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June 9, 2008

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New York State Office of the Attorney General, Andrew Cuomo
120 Broadway
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Re: Complaint Of Bronx Health REACH Pursuant To Title VI Of The Civil Rights Act Of 1964, The Hill Burton Act, The New York State Patients' Bill of Rights, and The New York City Human Rights Law

The New York Lawyers for the Public Interest ("NYLPI") brings this Complaint ("Complaint") on behalf of Bronx Health REACH, a coalition of community-based organizations whose mission is to end racial and ethnic disparities in health care in New York City. The Complaint is against New York-Presbyterian Hospital ("New York-Presbyterian"), The Mount Sinai Medical Center ("Mount Sinai"), and Montefiore Medical Center ("Montefiore") (collectively, "Respondents") for violations of: (1) Title VI of the Civil Rights Act of 1964 ("Title VI"), 42 U.S.C. §2000d, and regulations promulgated thereunder; (2) the Public Health Service Act ("Hill-Burton Act"), 42 U.S.C. §291 *et seq.,* and regulations promulgated thereunder; (3) New York State Patients' Bill of Rights ("Patients' Bill of Rights"), N.Y. COMP. CODES R. & REGS. tit. 10, §405.7(b)(2); and (4) the New York City Human Rights Law ("NYCHRL"), N.Y. City Code, tit. 8, § 8-107(17). The Complaint is concerned with discrimination on the basis of source of payment, race, and national origin at New York-Presbyterian, Mount Sinai, and Montefiore.

The Complaint alleges that Respondents operate two separate structures of cardiac and endocrine care within the same overall hospital system; that patients are sorted into these two systems of care based on payor source; and that Respondents do not ensure that comparable services are provided in both settings.

The separation of patients into two separate and unequal systems of outpatient care on the basis of payor source is a violation of the Patients' Bill of Rights and Hill-Burton, which obligates respondents to make their services available without discrimination to beneficiaries of governmental programs such as Medicaid. In addition, since the Medicaid recipients within Respondents' respective service areas are disproportionately more likely to be black or Latino, the physical separation of patients on the basis of source of payment has a disparate impact on the basis of race and national origin in violation of Title VI and the NYCHRL.

You may recall that in 1993-1994 similar complaints regarding segregation on the basis of payor source and race/national origin were brought to the Office of Civil Rights at the U.S. Department of Health and Human Services against Mount Sinai and New York-Presbyterian with respect to their inpatient maternity services. The issue of outpatient services was not addressed at that time, but similar practices persist at these hospitals in the outpatient context.

We urge the New York State Office of the Attorney General to investigate this matter fully, and to take any and all steps that may be necessary to bring New York-Presbyterian, Mount Sinai, and Montefiore into compliance with federal, state and local laws. A copy of the formal Complaint is enclosed with this letter as well as a copy of the settlement agreement reached in the prior cases with OCR, for your convenience.

Should you have any questions please do not hesitate to contact me.

Respectfully submitted,

Nisha Agarwal
Staff Attorney

Enclosures

Copies to:

Bronx Health REACH
16 East 16th Street
New York, NY 10003
Dr. Neil Calman, President and CEO/Principal Investigator, Institute for Family Health
Ms. Charmaine Ruddock, MS Project Director, Institute for Family Health
Ms. Maxine Golub, MPH Senior Vice President/Project Administrator, Institute for Family Health

NEW YORK STATE OFFICE OF THE ATTORNEY GENERAL

BRONX HEALTH REACH, complainant, - against - NEW YORK-PRESBYTERIAN HOSPITAL, THE MOUNT SINAI MEDICAL CENTER, and MONTEFIORE MEDICAL CENTER respondents.	Civil Rights Complaint

OVERVIEW OF THE COMPLAINT

1. Complainant Bronx Health REACH ("REACH"), a program of the Institute for Family Health, brings this civil rights complaint ("Complaint") with the New York State Office of the Attorney General ("OAG") against New York-Presbyterian Hospital ("New York-Presbyterian"), the Mount Sinai Medical Center ("Mount Sinai"), and Montefiore Medical Center ("Montefiore") (collectively, "Respondents") for violations of: (1) the Public Health Service Act ("Hill-Burton"), 42 U.S.C. §291 *et seq.,* and regulations promulgated thereunder; (2) the New York State Patients' Bill of Rights ("Patients' Bill of Rights"), N.Y. COMP. CODES R. & REGS. tit. 10, §405.7(b)(2); (3) Title VI of the Civil Rights Act of 1964 ("Title VI"), 42 U.S.C. §2000d, and regulations promulgated thereunder; and (4) the New York City Human Rights Law ("NYCHRL"), N.Y. City Code, tit. 8, § 8-107(17).

2. Specifically, the Complaint alleges that Respondents operate two separate structures of outpatient cardiac and endocrine care within the same overall hospital system; that patients are sorted into these two systems of care based on payor

source; and that Respondents do not ensure that comparable services are provided in both settings.

3. Respondents are three of the leading academic medical centers in New York City, offering a wide range of inpatient and outpatient health services, and all three are located in or near the Bronx, where the majority of REACH's members reside.

4. REACH is a community-based coalition, administered through the Institute for Family Health, whose mission is to eliminate racial and ethnic disparities in health care in New York City.

5. Individual members of the REACH coalition who receive Medicaid benefits face challenges in accessing high-quality outpatient services at the Respondent hospitals. The concerns expressed by community members prompted REACH to explore the problem further.

6. Focusing on pathways to endocrine and cardiac care, REACH found that New York-Presbyterian and Mount Sinai maintain and support two separate types of settings in which patients can receive outpatient endocrine care: (1) specialty clinics ("clinics") and (2) the offices of faculty doctors whose practices are located within and/or affiliated with Respondent hospitals through contractual or other arrangements ("faculty practices"). Similarly, REACH found that New York-Presbyterian and Montefiore maintain and support separate clinics and faculty practices for outpatient cardiology.

7. Survey data collected by REACH further showed that Respondents' maintain and support a dual system of care for these specialties whereby the source of payment used by the patient is one of the primary determinants of whether the patient is treated in the clinic or the faculty practices. Patients who are Medicaid beneficiaries,

particularly Medicaid Fee-for-Service ("Medicaid FFS"), are treated in the clinics and privately-insured patients are treated in faculty practices.

8. One mechanism by which this sorting occurs is through the physician referral process at each of the Respondent hospitals. Specifically, individuals seeking endocrine care who are on Medicaid, particularly Medicaid FFS, are referred to the endocrinology clinics at New York-Presbyterian and Mount Sinai. Individuals seeking cardiac care who are on Medicaid, particularly Medicaid FFS, are referred to the cardiology clinics at New York-Presbyterian and Montefiore. By contrast, patients with private insurance are referred to the relevant faculty practices.

9. Survey data collected by REACH also found that Respondents operate their clinics in such a manner that patients in the clinics do not have access to the same services and quality of care as their counterparts in the faculty practices, even though Respondents support and maintain both types of specialty care settings.

10. The result of the above-mentioned practices is the creation of two separate and unequal modes of service delivery within the same health care facility.

11. Under the Hill-Burton Act, medical facilities that received funding through the Hill-Burton program ("Hill-Burton Facilities") must take steps to ensure that the services of their facility are available to recipients of governmental programs such as Medicaid without discrimination because they are beneficiaries of such programs.

12. Respondents are Hill-Burton Facilities.

13. Nevertheless, in violation of Hill-Burton, Respondents filter patients into clinics or faculty practices based on payor source, and they do not ensure that

comparable services are offered in both settings even though the clinics and faculty practices are supported by and often located within the same health care facility.

14. Similarly, under the Patients' Bill of Rights, general hospitals in New York, as defined by Article 28 of the Public Health Law, have the obligation to treat patients without discrimination on the basis of, *inter alia,* source of payment.

15. Respondents are general hospitals.

16. Nevertheless, in violation of the Patients' Bill of Rights, Respondents filter patients into clinics or faculty practices based on payor source and do not ensure that comparable services are offered in both settings even though the clinics and faculty practices are supported by and often located within the same health care facility.

17. Under Title VI, recipients of federal financial assistance are prohibited from discriminating on the basis of race, color or national origin. The U.S. Department of Health and Human Services ("HHS") has interpreted Title VI to prohibit facially neutral conduct that has a disparate impact on the basis of race, color, or national origin.

18. Respondents are recipients of federal financial assistance and therefore obligated under Title VI and its implementing regulations.

