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Implementation of Health Care Reform in New York State:
Recommendations to Improve Access to Health Care and Coverage
February 2011

BACKGROUND

- Of the 4.2 million immigrants in New York, about 2.2 million are naturalized citizens,[1] about 1.4 million are lawfully residing, and about 700,000 are undocumented.[2] Therefore about 85% of immigrant New Yorkers are either citizens or legal residents.
- Noncitizens constitute a disproportionately high percentage of the uninsured,[3] including those who are eligible for public health insurance, but are not enrolled.[4]
- Over half a million children in New York live in immigrant households. Despite near universal eligibility for Child Health Plus, noncitizen children living with noncitizen parents are still more than twice as likely as citizen children living with noncitizen parents, and nearly four times as likely as citizen children living with citizen parents, to be uninsured.[5]
- 2.3 million New Yorkers are limited English proficient (LEP), meaning they need interpretation or translation services to communicate effectively. Only about half speak Spanish; the other half speak nearly 150 other languages and dialects. While many LEP individuals live in downstate New York, upstate areas also have high numbers of Spanish speakers as well as growing refugee populations who need language assistance services. Despite federal, state and local laws requiring free language assistance services for individuals served by government-funded agencies and health care providers – including hospitals, community health centers and local departments of social services – language barriers remain the most persistent and serious barriers to health care and health insurance for LEP New Yorkers.
- The majority of immigrants in New York will benefit from New York's implementation of the Affordable Care Act (ACA), simply because the majority of immigrants in New York are either citizens or lawful residents. In the NYIC's and our member groups' outreach and education to our constituents and members, this has been our main message, along with making sure people understand that all New Yorkers, regardless of immigration status, language spoken, or insurance status, have some options for affordable health care.
- It is expected that about 1.5 – 2.0 million individuals will remain uninsured even after health care reform is fully implemented. The majority will be citizens and legal immigrants who are eligible for insurance but not enrolled, as well as individuals who still cannot afford the cost of health insurance, and others who are exempt from the individual mandate or who choose

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[1] "2008 American Community Survey," Migration Policy Institute, http://www.migrationinformation.org/DataHub/state.cfm?ID=NY#3
[2] Holahan, D. and Cook, A. "Characteristics and Health Insurance Coverage of New York's Non-Citizens," United Hospital Fund, July 2009. Figures are from the Urban Institute analysis of 2006 Annual Social and Economic Supplement to the Current Population Survey.
[3] ibid.
[4] Holahan, D., Cook, A., Powell, L. "New York's Eligible but Uninsured," United Hospital Fund, 2008.
[5] Urban Institute/RWJF "Uninsured Children" Chartbook, August 2010. http://www.urban.org/url.cfm?ID=1001446

to pay the tax penalty rather than enroll in coverage.[6] However, the share of the uninsured population who are undocumented immigrants will grow as the ACA is implemented – they are the specifically excluded from the new benefits of the ACA and are already excluded from most public health insurance programs – at the same time resources for the safety net health care system will diminish.

- Undocumented immigrants represent only 3.5% of New York's total population, but are currently 15% of New York's uninsured. After reform is implemented, undocumented immigrants will be 25%-30% of the uninsured, or more if New York is able to improve enrollment in public health insurance programs.[7]

RECOMMENDATIONS

1. **Incorporate Diverse Consumer Stakeholder Input in State's Implementation of Health Care Reform, Including Immigrant Representation.** Immigrants are more than 20% of New York's total population, speaking nearly 150 languages and dialects, and representing dozens of cultures and religions.

   a. Immigrants and representatives from immigrant-serving community organizations should be included in the Governor's Health Care Reform Advisory Committee and subgroups, invited to public hearings, included in new governance structures, such as of the Exchange, and partnered with and funded for community outreach, education and enrollment efforts.
   b. Incorporate ongoing feedback loops and provide the opportunity for linguistically diverse consumers to provide input and suggestions. The implementation of health care reform will be an ongoing, evolving process, and it is unlikely we will get it right on the first try. There must be mechanisms for New Yorkers who are affected by the changes, including New Yorkers who speak languages other than English, to provide input and feedback on how the rollout is going and what should be improved.
      i. As an example of improvements needed, the Medicaid Redesign process has provided woefully inadequate opportunities for LEP individuals to get information and provide input, particularly for non-Spanish speakers. Notices of public hearings were provided in English only, a link in Spanish on the website originally led to a dead end and information in Spanish has been added slowly and incrementally, interpretation services were provided only in Spanish at the hearings, and only one consumer representative was included on the Medicaid Redesign Team. The roll-out of health reform must do better.

