York Hospital Association, "DOH Adds 11th Project to DSRIP Options," Press release, August 11, 2014. Available at: <http://gnyha.org/PressRoom/Publication/0ced3dfa-d37e-409a-b380-c7ef83a0735c/> Accessed February 26, 2015; Kate Breslin, "Overview of the Delivery System Reform Incentive Payment Program (DSRIP)," Presentation, September 10, 2014. Available at: http://www.scaany.org/wp-content/uploads/2014/09/DSRIP-PowerPoint_091014.pdf Accessed February 26, 2015.
17. Nancy Berlinger and Rajeev Raghavan, "The Ethics of Advocacy for Undocumented Patients," *Hastings Center Report* 43, no.1 (2013): 14-17.
18. Alan Sager, "Paying New York State Hospitals More Fairly for Their Care to Uninsured Patients," Report, August 31, 2011. Available at: http://www.cphsny.org/cphs/reports/paying_new_york_state_hospitals/Sager_Paying_New_York_StateHospitals_More_Fairly_for_Their_Care_of_Uninsured_Patients_FINAL31Aug11A.pdf Accessed February 26, 2015.
19. See: "About IDNYC," Webpage: <http://www1.nyc.gov/site/idnyc/about/about.page> Accessed February 26, 2015.
20. *Aliessa v. Novello*, 96 N.Y.2d 418, 422 n.2 (2001).
21. On immigration status and corresponding benefits, see: Empire Justice Center, "Health Coverage Crosswalk: Eligibility by Immigration Status," Report, March 2013. Available at: <http://www.empirejustice.org/assets/pdf/publications/reports/health-coverage-crosswalk.pdf> Accessed February 27, 2015.
22. New York State Senate Majority, "Finance Committee/Counsel Staff Analysis of the FY 2016 Executive Budget," Report, January 2015: 56. Available at: <http://www.nysenate.gov/files/pdfs/Whitebook%20FY%202016%20FINAL%20with%20cover3.pdf> Accessed February 26, 2015.

23. These neighborhoods are: Fordham/Bronx Park, Crotona/Tremont, High Bridge/Morrisania, and Hunts Point/Mott Haven in the Bronx; Bedford-Stuyvesant/Crown Heights, East New York, Sunset Park, East Flatbush, and Williamsburg/Bushwick in Brooklyn; East Harlem, Central Harlem/Morningside Heights, and Washington Heights/Inwood in Manhattan, and Long Island City/Astoria, West Queens, Flushing/Clearview and Jamaica in Queens. Source: CHCANYS.
24. Alan Sager, "Paying New York State Hospitals More Fairly for Their Care to Uninsured Patients," August 2011. Available at: http://www.cphsnyc.org/cphs/reports/paying_new_york_state_hospitals/Sager_Paying_New_York_StateHospitals_More_Fairly_for_Their_Care_of_Uninsured_Patients_FINAL31Aug11A.pdf Accessed March 25, 2015; see also Richard Daines "A Report on the Hospital Indigent Care Pool As required by Chapter 58 of the Laws of 2007," January 2008. Available at: http://www.health.ny.gov/facilities/hospital/indigent_care/docs/indigent_care_report.pdf Accessed February 26, 2015.
25. Health Services for Los Angeles County, "My Health LA," Webpage: <http://dhs.lacounty.gov/wps/portal/dhs/mhla> Accessed February 26, 2015.
26. Healthy San Francisco, "About HSF," Webpage: <http://healthysanfrancisco.org/> Accessed February 26, 2015.
27. Harris Health System, "Access Care," Webpage: <https://www.harrishealth.org/en/patients/access-care/pages/default.aspx> Accessed February 28, 2015.
28. These programs are described on the website of Health Care For All (HCFA), "Who We Are," Webpage: <https://www.hcfama.org/who-we-are> Accessed February 26, 2015.
29. Access to Healthcare Network (AHN), "Access to Healthcare Network," Webpage: <http://www.accesstohealthcare.org/> Accessed February 26, 2015.
30. Harris County's Access Care requires applicants to "show current or expired documents from the U.S. Citizenship and Immigration Services" if these documents exist. (See Access Care website, under "Eligibility.") The program's policy manual states that "Persons who claim to be undocumented and who have no USCIS documents to prove their legal residence in the United States are eligible for assistance if all other verifications are provided and if they are permanent resident[s] of Harris County." (4) Available at: <https://www.harrishealth.org/SiteCollectionDocuments/eligibility/policies/ineligible-residents.pdf> Accessed February 28, 2015.
31. Dennis Andrulis and Michael Gusmano. *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?*, New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations, 2000.
32. Quynh Nguyen and Michael Miller, "Healthy San Francisco: A Case Study of City-Level Health Reform," Report by Community Catalyst, August 2008. Available at: http://www.communitycatalyst.org/docstore/publications/healthy_san_francisco_sept_2008.pdf Accessed February 27, 2015.

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These individuals provided important information and perspectives through discussion and in consultation with the authors, and are not responsible for the recommendations in this report. Affiliations are provided for identification purposes.

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The Center's Undocumented Patients Project provides analysis, commentary, and resources on issues of access to health care for this population. www.undocumentedpatients.org



The New York Immigration Coalition, which includes nearly 200 member groups, is an independent nonprofit organization founded in 1987 to promote immigrants' full civic participation, foster their leadership, and provide a unified voice and a vehicle for collective action for New York's diverse immigrant communities. www.thenyic.org