19. There are almost 19 times as many African Americans and Latinos who qualify for Medicaid benefits than Whites in the Bronx.

20. There are 3.5 times as many African Americans and Latinos who qualify for Medicaid benefits than Whites in New York City.

21. Upon information and belief, African Americans and Latinos are substantially more likely than Whites in Respondents' respective patient populations to qualify for Medicaid benefits.

22. Respondents' practices of referring Medicaid beneficiaries, particularly Medicaid FFS recipients, to clinics, where they do not receive services comparable to those received by privately insured patients seen in faculty practices, has a disparate impact on the basis of race and national origin.

23. Respondents' practice of segregating patients on the basis of payor does not further any important legitimate program objective that could not be substantially accomplished through less discriminatory means, and is therefore in violation of Title VI and regulations promulgated thereunder.

24. Under the NYCHRL, places of public accommodation are prohibited from discriminating on the basis of, *inter alia,* race, color, or national origin, including conduct that has a disparate impact on the basis of race, color, or national origin.

25. Respondents are places of public accommodation for the purposes of the NYCHRL.

26. New York-Presbyterian and Mount Sinai's practices of referring Medicaid beneficiaries, particularly Medicaid FFS recipients, to endocrinology clinics, where they do not receive services comparable to those received by privately insured patients seen in faculty practices, has a disparate impact on the basis of race and national origin.

27. New York-Presbyterian and Montefiore's practices of referring Medicaid beneficiaries, particularly Medicaid FFS recipients, to cardiology clinics, where they do not receive services comparable to those received by privately insured patients seen in faculty practices, has a disparate impact on the basis of race and national origin.

28. Respondents' practices of segregating patients on the basis of payor does not further any significant business objective that could not be accomplished as well with an alternative policy or practice with less disparate impact, and is therefore in violation of the NYCHRL.

FACTUAL BASES FOR THE COMPLAINT

29. New York-Presbyterian, Mount Sinai and Montefiore are three of the most highly respected major medical centers located in and around the Bronx, where the majority of REACH's community members live and work.[1] Despite their proximity to institutions providing some of best medical care in the city, REACH members have difficulty accessing high-quality outpatient care, especially if they were on Medicaid.

30. REACH members primarily access medical care through hospital-based clinics for conditions such as diabetes, heart disease and cancer, which are especially prevalent in the Bronx.[2] At the clinics, community members experience frequent disruptions and uncertainties in accessing care as well as poor quality and treatment in the delivery of care.

31. To understand the nature and scope of the barriers to outpatient care reported by its members, REACH conducted a structured survey of the physician referral process for outpatient specialties ("specialty survey") at New York-Presbyterian, Mount

[1] New York-Presbyterian, Mount Sinai, and Montefiore were ranked as the first, second and sixth best overall hospitals, respectively, in a recently published ranking. "Best Hospitals 2006," New York Magazine (November 12, 2006).

[2] According to the New York City Department of Health and Mental Hygiene, in the Central Bronx: more than 1 in 10 adults have diabetes; annual heart disease hospitalization rates are 50% higher than for New York City as a whole; and cancer rates are 15% higher than for New York City overall. New York City Department of Health and Mental Hygiene, Community Health Profile: Central Bronx (2006), *available at* http://www.nyc.gov/html/doh/downloads/pdf/data/2006chp-105.pdf.

Sinai, and Montefiore, the three major teaching hospitals in or near the Bronx where community members had sought outpatient care or wished to seek outpatient care.

32. The physician referral service is a central point of access for individuals seeking outpatient care at a hospital, including Respondent hospitals. Prospective patients can call the hospital's physician referral service to determine which specialists, if any, they can see at that particular hospital.

33. Through prior experience and some preliminary research, REACH was aware that New York-Presbyterian, Mount Sinai, and Montefiore each maintained and supported two different types of settings in which patients could receive outpatient care: clinics and faculty practices.

34. For its specialty survey, REACH used testers to call Respondents' physician referral services and ask for an endocrinologist ("endo") or a cardiologist ("cardio") for a relative who was said to pay for health care using either Medicaid FFS, Medicaid managed care, private insurance, or self-pay/uninsured.[3]

35. Testers were given a uniform script and scheduled to make calls on staggered shifts over a two-month period. The script was developed after consulting with researchers at the N.Y.U. Center for Health and Public Service Research and has been tested for its validity and effectiveness. Please see Appendix A for a copy of the script and call schedule.

36. Testers were asked to take note of the following during each call: (1) whether they were referred to a physician or directly to a clinic; (2) the names and

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[3] The survey focused on endo and cardio because of the high level of need for such specialties in the Bronx. See *supra* note 2.

numbers of all physicians to whom they were referred; and (3) the numbers for all clinics to which they were referred.

37. In cases where the caller was referred directly to the clinic, a follow-up call was made to determine (1) the type of provider who would treat the patient at that location (faculty physician, attendings, fellows, residents, and/or medical students); (2) whether the patient would have access to the physician for after-hours or weekend care, or if the patient would be referred to the emergency department; and (3) whether the physician would follow-up with the patient's primary care physician.

38. In cases where the name and number of a physician was provided, follow-up calls were made to confirm that the physician accepted the insurance type in question and the address or location for the medical visit. Also during these follow-up calls, information was gathered as to: (1) the type of provider who would treat the patient at that location (faculty physician, attendings, fellows, residents, and/or medical students); (2) whether the patient would have access to the physician for after-hours or weekend care or if the patient would be referred to the emergency department; and (3) whether the physician would follow-up with the patient's primary care physician.[4]

39. All initial and both sets of follow-up calls were recorded.

40. Institutional Review Board approval for the testing and survey was received from the Institute for Family Health.

41. The following types of calls were made for New York-Presbyterian: 4 Medicaid FFS (2 endo/2 cardio); 2 Medicaid managed care (1 endo/1 cardio); 2 private

[4] This information was gathered even in those cases where the caller's insurance was rejected and the individual was referred elsewhere.

insurance (1 endo/1 cardio); and 2 uninsured (1 endo/1 cardio). **Table 1a**, in Appendix B, summarizes where testers were referred for each of these call types.

42. Follow-up calls were also made to each of the faculty practices and the clinics for which referrals were received at New York-Presbyterian to determine if equivalent services would be offered to patients being seen in the two different settings. **Table 1b,** in Appendix B, summarizes the results.

43. The following types of calls were made for Mount Sinai: 4 Medicaid FFS (2 endo/2 cardio); 2 Medicaid managed care (1 endo/1 cardio); 2 private insurance (1 endo/1 cardio); and 3 uninsured (1 endo/2 cardio). **Table 2a,** in Appendix B, summarizes where testers were referred for each of these types of calls.

44. Follow-up calls were also made to each of the faculty practices and the clinics for which referrals were received at Mount Sinai to determine if equivalent services would be offered to patients being seen in the two different settings. **Table 2b,** in Appendix B, summarizes the results.

45. The following types of calls were made for Montefiore: 4 Medicaid FFS (2 endo/2 cardio); 3 Medicaid managed care (2 endo/1 cardio); 2 private insurance (1 endo/1 cardio); 2 uninsured (1 endo/2 cardio). **Table 3a**, in Appendix B, summarizes where testers were referred for each of these types of calls.

46. Follow-up calls were also made to each of the faculty practices and the clinics for which referrals were received at Montefiore to determine if equivalent services would be offered to patients being seen in the two different settings. **Table 3b,** in Appendix B, summarizes the results.

47. REACH also collected testimonies from patients who have experienced discrimination on the basis of source of income and/or race when attempting to access outpatient health services. These testimonies provide compelling evidence of the human cost of maintaining a system of health care that is separate and unequal. Please see Appendix C for stories from two patients who have agreed to share their experiences.

CLAIMS

Respondents Are in Violation of Hill-Burton

48. The Hill-Burton Act requires federally assisted hospitals to provide health services without discrimination based on participation in a government program such as Medicaid. 42 U.S.C. §291c(e)(1). 42 C.F.R. §§124.601, 124.603(a) and (c)(2).

49. Respondents all received federal funding through the Hill-Burton program, and are therefore obligated by the community service assurances they provided as a condition of participation in the program. See Appendix D, HHS Hill-Burton Community Service Assurance Report for New York State.

50. The community service assurance binds a recipient of Hill-Burton funding in perpetuity. Lugo v. Simon, 426 F.Supp. 28, 36 (N.D. Ohio 1976).