2. **State Health Insurance Exchange – No Wrong Door. Ensure that the new Exchange is accessible to all New Yorkers, regardless of immigration status or language spoken.**

   a. **One-Stop-Shopping For Insurance or Financial Assistance For All New Yorkers.** Many undocumented immigrants are part of families that include lawfully residing immigrants and citizens ("mixed status" families) who will be eligible for public health insurance, private insurance, or subsidies through the Exchange. The Exchange should be a one-stop shop where a family can get information on, and assistance applying for, *all* programs for which their family members may be eligible, including Medicaid, Child

[6] Boozang, P., Dutton, M., Lam, A., Bachrach, D. "Implementing Federal Health Care Reform: A Roadmap for New York State," NYS Health Foundation, August 2010.
[7] ibid

Health Plus, Family Health Plus, Emergency Medicaid, Medicaid for Pregnant Women and Adolescents, private insurance, subsidies for private insurance, and the Basic Health Plan (if New York implements one). The Exchange should also facilitate enrollment in and provide information about financial assistance programs at hospitals and community health centers as well as information on where uninsured individuals can access affordable care.

i. According to the ACA, the Exchange must enroll individuals eligible for Medicaid, Child Health Plus, and other "state health programs" and facilitate enrollment in private plans. It should also administer subsidies and help individuals apply for exemptions from the individual mandate. Therefore the Exchange will interact with every segment of the population, including those eligible for public health insurance, those eligible for subsidies, those ineligible, and those exempt.

ii. It is important to note that the exclusion of undocumented immigrants specifically pertains to eligibility to buy private insurance in the individual Exchange[8]– this does not prohibit these individuals from accessing other information or applying for other programs in the Exchange.

b. **Prescreen and/or Enroll Uninsured Individuals in Statewide Financial Assistance Program.** Individuals who are not eligible for, are exempt from, or choose not to enroll in health insurance, should be screened for, enrolled in, and given a card for, a statewide financial assistance program. Hospitals and community health centers are already mandated by law to provide financial assistance (e.g. sliding fee scales, charity care, discounted care, etc.) to individuals who lack or have inadequate health insurance. The Exchange offers a tremendous opportunity to standardize application and enrollment for these financial assistance programs.

i. Hospitals and community health centers are already obligated to help their patients apply for financial assistance at their facilities.[9] Since the Exchange will already screen families and individuals for income and family size for insurance eligibility purposes, the same application and information could be used to enroll in a statewide financial assistance program. This would alleviate the administrative burden on health care providers and uninsured patients alike, and help alleviate uninsured individuals' primary barrier to care – cost.

ii. Our community-based partners regularly report that their uninsured clients have difficulty getting information about and applying for financial assistance programs, especially at private hospitals. Standardizing the application process through the Exchange would improve hospitals' compliance with the law, improve patients' access to affordable care, and improve the State's ability to demonstrate the need for continued Disproportionate Share Hospital funding to reimburse for care provided to the uninsured.

iii. Indigent Care Pool (ICP) Considerations – described more fully in section on strengthening the safety net health care system.

a) Improve accountability and transparency of the ICP by allocating 100% of the Pool based on the amount of actual care provided to uninsured patients, rather than 10% as proposed in this year's budget.

[8] Patient Protection and Affordable Care Act, §1312

[9] NYS Public Health Law § 2807-k (2006) - Hospital Financial Assistance Law requires all general hospitals, both public and private, to provide notice about, and help uninsured and underinsured patients with incomes lower than 300% of the Federal Poverty Level to apply for, sliding scale discounts. Federally qualified health centers, in order to be eligible for enhanced federal financing, must also provide care to all patients regardless of ability to pay.

b) The State should consider redirecting the ICP to directly compensate providers, by unit of service, for care provided to the uninsured.
c) The State should explore redirecting the Indigent Care Pool to fund a health insurance plan for the uninsured.