51. Respondent New York-Presbyterian provides endocrine care to patients in one of two settings: (1) the hospital-based endocrinology clinic operated as part of New York-Presbyterian's Ambulatory Care Network or (2) in faculty practices

located within and/or associated with New York-Presbyterian's various Centers for diabetes care through contractual or other arrangements.[5]

52. The specialty survey conducted by REACH shows that New York-Presbyterian supports and maintains a dual system of endocrine care whereby participation in the Medicaid program and, receiving Medicaid FFS benefits in particular, is one of the primary determinants of whether the patient is seen in the endocrinology clinic or the appropriate faculty practices.

53. One mechanism by which this sorting was found to occur is through the physician referral process at New York-Presbyterian. In REACH's survey, calls requesting endocrine care for Medicaid FFS patients were either referred directly to the endocrinology clinic, or referred to a physician's office, where the patient's insurance was rejected and he was referred to the clinic.[6] By contrast, when the referral service was called to request endocrine care for a privately-insured patient (Aetna PPO), two referrals were provided to faculty practices located on or in close proximity to the New York-Presbyterian medical campus. See Appendix B, Table 1a.

54. Further, the specialty survey conducted by REACH shows that New York-Presbyterian does not ensure that endocrinology clinic patients have access to the same services and quality of care as their counterparts in the faculty practices. For

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[5] Information about New York-Presbyterian's diabetes Centers can be found on the New York-Presbyterian website: http://nyp.org/services/diabetes.html. Details about the Ambulatory Care Network are also available on the website: http://www.nyp.org/services/amb-care-network.html.

[6] Survey results were unclear with respect to endocrine patients on Medicaid managed care plans who were seeking care at New York-Presbyterian. As indicated in Table 1a, in this case, the caller asked for a doctor who accepted GHI and was provided the number for the private office of a diabetes specialist, but follow-up calls to the doctor's office revealed that she only accepted the Affinity and New York-Presbyterian Medicaid managed care plans. Meanwhile, a search of the online physician referral directory on New York-Presbyterian's website (http://app1.nyp.org/fad/searchDoctor.htm) indicates that faculty endocrinologists at New York-Presbyterian only accept 3 out of the 14 Medicaid managed care plans available in New York City. The question of where a patient would be referred for endocrine care if none of the faculty endocrinologists accept his or her Medicaid managed care plan merits further investigation.

instance, as indicated in Appendix B, Table 1b, patients in New York-Presbyterian's faculty practices consistently have access to their physicians through evening and weekend office hours or telephone coverage for emergencies, while patients at the clinics are referred to the emergency room during weekends and after-hours.

55. Respondent Mount Sinai provides endocrine care to patients in one of two settings: (1) the hospital-based endocrinology clinic or (2) in faculty practices located with a complex called the "Faculty Practice Associates," which houses more than 800 physicians "who form an integral part of the Mount Sinai Medical Center," according to the hospital's website.[7]

56. The specialty survey conducted by REACH shows that Mount Sinai supports and maintains a dual system of endocrine care whereby participation in the Medicaid program and, receiving Medicaid FFS benefits in particular, is one of the primary determinants of whether the patient is seen in the endocrinology clinic or the appropriate faculty practices.

57. One mechanism by which this sorting was found to occur is through the physician referral process at Mount Sinai. In the survey, calls requesting endocrine care for Medicaid FFS patients were either referred directly to the endocrinology clinic, or referred to a physician's office, where the patient's insurance was rejected and no further referrals were provided.[8] By contrast, when the referral service was called to

[7] http://www.mountsinai.org/Education/School%20of%20Medicine/Faculty%20Practice%20Associates

[8] The results for Medicaid managed care are unclear because calls were not made asking for endocrine care using all of the 14 Medicaid managed care plans available in New York City to determine where patients would be referred for each. Notably, however, in this case, when the caller requested endocrine care for a patient using the Medicaid managed care plan GHI, he was told that no endocrinologists at Mount Sinai accept that insurance plan and the operator of the referral service did not provide any further referrals; the caller was effectively denied care based on participation in Medicaid managed care, a governmental third-party payor program.

request endocrine care for a privately-insured patient (Aetna PPO), two referrals were provided to the Faculty Practice Associates complex. See Appendix B, Table 2a.

58. Further, the specialty survey conducted by REACH suggests that Mount Sinai does not ensure that endocrinology clinic patients have access to the same services and quality of care as their counterparts in the faculty practices. Patients in Mount Sinai's faculty practices consistently have access to their physicians through evening and weekend office hours or telephone coverage for emergencies, while patients at the clinics are referred to the emergency room during weekends and after-hours. Also, patients in Mount Sinai's faculty practices are seen by board-certified faculty endocrinologists, whereas the clinic patients are seen by a rotating group of residents, who are less able to provide the continuity of care that is critical to patients with chronic conditions such as diabetes. Finally, physicians in the endocrinology clinic do not, as a matter of policy, coordinate communication and follow-up care with the patient's primary care physician, as is the practice in the faculty practices. See Appendix B, Table 2b.

59. Based upon the findings in ¶51-58, REACH alleges that Respondents New York-Presbyterian and Mount Sinai operate a two-tiered system of care for endocrinology based on payor source, in violation of the Hill-Burton obligation to make services available without discrimination to beneficiaries of governmental programs such as Medicaid.

60. Respondent New York-Presbyterian provides cardiac care to patients in one of two settings: (1) the hospital-based cardiology clinic operated as part of New York-Presbyterian's Ambulatory Care Network or (2) in faculty practices located within and/or associated with New York Presbyterian's Division of Cardiology and

Cardiovascular Interventional Therapy Program through contractual or other arrangements.[9]

61. The specialty survey conducted by REACH shows that New York-Presbyterian supports and maintains a dual system of cardiac care whereby participation in the Medicaid program and, receiving Medicaid FFS benefits in particular, is one of the primary determinants of whether the patient is seen in the cardiology clinic or the faculty practices.

62. One mechanism by which this sorting was found to occur is through the physician referral process at New York-Presbyterian. In REACH's survey, calls requesting cardiac care for Medicaid FFS and Medicaid managed care patients were referred directly to the cardiology clinic.[10] By contrast, when the referral service was called to request cardiac care for a privately-insured patient (Empire BCBS), a referral was provided to a faculty practice located on the New York-Presbyterian campus. See Appendix B, Table 1a.

63. Further, the specialty survey conducted by REACH shows that New York-Presbyterian does not ensure that cardiology clinic patients have access to the same services and quality of care as their counterparts in the faculty practices. With one exception, patients in New York Presbyterian's faculty practices were consistently found to have access to their physicians through evening and weekend office hours or telephone coverage for emergencies, while patients at the clinics are referred to the emergency

[9] http://nyp.org/services/cardiology.html

[10] The results for Medicaid managed care are unclear because calls were not made asking for cardiac care using all of the 14 Medicaid managed care plans available in New York City to determine where patients would be referred for each. Notably, however, in this case, when the caller requested cardiac care for a patient using a Medicaid managed care plan that none of the faculty physicians accept, the caller was referred to the cardiology clinic.

room during weekends and after-hours. Also, patients in New York-Presbyterian's faculty practices are seen by board-certified faculty cardiologists, whereas the clinic patients are seen by a rotating group of residents, who are less able to provide the continuity of care that is critical to patients with chronic conditions such as heart disease. See Appendix B, Table 1b.

64. Respondent Montefiore provides cardiac care to patients in one of two settings: (1) the hospital-based cardiology clinic or (2) in faculty practices associated with the Montefiore-Einstein Heart Center through contractual or other arrangements.[11]

65. The specialty survey conducted by REACH shows that Montefiore supports and maintains a dual system of cardiac care whereby participation in the Medicaid program and, receiving Medicaid FFS benefits in particular, is one of the primary determinants of whether the patient is seen in the cardiology clinic or the faculty practice.

66. One mechanism by which this sorting was found to occur is through the physician referral process at Montefiore. In the survey, calls requesting cardiac care for Medicaid FFS and Medicaid managed care patients were either referred directly to the cardiology clinic, or to a physician's office where the caller's insurance was rejected and a referral to the clinic was provided.[12] By contrast, when the referral service was called to request cardiac care for a privately-insured patient (Empire BCBS), a referral was

[11] http://www.montefiore.org/services/coe/heart/cardiology/

[12] The results for Medicaid managed care are unclear because calls were not made asking for cardiac care using all of the 14 Medicaid managed care plans available in New York City to determine where patients would be referred for each. Notably, however, in this case, the operator of the physician referral service did not ask the caller to specify which Medicaid managed care plan she was seeking a referral for; the caller was immediately given the number for the cardiology clinic.

provided to faculty practices located in Montefiore's Medical Arts pavilion or in a satellite office affiliated with the hospital. See Appendix B, Table 3a.

67. Further, the specialty survey conducted by REACH shows that Montefiore does not ensure that cardiology clinic patients have access to the same services and quality of care as their counterparts in the faculty practices. Patients in Montefiore's faculty practices are more likely to have access to their physicians through evening and weekend office hours or telephone coverage for emergencies, while patients at the clinics are referred to the emergency room during weekends and after-hours. Also, patients in New York-Presbyterian's faculty practices are seen by board-certified faculty cardiologists, whereas the clinic patients are seen by a rotating group of residents, who are less able to provide the continuity of care that is critical to patients with chronic conditions such as heart disease. Finally, physicians in the cardiology clinic do not, as a matter of policy, coordinate communication and follow-up care with the patient's primary care physician, whereas physicians in the faculty practices are more likely to do so. See Appendix B, Table 3b.

68. Based upon the findings in ¶60-67, REACH alleges that Respondents New York-Presbyterian and Montefiore operate a two-tiered system of care for cardiology based on payor source, in violation of the Hill-Burton obligation to make services available without discrimination to beneficiaries of governmental programs such as Medicaid.

Respondents Are in Violation of the Patients' Bill of Rights

69. Under the New York Public Health Law § 2803-c(1), all general hospitals are required to adopt and publicize a statement of patients' rights and responsibilities.

70. The New York State Department of Health has also promulgated regulations pursuant to the Public Health Law requiring that all general hospitals adopt and publicize patients' rights known as the "Patients Bill of Rights." N.Y. COMP. CODES R. & REGS. tit. 10, §405.7. These rights include the right to "[r]eceive treatment without discrimination as to . . . source of payment." N.Y. COMP. CODES R. & REGS. tit. 10, §405.7 (c)(2).

71. A general hospital is defined as a "hospital engaged in providing medical or medical and surgical services primarily to in-patients by or under the supervision of a physician on a twenty-four hour basis with provisions for admission or treatment of persons in need of emergency care and with an organized medical staff and nursing service, including facilities providing services relating to particular diseases, injuries, conditions or deformities." N.Y. Pub. Health L. §2801(10).

72. Respondents are all general hospitals licensed pursuant to the Public Health Law.[13]

73. Paragraphs 51-54, discussing the provision of endocrine care at New York-Presbyterian, are realleged and incorporated herein by reference.

[13] The New York State Department of Health Operating certificate numbers for Respondent hospitals are as follows: New York-Presbyterian, including the Allen Pavilion, Columbia-Presbyterian Center, and Weill Cornell (#7002054H); Mount Sinai (#7002024H); and Montefiore, including the Weiler and Moses Divisions (#7000006H).

74. Paragraphs 55-58, discussing the provision of endocrine care at Mount Sinai, are realleged and incorporated herein by reference.

75. Based upon the findings in ¶73-74, REACH alleges that Respondents New York-Presbyterian and Mount Sinai operate a two-tiered system of care for endocrinology based on payor source, in violation of the proscription against discrimination on the basis of source of payment in the Patients' Bill of Rights.

76. Paragraphs 60-63, discussing the provision of cardiac care at New York-Presbyterian, are realleged and incorporated herein by reference.

77. Paragraphs 64-67, discussing the provision of cardiac care at Montefiore, are realleged and incorporated herein by reference.

78. Based upon the findings in ¶76-77, REACH alleges that Respondents New York-Presbyterian and Montefiore operate a two-tiered system of care for cardiology based on payor source, in violation of the proscription against discrimination on the basis of source of payment in the Patients' Bill of Rights.

Respondents are in Violation of Title VI

79. Title VI provides that "no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d.

80. Regulations promulgated by HHS prohibit a recipient of federal financial assistance from "directly or through contractual or other arrangements, utiliz[ing] criteria or methods of administration which have the effect of subjecting

individuals to discrimination because of their race, color, or national origin." 45 C.F.R. 80.3(b)(2).

81. Since 1999, New York-Presbyterian and its affiliated entities received in excess of $3 billion, including federal financial assitance, from, *inter alia,* HHS, the U.S. Department of Agriculture ("DoA"), the National Aeronautics and Space Administration ("NASA"), the U.S. Department of Housing and Urban Development ("HUD"), the U.S. Department of Education ("DoE"), the Environmental Protection Agency ("EPA), and the Department of Justice ("DOJ") based on completed audit packages submitted to the Federal Audit Clearinghouse.[14]

82. Since 1997, Mount Sinai and its affiliated entities received in excess of $235 million, including federal financial assistance, from, *inter alia,* HHS, HUD, DoD, NASA, DoE, EPA, and the Department of Commerce based on completed audit packages submitted to the Federal Audit Clearinghouse.

83. Since 2001, Montefiore and its affiliated entities have received in excess of $2.5 billion, including federal financial assistance, from, *inter alia,* HHS, DoE, DoD, DoA, HUD, NASA, and the EPA based on completed audit packages submitted to the Federal Audit Clearinghouse.

84. Census data, together with information about Medicaid enrollment, shows that in the State of New York recipients of Medicaid are disproportionately African-American or Latino. According to statistics compiled by the Kaiser Family Foundation based on the Bureau of the Census' March 2005 and 2006 Current Population Surveys, 65% of non-elderly African-American and Latino persons in New York State are enrolled in Medicaid, as opposed to only 11% of non-elderly white persons. Non-

[14] http://harvester.census.gov/sac/dissem/entity.html

elderly African-American and Latino persons are therefore nearly six times more likely than white persons to be enrolled in Medicaid.[15]

85. Data obtained from the New York City Department of Health and Mental Hygiene estimate that approximately 189,000 African-American and Latino individuals receive Medicaid benefits in the Bronx, as compared with approximately 10,000 whites. Additionally, these data indicate that approximately 623,000 African-American and Latino individuals receive Medicaid benefits in New York City as a whole, as compared with approximately 178,000 whites. In absolute terms, there are almost 19 times more African-Americans and Latinos receiving Medicaid benefits in the Bronx, and 3.5 times more in New York City as a whole, than Whites.

86. Upon information and belief, African-American and Latinos are substantially more likely than Whites in Respondents' respective patient populations to qualify for Medicaid benefits.

87. Paragraphs 51-54, discussing the provision of endocrine care at New York-Presbyterian, are realleged and incorporated herein by reference.

88. Paragraphs 55-58, discussing the provision of endocrine care at Mount Sinai, are realleged and incorporated herein by reference.

89. New York-Presbyterian and Mount Sinai's practices of referring Medicaid beneficiaries, particular Medicaid FFS recipients, to endocrinology clinics, where they do not receive services comparable to those received by privately insured patients seen in faculty practices, has a disparate impact on the basis of race and national origin.

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[15] http:// www.statehealthfacts.org

90. New York-Presbyterian and Mount Sinai's practices of segregating endocrinology patients on the basis of payor does not further any important program or business objective that could not be substantially accomplished through less discriminatory means. It may be possible, for example, for New York-Presbyterian and Mount Sinai to, *inter alia,* integrate their respective endocrinology clinics and faculty practices via a single "mixed model" arrangement in which New York-Presbyterian and Mount Sinai operate both an outpatient clinic and a faculty practice in the same licensed space at the same time without any impact on New York-Presbyterian and Mount Sinai's medical malpractice liability, cost reporting structures, or reimbursement rates. See Appendix E, Correspondence Between REACH and the New York State Department of Health (January 18, 2006), discussing viability of mixed model arrangement.

91. Based upon the findings in ¶87-90, REACH alleges that Respondents New York-Presbyterian and Mount Sinai are in violation of Title VI and regulations promulgated pursuant to it.

92. Paragraphs 60-63, discussing the provision of cardiac care at New York-Presbyterian, are realleged and incorporated herein by reference.

93. Paragraphs 64-67, discussing the provision of cardiac care at Montefiore, are realleged and incorporated herein by reference.

94. New York-Presbyterian and Montefiore's practices of referring Medicaid beneficiaries, particularly Medicaid FFS recipients, to cardiology clinics, where they do not receive services comparable to those received by privately insured patients seen in faculty practices, has a disparate impact on the basis of race and national origin.