c. **Incorporate Prequalification for Emergency Medicaid, as well as an Extension of the Medical Recertification Period for Certain Conditions.** The current variety across hospitals of procedures to administer Medicaid for the treatment of emergency medical conditions (Emergency Medicaid), general confusion and reluctance about using the program, and complex administrative burden hurts patients, results in the misuse of the state's Indigent Care Pool and other safety net funding, and misses an opportunity to leverage federal Medicaid funding.

i. **Clarify Emergency Medicaid policies and procedures** through administrative directives, provider updates and training, and consumer outreach so as to prevent confusion as to when Emergency Medicaid can be used, and to encourage its use whenever appropriate. Encourage improved coordination between the physician, the patient and the hospital's billing department so that individuals are notified about the program and how to apply, and sign any necessary paperwork, such as the DOH-4471 form, before they receive a bill.

ii. **Allow for prequalification of financial eligibility.** Create a restricted scope Emergency Medicaid enrollment category code and allow local district Social Services offices and other community based facilitated enrollers to screen and determine eligibility for individuals who are likely to qualify for Emergency Medicaid coverage based on meeting all of the non-medical state eligibility requirements.
a) No new or expanded benefits are sought, simply a streamlined application process that would promote proper utilization of the program and leverage federal funding rather than relying on the state-funded Indigent Care Pool.
b) Several states already do this, including California, Maine, Massachusetts, Michigan, and Oregon.

iii. **Create a clinically-appropriate 12-month medical certification period for coverage of certain treatments and conditions under the state's Emergency Medicaid program**, as states like California, Connecticut, Maine, Virginia and Washington have done**.** Extending medical certification periods for certain conditions—for example, for cancer and renal failure—would streamline the process by eliminating paperwork and administrative requirements for providers, local social services districts, and patients. It would also provide security for providers and peace of mind to patients, encouraging proper compliance with treatment plans and improved health outcomes.

d. Ensure that All Limited-English Proficient New Yorkers have Access to All Aspects of the Exchange, and that Immigrants' Unique Concerns are Proactively Addressed.

i. Background - 2.3 million New Yorkers are limited English proficient (LEP), meaning they need interpretation and translation services to communicate effectively with the Exchange, government agencies, health insurance plans, navigators, enrollers, as well as health care providers.
a) Pursuant federal, state and local laws and policies, all public agencies are obligated to provide free interpretation and translation services to limited-English proficient consumers. Already, several state agencies have taken important steps to improve their services to LEP consumers – the Department of Labor and Department of Education have language access policies; the Office of Mental Health recently issued a cultural competency strategic plan, which includes

strong language access provisions; and the tri-agency language access task force of the Department of Health, Office of Children and Family Services and Office of Temporary and Disability Assistance recently released a draft language access policy. Mayor Bloomberg issued Executive Order 120, a citywide language access policy applying to all city agencies.

b) Despite existing laws and policies, language barriers remain the most serious and persistent barriers to health care and health insurance for New York's millions of LEP residents.

ii. The Departments of Health and Insurance, as well as the entity that administers the Exchange, should designate language access coordinators responsible for creating and implementing language access policies and procedures.

iii. Ensure competent interpretation and translation services at all levels of the state Exchange.
   a) All consumer access points, from phone to website to postal mail to in-person assistance, should provide meaningful access to LEP individuals. The provision of language assistance services may include the use of trained bilingual staff, trained in-person interpreters, language banks, and telephonic interpretation services.
   b) Issues of language and cultural competence should inform workforce and hiring policies, and workers with direct consumer contact should be trained on the language access policy and working with LEP consumers.
   c) Provide language assistance services in all direct service interactions – including translation of written information about insurance options, cost, enrollment, subsidies, appeals, and other issues.
   d) Websites should follow federal guidance on language accessibility, should be translated in the most common languages in New York, and provide taglines and information on how to obtain interpretation services in multiple languages. Web-based translation tools, such as Google translate and Babel Fish, are notoriously inaccurate and are not acceptable.

iv. Qualified health plans' summaries of coverage and claims and appeals processes should be translated into the most common languages and include multilingual taglines.

v. New York State should require health insurers to provide and pay for interpretation, translation and literacy-appropriate information, including enabling Medicaid reimbursement for interpretation and translation services.[10]

vi. Require health insurers and the Exchange to collect primary language data of applicants and enrollees, requests for and the provision of language assistance services.

vii. Create consistent methods for collecting and reporting health data by race, ethnicity and language to identify disparities, monitor efforts to reduce disparities, and ensure compliance with non-discrimination provisions.