95. New York-Presbyterian and Montefiore's practices of segregating cardiology patients on the basis of payor does not further any important program or business objective that could not be substantially accomplished through less discriminatory means. It may be possible, for example, for New York-Presbyterian and Montefiore to, *inter alia,* integrate their respective cardiology clinics and faculty practices via a single "mixed model" arrangement in which New York-Presbyterian and Montefiore operate both an outpatient clinic and a faculty practice in the same licensed space at the same time without any impact on New York-Presbyterian and Montefiore's medical malpractice liability, cost reporting structures, or reimbursement rates. See Appendix E, Correspondence Between REACH and the New York State Department of Health (January 18, 2006), discussing viability of mixed model arrangement.

96. Based upon the findings in ¶92-95, REACH alleges that Respondents New York-Presbyterian and Montefiore are in violation of Title VI and regulations promulgated pursuant to it.

Respondents are in Violation of the NYCHRL

97. Under the NYCHRL, it is an unlawful discriminatory practice for any place of public accommodation "because of the actual or perceived race,… color [or] national origin… of any person directly or indirectly, to refuse, withhold from or deny to such person any of the accommodations, advantages, facilities or privileges privileges thereof…." N.Y. City Code, tit. 8, § 8-107(4).

98. Further, pursuant to the NYCHRL, an unlawful discriminatory practice is established when it is demonstrated that "a policy or practice of a covered entity or a

group of policies or practices of a covered entity results in a disparate impact to the detriment of any group protected by [the NYCHRL].” N.Y. City Code, tit. 8, § 8-107(17)(a)(1).

99. Place of public accommodation is defined in the NYCHRL as “providers, whether licensed or unlicensed, of goods, services, facilities, accommodations, advantages or privileges of any kind, and places, whether licensed or unlicensed, where goods, services, facilities, accommodations, advantages or privileges of any kind are extended, offered, sold, or otherwise made available.” N.Y. City Code, tit. 8, § 8-102(9).

100. Respondents are all places of public accommodation for the purposes of the NYCHRL and therefore must abide by its prohibitions against discrimination on the basis of race, color, or national origin.

101. Paragraphs 84-86, discussing the demographic composition of the Medicaid population in New York State, New York City and the Bronx, are realleged and incorporated herein by reference.

102. Paragraphs 51-54, discussing the provision of endocrine care at New York-Presbyterian, are realleged and incorporated herein by reference.

103. Paragraphs 55-58, discussing the provision of endocrine care at Mount Sinai, are realleged and incorporated herein by reference.

104. New York-Presbyterian and Mount Sinai’s practices of referring Medicaid beneficiaries, particular Medicaid FFS recipients, to endocrinology clinics, where they do not receive services comparable to those received by privately insured

patients seen in faculty practices, has a disparate impact on the basis of race and national origin.

105. New York-Presbyterian and Mount Sinai's practices of segregating endocrinology patients on the basis of payor does not further any significant business objective that could not be accomplished as well with an alternative policy or practice with less disparate impact. It may be possible, for example, for New York-Presbyterian and Mount Sinai to, *inter alia,* integrate their respective endocrinology clinics and faculty practices via a single "mixed model" arrangement in which New York-Presbyterian and Mount Sinai operate both an outpatient clinic and a faculty practice in the same licensed space at the same time without any impact on New York-Presbyterian and Mount Sinai's medical malpractice liability, cost reporting structures, or reimbursement rates. See Appendix E, Correspondence Between REACH and the New York State Department of Health (January 18, 2006), discussing viability of mixed model arrangement.

106. Based upon the findings in ¶102-105, REACH alleges that Respondents New York-Presbyterian and Mount Sinai are in violation of the NYCHRL.

107. Paragraphs 60-63, discussing the provision of cardiac care at New York-Presbyterian, are realleged and incorporated herein by reference.

108. Paragraphs 64-67, discussing the provision of cardiac care at Montefiore, are realleged and incorporated herein by reference.

109. New York-Presbyterian and Montefiore's practices of referring Medicaid beneficiaries, particular Medicaid FFS recipients, to cardiology clinics, where they do not receive services comparable to those received by privately insured patients seen in faculty practices, has a disparate impact on the basis of race and national origin.

110. New York-Presbyterian and Montefiore's practices of segregating cardiology patients on the basis of payor does not further any significant business objective that could not be accomplished as well with an alternative policy or practice with less disparate impact. It may be possible, for example, for New York-Presbyterian and Montefiore to, *inter alia,* integrate their respective cardiology clinics and faculty practices via a single "mixed model" arrangement in which New York-Presbyterian and Montefiore operate both an outpatient clinic and a faculty practice in the same licensed space at the same time without any impact on New York-Presbyterian and Montefiore's medical malpractice liability, cost reporting structures, or reimbursement rates. See Appendix E, Correspondence Between REACH and the New York State Department of Health (January 18, 2006), discussing viability of mixed model arrangement.

111. Based upon the findings in ¶107-110, REACH alleges that Respondents New York-Presbyterian and Montefiore are in violation of the NYCHRL.

REQUEST FOR RELIEF

112. We respectfully urge the OAG to conduct a thorough investigation of the allegations contained herein and bring Respondents into full compliance with federal, state, and local laws.

Respectfully submitted,

_____

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Bronx Health REACH

Call to Hospital

Date and time of call:	Name of caller:
Name of hospital:	Number called:

Caller Introduction:
Hi, I am calling on behalf of my *grandmother/grandfather/aunt/uncle* who is looking to see a doctor at your hospital. *She*/*He* would like to see a *cardiologist*/*nephrologists*/*ophthalmologist*/*endocrinologist*.

Typical Responses: "What insurance do they have?" OR "I can help, but first, I need some additional information."

Caller: Medicaid Managed / Medicaid (FFS) / Aetna (PPO) /Medicare / Uninsured

Caller: "My _____ is actually not with me right now. I was calling because they have limited English ability. It's probably better if I call back with them next to me, but may I ask you a quick question first?"
"Where will they be seen? Are they seeing a doctor or being sent to the clinic?"

Notes:

Appendix A: Survey Instrument and Schedule

		Endocrinology	Cardiology
Sinai	***Medicaid Fee-for Service (Straight)***	Day 1- Tester 1	Day 14- Tester 2
	Medicaid Managed Care	Day 5- Tester 4	Day 9- Tester 1
	Uninsured	Day 8- Tester 5	Day 2- Tester 3
	Medicare	Day 15- Tester 6	Day 11- Tester 7
	Aetna PPO	Day 12- Tester 8	Day 7- Tester 6
Montefiore	***Medicaid Fee-for Service (Straight)***	Day 1- Tester 1	Day 14- Tester 2
	Medicaid Managed Care	Day 5- Tester 4	Day 9- Tester 1
	Uninsured	Day 8- Tester 5	Day 2- Tester 3
	Medicare	Day 15- Tester 6	Day 11- Tester 7
	Aetna PPO	Day 12- Tester 8	Day 7- Tester 6
N YP	***Medicaid Fee-for Service (Straight)***	Day 1- Tester 1	Day 14- Tester 2
	Medicaid Managed Care	Day 5- Tester 4	Day 9- Tester 1
	Uninsured	Day 8- Tester 5	Day 2- Tester 3
	Medicare	Day 15- Tester 6	Day 11- Tester 7
	Aetna PPO	Day 12- Tester 8	Day 7- Tester 6

Appendix B: Summary of Survey Results

N.B. For some calls, testers were provided more than one referral. Follow-up calls were made for all of the referrals, and their outcomes recorded. The outcomes of these referrals are recorded in split cells in the right-hand column.

Table 1a: NEW YORK-PRESBYTERIAN Referral Results	
Patient Type: Medicaid Fee-for-Service	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller #1	**Clinic:** Given physician's name, but she specialized in only pituitary tumors → referral to another physician who does not take Medicaid, suggested clinic
Endo Caller #2	**Clinic:** Referred directly to clinic, no specific physician name given
Cardio Caller #1	**Clinic:** Referred directly to clinic, no specific physician name given
Cardio Caller #2	**Clinic:** Referred directly to clinic, no specific physician name given
Patient Type: Medicaid Managed Care	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller (GHI)	**Unsuccessful referral:** Referred to faculty practice, but office only accepts Affinity and New York-Presbyterian managed care plans
	Unsuccessful referral: Initial referral was osteoporosis specialist, whose office then referred to same faculty practice as above
Cardio Caller (Affinity)	**Clinic:** Referred directly to clinic, no specific physician name given
Patient Type: Private Insurance[1]	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller	**Doctor:** Referred to faculty practice located on medical center campus, insurance accepted
	Doctor: Referred to faculty practice near medical center campus, insurance accepted
Cardio Caller	**Doctor:** Referred to faculty practice located on medical center campus, insurance accepted
Patient Type: Uninsured	
SPECIALTY SERVICE SOUGHT	OUTCOME
Cardio Caller	**Unsuccessful referral:** Given physician's name, but no sliding fee available
	Unsuccessful referral: Given physician's name, but do not accept uninsured patients
Endo Caller	**Unsuccessful referral:** Given physician's name, but no sliding fee available

[1] For all calls made requesting an endocrinologist for a privately-insured patient, testers told the referral service that their relative had Aetna PPO. For all calls made requesting a cardiologist for a privately-insured patient, testers told the referral service that their relative had Empire Blue Cross-Blue Shield (Empire BCBS).

Table 1b: NEW YORK-PRESBYTERIAN[2] Services Offered				
Specialty	**Setting**	**Primary Caregiver**	**Follow-up with Primary Care Physician?**	**Weekend/after-hours care available?**
Endo	Clinic	Attendings	Yes	No – must go to emergency room[3]
Endo	Faculty Practice	Faculty physician	Yes	Yes
Endo	Faculty Practice	Faculty physician	Yes	Yes
Endo	Faculty Practice	Faculty physician	Yes	Yes
Endo	Faculty Practice	Faculty physician	Yes	Yes
Cardio	Clinic	Residents	Yes	No – must go to emergency room
Cardio	Faculty Practice	Faculty physician	Yes	No – must go to emergency room
Cardio	Faculty Practice	Faculty physician	Yes	Yes
Cardio	Faculty Practice	Faculty physician	Yes	Yes
Cardio	Faculty Practice	Faculty physician	Yes	Yes

[2] Table 1b, 2b and 3b do not include those follow-up calls for which no relevant information was provided.

[3] The individual answering the phone for this follow-up call was not sure whether patients seen in the clinic would be able to receive after-hours or weekend care from their physicians, or if they would be referred to the emergency room. A second follow-up call was made during the weekend, and the caller was referred to the emergency room.

Appendix B: Summary of Survey Results

Table 2a: MOUNT SINAI Referral Results	
Patient Type: Medicaid Fee-for-Service	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller #1	**Clinic:** Referred directly to clinic, no specific physician name given
Endo Caller #2	**Clinic**: Referred directly to clinic, specific physician name given
	Unsuccessful referral: Given physician's name, but insurance rejected; no further referrals given
Cardio Caller #1	**Unsuccessful referral**: Given physician's name, but insurance rejected; no further referrals given
	Clinic: Given physician's name, but only sees Medicaid FFS patients in the clinics on Fridays from 9am-12pm.
Cardio Caller #2	**Clinic**: Given physician's name, but only sees Medicaid FFS patients in the clinics on Fridays from 9am-12pm.
Patient Type: Medicaid Managed Care	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller (GHI)	**Denied service:** No physicians listed as accepting plan; no further referral given
Cardio Caller (Affinity)	**Unsuccessful referral:** Referred to faculty practice located on medical center campus, but physician does not accept Affinity
	Unsuccessful referral: Referred to faculty practice located on medical center campus, but physician does not accept Affinity
Patient Type: Private Insurance	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller	**Doctor:** Referred to "Faculty Practice Associates" office complex
	Doctor: Referred to "Faculty Practice Associates" office complex
Cardio Caller	**Clinic:** Given physician's name, but would see patient in the clinic
Patient Type: Uninsured	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller #1	**Unsuccessful referral:** Given physician's name, but no sliding fee available
	Unsuccessful referral: Given physician's name, but no sliding fee available
	Unsuccessful referral: Given physician's name, but no sliding fee available
Cardio Caller #1	**Denied service:** No physicians listed as accepting uninsured patients on sliding fee scale; no further referral given
Cardio Caller #2	**Clinic:** Referred directly to clinic, but was given specific physician's name

Appendix B: Summary of Survey Results

Table 2b: MOUNT SINAI Services Offered				
Specialty	**Setting**	**Primary Caregivern**	**Follow-up with Primary Care Physician?**	**Weekend/after-hours care available?**
Endo	Clinic	Residents	If requested	No – must go to emergency room
Endo	Faculty Practice	Faculty physician	Yes	Yes
Endo	Faculty Practice	Faculty physician	Yes	Yes
Endo	Faculty Practice	Faculty physician	Yes	Yes
Endo	Faculty Practice	Faculty physician	Yes	Yes
Endo	Faculty Practice	Faculty physician	Yes	Yes
Cardio	Clinic	Residents & Attendings	If requested	No - must go to emergency room
Cardio	Faculty Practice	Faculty physician	Yes	Call hospital
Cardio	Faculty Practice	Faculty physician	n/a	n/a
Cardio	Faculty Practice	Faculty physician	Yes	Yes
Cardio	Faculty Practice	Faculty physician	Yes	Yes
Cardio	Faculty Practice	Faculty physician	Yes	Yes
Cardio	Faculty Practice	Faculty physician	Yes	Leave message or go to emergency room

Appendix B: Summary of Survey Results

Table 3a: MONTEFIORE Referral Results	
Patient Type: Medicaid Fee-for-Service	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller #1	**Clinic:** Given physician's name, but not accepting new patients and does not accept Medicaid FFS, gave referral to clinic
	Unsuccessful referral: Given physician's name, but not accepting new patients and does not accept Medicaid FFS, no further referral given
	Unsuccessful referral: Given physician's name, but not accepting new patients, sent back to main referral line
Endo Caller #2	**Unsuccessful referral:** Given physician's name, but does not accept Medicaid FFS, no further referral given
	Unsuccessful referral: Given physician's name, but does not accept Medicaid FFS, no further referral given
Cardio Caller #1	**Unsuccessful referral:** Outdated contact information
	Clinic: Given physician's name, but does not accept Medicaid FFS, gave referral to clinic
Cardio Caller #2	**Clinic:** Referred directly to clinic, no specific physician name given
Patient Type: Medicaid Managed Care	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller #1 (no plan specified)	**Doctor:** Referred to faculty practice in Montefiore medical park
	Doctor: Referred to faculty practice in Montefiore medical park
	Doctor: Referred to faculty practice, but told that Medicaid managed care only accepted "as a last resort"
Endo Caller #2 (no plan specified)	**Clinic:** Referred directly to clinic, but specific physician name given
	Clinic: Given physician's name, but patient would be seen in clinic
	Doctor: Patient would be seen in private office in Department of Medicine
Cardio Caller (no plan specified)	**Clinic:** Referred directly to clinic, no specific physician name given
Patient Type: Private Insurance	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller	**Unsuccessful referral:** Given physician's name, but not accepting new patients, sent back to main referral line

	Unsuccessful referral: Given physician's name, but not accepting new patients
	Unsuccessful referral: Given physician's name, but not accepting new patients
Cardio Caller	**Doctor:** Referred to faculty practice in located in Medical Arts Pavillion
	Doctor: Referred to practice in satellite office affiliated with Montefiore
Patient Type: Uninsured	
SPECIALTY SERVICE SOUGHT	OUTCOME
Endo Caller	**Clinic:** Referred directly to clinic, no specific physician name given
	Clinic: Referred directly to clinic, no specific physician name given
	Unsuccessful referral: Given physician's name, but no sliding fee available
Cardio Caller	**Clinic:** Referred directly to clinic, no specific physician name given

Table 3b: MONTEFIORE Services Offered				
Specialty	**Setting**	**Primary Caregiver**	**Follow-up with Primary Care Physician?**	**Weekend/after-hours care available?**
Endo	Clinic	Residents & Attendings	Depends on physician	No – must go to emergency room
Cardio	Faculty Practice	Faculty physician	Yes	Yes
Cardio	Faculty Practice	Faculty physician	Yes	Yes
Cardio	Faculty Practice	Faculty physician	If necessary	Yes
Cardio	Faculty Practice	Faculty physician	If requested	Yes
Cardio	Faculty Practice	Faculty physician	n/a	n/a
Cardio	Faculty Practice	Faculty physician	If necessary	Yes
Cardio	Faculty Practice	Faculty physician	Yes	No – must go to emergency room
Cardio	Faculty Practice	Faculty physician	Yes	No – must go to emergency room

Appendix C: Patient Experiences

Vanessa G.