[10] NYS Assembly bill A00661 (Gottfried) would enable Medicaid reimbursement for language assistance services, which the NYIC strongly supports. Twelve states and the District of Columbia are already receiving Medicaid reimbursement for language assistance services. The Children's Health Insurance Program Reauthorization Act of 2009 included 75% federal matching Medicaid funds for language services for children and pregnant women.

a) Applicable programs include Medicaid, Child Health Plus, waiver programs, demonstration and pilot programs, the Exchange, qualified health plans, consumer assistance programs, etc.

viii. The State should include funding for language assistance services when applicable in grant and waiver requests to US Health and Human Services.

ix. Immigrants' unique fears and concerns about utilizing health care or applying for insurance programs should be addressed proactively.

a) The Exchange and other new programs (including the NY Bridge Plan) should create confidentiality policies ensuring that information about immigration status will not be reported to law enforcement or immigration officials, and notify applicants of the policy, as is currently done in New York's public health insurance programs.[11]

b) The Exchange should also proactively address immigrants' concerns about public charge—the concern about whether using health care or insurance will affect an individual's ability to adjust status to lawful permanent resident, get a green card, or naturalize—as is done in New York's public health insurance programs.[12]

c) Training for individuals that provide direct customer assistance in the Exchange, as well as navigators, facilitated enrollers, and consumer assistance programs should include information about immigrants' unique concerns, as well as techniques and tools for allaying immigrants' concerns.

e. <u>Minimize Citizenship and Immigration Status Documentation and Verification Requirements.</u>

i. Streamline verification requirements to correspond with existing programs (Medicaid) when more stringent requirements are necessary to comply with federal law.

ii. When verification is required, utilize DHS's Systematic Alien Verification for Entitlements (SAVE) system, currently used by Medicaid to verify immigration status information rather than SSA database, which is not an adequate or accurate database for verifying immigrants' citizenship or immigration statuses.

iii. Allow for a reasonable opportunity to provide documentation while providing private coverage in the Exchange, as is already required for public insurance programs.

iv. Explicitly incorporate Section 1411 of the Affordable Care Act into New York's Exchange policies and procedures limiting the inquiries, use and disclosure of information provided by applicants.

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[11] Comparable policies exist in the Medicaid program, see GIS 04 MA/014 - Reporting Immigrant Status and Disclosure of Medicaid Benefits Information. The Access NY Health Care application also includes this helpful Confidentiality Statement in the very beginning of the Instructions: *"CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. The only people who will see this information are the Facilitated Enrollers and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information."* and later clearly states: "*The state will not report any information on this application to the USCIS.*"

[12] Again, the Access NY Health Care application instructions includes helpful guidance about Public Charge: *"PUBLIC CHARGE INFORMATION The United States Citizenship and Immigration Services (USCIS) has stated that enrollment in Medicaid, Family Health Plus, Child Health Plus or the Family Planning Benefit Program CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member, or travel in and out of the country. This is not true if Medicaid pays for long-term care in a place such as a nursing home or psychiatric hospital."*

3. **Consider Merging Individual and Small Business Health Options Program (SHOP) Exchanges, But Keep it Simple.** If the individual and small group Exchanges are merged, do so in a way that maximizes the benefits of combining the risk pools, but does not subject beneficiaries of small group plans to additional documentation and verification requirements.[13]

    a. Enrollment in the SHOP Exchange should closely resemble those of large employers in today's group insurance market and be even more streamlined where possible.
        i. Unnecessary documentation requirements would result in substantial costs to small businesses and governments. They would create hurdles for many (immigrant and native citizen alike), including people born outside of hospitals, those who have lost documents in disasters like fires or tornadoes, and the homeless.
    b. Additional documentation and verification requirements would put the Exchange at a disadvantage in competing for small business customers if insurance sold outside the Exchange had significantly fewer paperwork burdens.