Vanessa G. is a cancer patient and Medicaid managed care recipient who was shuttled between the clinic system and the emergency room during the early stages of her disease. As a result, her condition was not diagnosed in a timely fashion, and her cancer was able to progress to a more advanced stage.

Before she was diagnosed with cancer, Vanessa was a single mom who was going to school full time and working as a nanny part time to make money. She was on food stamps and Medicaid managed care. At first, Vanessa was quite happy with her Medicaid managed care plan because she could choose a provider and go to them. Both she and her son would receive care at the Montefiore Marble Hill Health Clinic.

In 2001, when Vanessa was 27 years old, she began noticing a sharp pain on her right-hand side, near her lower abdomen. She also found that she did not have an appetite and had difficulty going to the bathroom. Vanessa went to her primary care physician at the clinic to get her condition checked out. The doctor told her that she was "doing too much" and just need to "take it easy." Vanessa graduated from school and decided to take the summer off to rest, as per her doctor's advice, but her physical problems persisted.

In the fall, Vanessa returned to the clinic to get a second check-up, but when she arrived, the nurses told her that her primary care physician was "gone." Vanessa was shocked: "what do you mean my doctor's gone? You know, they're supposed to let me know… they're supposed to… inform me when she leaves so that I can choose to stay with the doctor they replaced her with or go somewhere else." Vanessa's new doctor, like her previous one, also dismissed her physical symptoms as nothing serious. She recalls him saying, "'you know, that's just gas because you're unhealthy and you smoke and you're diabetic.'" But Vanessa had difficulty accepting this explanation because, by this time, she had a large bump on her wrist, her stomach had distended, and her lower abdomen was misshapen and "rock hard." When Vanessa pushed the new doctor, suggesting that perhaps it was a problem with her ovaries, the doctor insisted that she just needed to eat more roughage and lose weight, and he began to criticize her personal behavior. She recalls, "after that whole experience with that doctor, I felt *stupid*. That's the perfect word. I felt stupid to tell anybody anything, cause then everyone's going to say, 'you're fat, what did you expect?'"

Vanessa also tried to file a complaint about the doctor and switch to a new provider: "I kept calling my health insurance company to get… a paper to make a complaint against that doctor, and I also wanted the book where you can choose another doctor…." But she never received the relevant paperwork from her Medicaid managed care plan: "That's the whole point of managed care, to have a choice. And they never sent me anything…." In the meantime, Vanessa's physical symptoms persisted and, unable to switch to another primary care physician, she sought care in the emergency room. Again, she was told to "lose some weight and eat healthier."

That spring, Vanessa became extremely ill for about three days, unable to eat or drink because her nausea was so bad. Her parents took her to the emergency room at Montefiore,

where she was admitted immediately. A series of tests were performed on Vanessa and, eventually, the doctors decided to do a biopsy. Vanessa remained in the hospital for four days without any word about the results of her biopsy, and finally on the fourth day, she was informed that she had colon cancer: "the doctor—who is not my doctor, but she does the rounds for the whole floor—she came in with about seven interns, and she tapped my leg… 'well we finally got the results and it's cancer, okay?' And I'm like, 'okay.' [Then] she goes, 'alright, good' [and] walked out. And then every single intern touched my knee and went, 'okay?' And I went, 'okay.' Every single one of them. I'll never forget that, ever: 'okay?' 'okay.' 'okay?' 'okay.' 'okay?' 'okay.'

Vanessa later met her surgeon, who told her that it seemed like her cancer was everywhere—that it may have started in her appendix but now was in and out of her entire colon. She recalled that he didn't really explain to her what colon cancer was, but instead told her about some of the risks of the surgery to remove the cancer from her colon: "it was just very overwhelming, and there was no social worker to talk to… And no one knew anything about colon cancer! You hear about lung cancer; you hear about breast cancer; and prostate—leukemia, even—but colon? Nothing, nothing." Vanessa remained in Montefiore for another week and a half, but grew frustrated by the fact that she could not get clear answers about what was happening to her from the many, different doctors who came in briefly to treat her.

Eventually, her family was able to get her discharged to their care, and they began advocating to get a second opinion for her at another facility, where a family friend was a nurse and the assistant to an oncologist. Vanessa's Medicaid managed care plan refused to approve the second opinion, however. A several-month long battle ensued with Health First until, finally, Vanessa was able to get in to see the doctor: "He saw me and he said, 'you know, it's stage four…. It's—it's—it's everywhere. Your surgeon may not have told you but it's all over your abdomen wall and if you would've been home another week or two it would have completely burst through your wall.'"

Looking back, Vanessa realized that her condition was allowed disintegrate as much as it did because she was not able to get an accurate diagnosis and treatment early enough in the onset of the disease. Bouncing between her clinic and the emergency room, she was repeatedly told to simply eat healthier instead of being properly examined to determine if there was a more serious problem. Vanessa thinks her concerns were dismissed out-of-hand because there is a pervasive negativity among staff in clinics and emergency rooms toward Medicaid patients. She recalls that a nurse once told her: "'well, you know you people'—just like that—'you know you people with those, you know, managed care Medicaids, you guys don't really take care of yourselves anyway… [and] that's how all of the doctors feel about you guys anyway, because it's like, well, you know, if you really took care of yourself you wouldn't have managed care—you wouldn't have Medicaid.'"

Today, Vanessa is regularly treated by Dr. S, the oncologist who provided the second opinion for her. She is seen in his private faculty practice and describes the care as excellent: "they treat you like you're a person; they treat you like you matter." Vanessa is able to receive care in Dr. S's faculty practice because he was able to mobilize resources from colleagues and research grants to treat her for free: "Why? Because… there's always a blessing, even in

ugliness. If I would've gotten diagnosed right now...with the same thing, I would've been lost. But because, at that time, at 27, I was the youngest female ever diagnosed with that advanced-stage [colon] cancer. So I was a big study for them, [and] that's big money that comes in...." At the new facility, Vanessa receives a comprehensive package of care to mediate the interactions of her cancer, the treatments, and her diabetes, instead of the piecemeal care she was receiving before.

Vanessa is now also actively involved with various cancer support and advocacy groups. Through these activities, she has learned that "there are two totally different worlds" of care, even for cancer patients. Vanessa is sure that if she had not, through luck, been transported from one world of care to the other, she would not be alive today. She is happy and eager to share her story with others in the hope that the system can be improved for Medicaid patients like herself and her son.

Appendix C: Patient Experiences

Zoraima R.

Zoraima R., a longtime resident of the Bronx, has a young daughter with asthma. They are both Medicaid beneficiaries, who use the local clinic for their health care needs. Zoraima says she is frustrated by the lack of access to and continuity of care for herself and her daughter in the clinic.

Zoraima came to the Bronx from Puerto Rico 20-30 years ago and has lived there ever since. She is a working mother with an 11-year old daughter, but none of her jobs have ever provided her with health insurance, so she has been on Medicaid, on and off, for the past 20-30 years. Both Zoraima and her daughter rely on hospital and community clinics for their health care. Zoraima's daughter suffers from asthma, and Zoraima lives in constant fear and uncertainty about whether she will be able to access medical care for her in an emergency: "if… my daughter gets sick, like they come home from school [around 3:30], I don't want to go to the emergency room, because it's a time when… I could go [to the clinic] as a walk-in…. Why would I go to the emergency room if I have a doctor and I have a clinic I could take her to? [But] the clinic closes at 4…. so if I go to the clinic [at 3:30] they tell me that… they might not take me because the doctor might not want to take me. Then if I go to the emergency room they told me, 'at this time you have [the] clinic [as an option], why don't you go to the clinic?'" Shuttled back-and-forth between the clinic and the emergency room, Zoraima is never sure where she will be able to get care for her daughter in an emergency and worries that one of these days something terrible could happen.

Zoraima feels that there is a negative attitude toward Medicaid patients in the health care system: "What I see is that, well, if you [have] Medicaid, you can't complain because you're poor and you be happy that you have an insurance, you know?" But she is very excited to see that the community in the Bronx is taking action to fight against these problems in the health care system.