4. **Coordinate Screening and Enrollment Among All Programs in the Exchange—Including Public and Private Health Insurance, Affordability Credits, Exemptions from the Individual Mandate, and Financial Assistance Programs.**

    a. Streamline, Simplify and Coordinate Enrollment Among All Programs. Health care reform reinforces the State's goals to streamline and simplify enrollment in insurance programs. These efforts must be expanded to coordinate with private plans and financial assistance programs, as well.
        i. Coordinate income determination, documentation and verification, standardization of enrollment/renewal periods, and due process protections across public and private plans, application for affordability credits, as well as for financial assistance programs at hospitals and community health centers.
            a) Standardize, when possible, and minimize documentation and verification rules for all programs mentioned above, as well.
            b) Continue to allow for attestation of income or letters from an employer for non-traditional workers, as is currently done in New York's public insurance programs.
        ii. Procedures for claiming and obtaining an exemption from the individual mandate should be streamlined, not solicit unnecessary information, protect the confidentiality of the information, limit the sharing of information only for purposes of determining eligibility for the exemptions, and include due process protections.
        iii. Build technological infrastructure to foster cross-coordination and integration of public programs and private coverage to ensure seamless transitions and cross-information sharing.
        iv. Ensure continuity of coverage in plans/providers across Medicaid and private plans in the Exchange.
    b. Expand Culturally and Linguistically Appropriate Outreach, Education, and Consumer Assistance Programs. Continue and expand rigorous and well-funded outreach and education efforts targeted at individuals who are eligible for public health insurance but uninsured. Ensure these efforts are integrated with outreach and education about

affordable care options (e.g. financial assistance at hospitals and community health centers) for individuals who remain uninsured. Immigrants are a disproportionately large segment of both these groups.

i. Continued outreach and improved enrollment in public health insurance remains critical to ensure that the State maximizes federal financial participation through Medicaid, which will help alleviate effects of decreasing DSH and other funding for the safety net health care system.

ii. Ensure that Consumer Assistance Program grants and funding for Navigators reaches community-based organizations (CBOs) that are embedded in immigrant and other underserved communities. Culturally and linguistically appropriate advocates at community groups who are trusted by the communities they serve are best situated to provide navigation, outreach and enrollment assistance to their communities, and many have a strong track record doing so. Groups should be able to use the funding to assist all New Yorkers, regardless of the health program for which they may be eligible.

a) The NYIC's Immigrant Health Access and Advocacy Collaborative is a nationally recognized model program composed of community-based organizations, legal services providers, and policy and advocacy expertise. Advocates at CBOs receive ongoing intensive training and technical assistance, provide culturally and linguistically appropriate direct client services, conduct community outreach and education, and engage in systemic advocacy to improve immigrants' access to health care and health insurance in New York.

iii. Alleviate immigrants' concerns about enrolling in public health insurance or using a government-funded Exchange by actively allaying immigrants' concerns about public charge (concern that using public health insurance or buying insurance through government-run Exchange will prohibit someone from legalizing or naturalizing), sponsor liability (concern that an immigrant's sponsor will have to pay for the immigrant's use of insurance or health care services), and reporting to immigration officials (fear that enrollment in public health insurance or use of health care services may lead to the deportation of the immigrant or a family member).

a) Provide consistent and ongoing training to front line staff, facilitated enrollers, eligibility workers, navigators, etc. in immigrant eligibility for health insurance, immigrants' concerns, and language access policies and procedures, including working with interpreters and LEP customers.

c. <u>Maintain current eligibility levels, as well as benefits, in New York's public health insurance programs.</u>

i. The implementation of health reform should NOT result in any person losing coverage that currently has it.

ii. Explore how the Basic Health Plan can be used to leverage 100% federal financing to cover populations currently paid for with state-only funding.

iii. Ensure comparable, affordable coverage for all children currently covered in New York's Child Health Plus program once the State Children's Health Insurance Program phases out in 2019, or as early as 2015.

5. **<u>Continue To Move Toward Universal Coverage for All New Yorkers.</u>** Explore opportunities to offer affordable health insurance to individuals ineligible, exempt, or unwilling to buy insurance in the Exchange.

a. Refer people ineligible for public or private plans in the Exchange to comparable plans outside of the Exchange; do so in way that does not de-stabilize the Exchange.

b. Explore ensuring affordable private plans are available outside of the federally financed Exchange, perhaps through a "mirrored," parallel, state-funded Exchange.
   i. Points of entry for both Exchanges should be identical and seamless to the individual. In the case of mixed status families, certain family members may be eligible for coverage in the federally funded Exchange, while others may be eligible for coverage in the state-funded Exchange.
   ii. Similarly, screening and enrollment should be identical and coordinated, so that a family whose members may have coverage through the different Exchanges are screened and enrolled only once—financing issues should be dealt with on the back-end.
   iii. All plans in the federally funded Exchange should be required to offer plans in the state-funded Exchange, to foster cross-coordination and integration to ensure that all members of a single family have coverage on the same plan.
c. Explore how the Basic Health Plan can be used to leverage 100% federal financing to cover populations currently paid for with state-only funding.
d. Explore a state-funded "public option" available to all New Yorkers, regardless of immigration status.

6. <u>Protect and Strengthen the Safety Net Health Care System (i.e. health care providers that see high number of uninsured) and Promote Integrated Care for the Uninsured</u>

a. <u>Maximize enrollment in public health insurance programs by continuing and strengthening robust outreach, education, and enrollment efforts.</u>
   i. Federal financial participation through the Medicaid program will help alleviate the effects of DSH cuts and Medicaid cuts, providing a stream of new revenue to safety net providers, and leveraging federal Medicaid funding rather than the ICP.
   ii. Since immigrants and LEP individuals are more likely to be eligible for insurance but not enrolled, education and enrollment efforts must be culturally and linguistically appropriate.
b. <u>Immediately improve accountability of safety net funding, especially the State's Indigent Care Pool (ICP), by allocating 100% of the ICP based on actual services provided to uninsured patients.</u>
   i. The ACA mandates progressive cuts to Disproportionate Share Hospital (DSH) funding. States that can prove they continue to serve high numbers of uninsured individuals by *unit of service* will see smaller decreases in DSH.[14]
   ii. Further, enforce the State's hospital financial assistance law (HFAL) and direct ICP funding to hospitals based on their compliance with the law.
      a) Incentivize compliance by offering ICP enhancements to hospitals that demonstrate compliance or improved compliance with the law AND with all of the DOH's guidance, including use of simple, uniform enrollment forms and simplified documentation requirements.
      b) Consider transforming the ICP to directly reimburse providers, including hospitals, private specialists, and labs, per unit of service for uninsured patients.
c. <u>Site newly created federally qualified health centers (FQHCs) in communities where significant numbers of low-income individuals will remain uninsured even after reform is fully implemented.</u> The ACA's increased federal funding of existing clinics should be directed to those that will continue to serve large numbers of uninsured individuals.
d. <u>Expand and Support Primary Care.</u> Community-based primary care services have been proven to provide better care and be more cost effective because good primary care

[14] Patient Protection and Affordable Care Act, § 2551

prevents the need for hospitalizations. By expanding primary care services in a way that works for everyone, including expansion of hours, guarantee of continuity, comprehensiveness, and cultural competence – New York could lower health care costs in general, as well as in Medicaid.

e. Promote integrated care for the uninsured. Particularly outside of New York City, it is difficult, if not impossible, for uninsured individuals to access affordable specialty and follow-up care. First, hospitals', especially private hospitals', compliance with the hospital financial assistance law is inconsistent and generally poor. Even individuals who receive primary care at community health centers fall through the cracks when specialty or surgical care is needed, because of hospitals' spotty compliance with the HFAL and HFAL's lack of jurisdiction over private physicians, even those who work at hospital Emergency Rooms. As a result, uninsured individuals suffer needlessly, as they are unable to access needed medical care that would prevent a deterioration of their health condition and an eventual costly visit to the Emergency Room.
   i. New York State should pursue federal Medicaid waivers and other grant programs available through the ACA that will strengthen and promote integration and collaboration within the health care safety net.
   ii. Accountable Care Organizations, patient-centered medical home demonstrations, etc. should be structured to help integrate and strengthen local safety nets, promoting continuity of care both for insured and uninsured patients.
   iii. New York State should explore health care delivery systems (perhaps as a demonstration or pilot project in a specific locality) that promote continuity of care for the uninsured in need of laboratory, specialty, surgery, prescriptions, dental and mental health services. Similar efforts have been undertaken on Staten Island (Staten Island Health Access) and elsewhere including DC Healthcare Alliance, Healthy San Francisco, Toledo/Lucas County CareNet and others.
      a) These health care delivery systems may bring together government, funders, hospitals, community health centers, private specialists, mental health providers, labs, pharmacies and community-based organizations to coordinate care for uninsured patients with special needs or serious or chronic conditions.
      b) This may also include coordinated and standardized enrollment in a financial assistance program that is accepted at all participating providers; the Exchange could facilitate this process.

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