Appendix D: Hill-Burton Community Service Assurance Report

ALPHABETICAL LISTING OF FACILITIES BY FACILITY NAME WITHIN STATE

STATE: NCW YORK

FACILTY NAME	ID #	CITY	TYPE
MEMORIAL HOSP	360002	ALBANY	HOSPITAL
MERCY HOSP	360198	ROCKVILLE CTR	HOSPITAL
MERCY HOSPITAL OF BUFFA	360043	BUFFALO	HOSPITAL
MERCY HOSPITAL OF WATER	360026	WATERTOWN	HOSPITAL
MISERICORDIA HOSP MED C	360149	BRONX	HOSPITAL
MONROE COUNTY HEALTH DE	360192	ROCHESTER	CLINIC
MONTEFIORE HOSP	360150	BRONX	HOSPITAL
MONTGOMERY COUNTY INFIR	360012	AMSTERDAM	NURSING
MOUNT SINAI HOSP	360151	NEW YORK	HOSPITAL
MOUNT ST MARYS HOSP	360116	LEWISTON	HOSPITAL
MOUNT VERNON HOSPITAL	360136	MOUNT VERNON	HOSPITAL
MYERS COMMUNITY HOSP	360211	SODUS	HOSPITAL
N Y UNIVERSITY MEDICAL	360139	NEW YORK	HOSPITAL
NASSAU HOSP-	360131	MINEOLA	HOSPITAL
NATHAN LITTAUER HOSP	360083	GLOVERSVILLE	HOSPITAL
NEWARK WAYNE COMM HOSP	360159	NEWARK	HOSPITAL
NIAGARA FALLS MEMORIAL	360161	NIAGARA FALLS	HOSPITAL
NIAGARA FRONTIER VOC -	360044	BUFFALO	OTHER
NICHOLAS NOYES MEM HOSP	360063	DANSVILLE	HOSPITAL
NICK STERIO HEALTH CENT	360172	OSWEGO	CLINIC
NORTH SHORE HOSP	360125	MANHASSET	HOSPITAL
NORTHERN DUTCHESS HOSPI	360187	RHINEBECK	HOSPITAL
NORTHERN WESTCHESTER	360135	MOUNT KISKO	HOSPITAL
NYACK HOSPITAL	360126	NYACK	HOSPITAL
OCEAN GENERAL HOSPITAL	360169	[illegible]	HOSPITAL
ONEIDA CITY HOSPITAL	360170	ONEIDA	HOSPITAL
ORANGE COUNTY HOME AND	360085	GOSHEN	NURSING
ORLEANS COUNTY NURSING	360009	ALBION	NURSING
OSWEGO HOSP	360173	OSWEGO	HOSPITAL
PENINSULA GENERAL HOSP	360186	RCKWY BCH	HOSPITAL
PLACID MEMORIAL HOSP	360114	LAKE PLACID	HOSPITAL
PLEASANT VALLEY HOME	360014	ARGYLE	NURSING
PRESBYTERIAN HOSP	360153	NEW YORK	HOSPITAL
PUTNAM COMMUNITY HOSP	360058	CARMEL	HOSPITAL
QUEENS GENERAL HOSP	360102	JAMAICA	HOSPITAL
READ MEM HOSP	360021	HANCOCK	HOSPITAL
RICHMOND MEMORIAL HOSP	360215	STATEN IS	HOSPITAL
ROCHESTER GENERAL HOSP	360193	ROCHESTER	HOSPITAL
ROME HOSPITAL MURPHY ME	360199	ROME	HOSPITAL

Appendix E: Correspondence Between REACH and New York State Department of Health

THE INSTITUTE
FOR URBAN
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VIA OVERNIGHT MAIL

January 18, 2006

David B. Wollner
Director, Office of Health Systems Management
NYS Department of Health
Corning Tower, Room 1408
Empire State Plaza
Albany, New York 12237

Re: "Mixed Model" Arrangements

Dear David:

I am writing to follow up on the issues raised at our meeting on November 21, 2005 regarding the "mixed model" arrangement in which a hospital operates both an outpatient clinic and a faculty practice in the same licensed space at the same time. As you know, the Institute is seeking confirmation that the "mixed model" meets Department of Health approval.

As you will recall, and as described in more detail in my July 8, 2005 letter to Commissioner Novello and Dennis Whalen (a copy of which is attached for your convenience), the mixed model concept evolved due to concerns about the lower level of access to and use of health care services by minorities and low-income individuals who are covered by Medicaid or are uninsured. Hospital-employed physicians typically will see Medicaid and uninsured patients at a hospital clinic, but due to inadequate Medicaid reimbursement rates, often will not see these patients in their faculty practice offices. The "mixed model" addresses this issue by allowing for the delivery of services at a single site licensed as a hospital clinic that operates as both an outpatient clinic and a faculty practice. As a result of this arrangement, patients receive care from the same clinicians in the same location during the same hours, regardless of whether they have government insurance such as Medicare or Medicaid, commercial insurance or no insurance. Under the mixed model, services provided to government-insured or uninsured individuals are billed as hospital outpatient services, while services provided to the commercially insured are billed as private practice services.

The three issues that were raised in our meeting regarding the "mixed model" were as follows: (1) whether any malpractice-related concerns would result based on the fact that it may not be clear to patients how the services they receive are being billed (i.e., as an outpatient clinic visit or a physician practice visit); (2) how cost reports will be prepared to accurately reflect the model; and (3) how services for Medicare patients will be billed. We reviewed each of these issues with our counsel, Deborah Bachrach. As you will see from the following discussion, resolution of these issues is not difficult and does not limit the appropriateness or effectiveness of the "mixed model."

Malpractice Liability. That it may not be clear to patients whether, under the mixed model, services are billed as hospital outpatient clinic services or faculty practice services does not appear to present any medical malpractice-related concerns. The patient will be aware of both the name of the facility at which care was provided and the identity of the physician providing such care. The scope of each party's liability will be set by malpractice law principles without regard to who billed for the service. It is also worth noting that, in practice, malpractice plaintiffs frequently sue both the facility and individual physicians that treat them. In short, a patient's possible lack of understanding of the billing practices or whether the hospital or the physician may ultimately be liable in the event of malpractice involving the "mixed model" arrangement does not appear to raise any concerns related to malpractice law.

Cost Reports. Revenues and expenses associated with services provided at a mixed model site will be reported on a hospital's cost report in the same manner as if they were provided at separate hospital outpatient or faculty practice sites. In other words, revenues and expenses associated with services that were billed as hospital outpatient clinic visits at a mixed model site will be reported in the same manner as revenues and expenses associated with services provided at a "pure" hospital outpatient clinic, and revenues and expenses associated with services that were billed as faculty practice visits at a mixed model site will be reported in the same manner as revenues and expenses associated with services provided at a "pure" faculty practice site.

All costs and expenses associated with the mixed model site, including direct costs (e.g., salaries and site overhead) and indirect costs (hospital administrative and general costs), will be apportioned between the two categories based on number of visits. For example, if a mixed model site has $100,000 in annual direct and indirect costs, and 70% of its visits are billed as hospital outpatient clinic visits and 30% of its visits are billed as faculty practice visits, $70,000 of those costs will be reported as hospital outpatient clinic expenses, and $30,000 will be reported as faculty practice expenses. This will ensure that Medicare and Medicaid bear only their proportionate share of the mixed model site's costs.

Medicare Patients. We presume that most if not all of the hospital outpatient clinics interested in implementing the "mixed model" will have been previously established as "provider-based" under federal Medicare regulations. Federal regulations set several criteria for "provider-based" status which relate largely to the level of an off-site location's integration with

the main provider (here, the hospital). *See* 42 C.F.R. § 413.65. "Provider-based" status is generally attractive to hospitals because it allows for higher reimbursement rates.

Under the federal "provider-based" regulations, the hospital outpatient clinic must treat Medicare patients, for billing purposes, as hospital outpatients, not as physician office patients. 42 C.F.R. § 413.65(g)(5). Hence, services provided to Medicare patients at mixed model sites that are provider-based will be billed as hospital outpatient visits under the mixed-model arrangement.

* * *

In summary, we do not see a practical or legal obstacle to implementation of an Article 28 license site "mixed model". Moreover, the prospect of reducing the disparity in health care services would appear to be significant.

We would appreciate the opportunity to meet with you again to discuss these issues, and will contact you to schedule a mutually convenient time. In the interim, please do not hesitate to contact me or Deborah Bachrach (212-830-7223) if you have any questions.

Sincerely,

Neil S. Calman, M.D.

Enclosure

cc: Tom Fanning
John Gahan
Tom Jung
Richard Nussbaum
Robert Veino, Esq.
Deborah Bachrach, Esq.

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