

Chapter 11:

Adequacy of the Ambulatory Care Safety Net and Other Access Barriers

Key Points

- **Many patients come to emergency rooms with conditions that are preventable or best treated by a primary care provider – this is due in part to deficiencies in the ambulatory safety net. New models of care management are needed to decrease reliance on traditional emergency room care.**
- **Ambulatory safety net clinics have limited access to specialty care. New programs to increase the supply of specialty care should be pursued.**
- **Mental health and substance abuse are major public health issues and a common cause of ED visits and inpatient admissions. The State should explore expanding mental health and substance abuse services with a focus on wellness and recovery needs while maintaining acute inpatient options.**
- **Low Medicaid rates limit physician willingness to care for Medicaid patients. Rates should be set at 75% or more of current Medicare rates.**
- **Uninsured patients face the highest prices for hospital-based care. The current system should be abandoned and replaced by a system of sliding scale fees based on income with a maximum price for uninsured New Jersey residents of no more than what Medicare pays for the same service. Hospital policies should be publicly available on the hospital's website and elsewhere.**
- **Efforts should be undertaken to enhance the physician workforce in underserved areas through loan forgiveness, medical school expansions, programs to increase the diversity of medical students, telemedicine, and advocacy to increase the number of Medicare-funded training residency training positions.**
- **Special-needs populations face unique barriers to accessing care. Accommodations and programs are needed to address barriers such as transportation, communication support, and barrier-free access.**

One of the goals of a health care system is that it ought to be equitable – people should have the same health care experience regardless of socioeconomic status. Despite being the richest nation in the world, the US health care system leaves millions without insurance coverage and ranks poorly on measures of health system performance and equity in access relative to our massive investment in health care.¹¹⁹ New Jersey is not unlike much of the rest

of the nation in the types of challenges vulnerable populations face related to health and health care.

In addition to the impact on individuals, hospitals are profoundly affected by the availability of care throughout the community. In many ways, hospitals serve as the provider of last resort and deficiencies in the ambulatory care system ultimately manifest themselves in hospital emergency rooms. The Commission sought to examine the adequacy of the safety net and formed a subcommittee

¹¹⁹Davis, K., et al. *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, The Commonwealth Fund, May 2007

on “Access and Equity for the Underserved.” The Commission, guided by the subcommittee, examined deficiencies of the ambulatory care system that create pressures on hospitals and barriers for vulnerable populations seeking high quality care.

The Subcommittee and Commission’s deliberations focused on the following gaps and barriers:

1. Over-reliance on hospital emergency rooms due to access barriers for ambulatory care;
2. Disparate and/or disconnected local health planning, in connection and in cooperation with community-based partnerships;
3. The dearth of primary and specialty healthcare providers available in certain areas and for certain populations;
4. Transportation barriers for certain populations;
5. Cultural and communication barriers, including access for individuals who have mobility impairments, or are deaf, hard of hearing, blind or visually impaired;
6. Language barriers for persons for whom English is not their primary language;
7. Medical and dental care needs for individuals with developmental disabilities;
8. Lack of health insurance;
9. Historically low Medicaid reimbursement rates that compromise access.

Barriers to care can be broadly categorized as either economic, environmental, or both. Economic barriers include lack of access to health insurance, hospital finances, and Medicaid reimbursement rates. Environmental barriers include lack of geographic proximity to some other locus of care as a viable alternative to a hospital emergency room, inadequate transportation availability, language and other cultural or communication difficulties, physical access barriers for individuals with mobility impairments, well-established behaviors (one may be accustomed to accessing care through a hospital emergency room), and traditional focus on and funding of acute versus preventative care.

Three general notions provided the underpinning for the Commission’s deliberations and formulation of recommendations:

- (1) The relationship between a community and its hospitals is complex. A lack of services within a community, for example, often results in inappropriate or over-reliance on a given hospital, which strains the hospital’s finances and overall capacity. Conversely, hospital closures frequently strain community services and negatively impact capacity. What would ideally be a symbiotic relationship is often fraught with tension.
- (2) Health disparities associated with income, race, ethnicity and disability are due to a range of factors including: differential financial access to health care, differential physical access to care (e.g. distance), differential income and associated environmental conditions, and variations in personal and cultural preferences. While health care access is only part of the solution to health disparities, it is an important component. Indeed, barriers to accessing quality health care are at a least a contributing factor to the grim reality that death rates from heart disease are more than 40 percent higher for African Americans than for whites and that Hispanics are nearly twice as likely as non-Hispanic whites to die from complications of diabetes.
- (3) One of the most significant predictors of access to health services and treatment is health insurance coverage.¹²⁰ Policy changes that fall short of universal coverage will not address the root cause of current problems in New Jersey’s health care system.

I. Excess Use of Emergency Rooms for Primary Care or Preventable Conditions

Hospitals are in trouble, at least in part, because they are serving patients that are not matched with the proper level of care at the right time. Hospitals in low-income areas all too often report a large volume of cases that come to their emergency departments with late stage illnesses such as cancer and kidney failure or come repeatedly for chronic conditions such as asthma,

¹²⁰Institute of Medicine. *Insuring America’s Health: Principles and Recommendations*. Washington, DC: National Academies Press, 2004.

diabetes, and congestive heart failure. President Bush recently remarked that, “people have access to health care in America. After all you just go to the emergency room.”¹²¹ This view reiterates the false belief that emergency rooms can substitute for reliable and regular medical care. It also ignores the need for timely, cost-effective care – the Institute of Medicine estimates that 18,000 Americans die prematurely each year due to lack of health insurance.¹²² A September 2007 Rutgers Center for State Health Policy report (Rutgers Study) found that emergency department visits are on the rise in New Jersey and that a significant percentage of the visits may have been avoided through better access to primary care.¹²³

Recommendation:

Successful patient case management models should be supported and replicated in order to address the large volume of ambulatory care sensitive conditions in Emergency Departments.

For example, certain case study hospitals included in the September 2007 Rutgers Study have developed “fast track” systems to separate emergent from other cases in the emergency department. Under this model, patients are routinely referred to outpatient clinics for non-emergent care. Other hospitals are having success as a result of developing elaborate case management and chronic disease management systems within the emergency department itself. While this is a clear departure from the traditional role of the emergency department, these facilities have decided that community need and patient preference have made the departure necessary.

Additionally, New Jersey should seek to replicate and implement emergency room (ER) diversion programs. Under such programs, hospitals employ a nurse to provide care management to patients after their ER visit. For Medicaid clients enrolled in an HMO, after the ER visit, the care manager works with the patient and the HMO in order to ensure that the proper follow-up care is

coordinated with the patient’s primary care provider. In cases of Medicaid fee-for-service, the care manager connects the patient with a Federally Qualified Health Center (FQHC) to provide them with a medical home. The goal is to provide primary care as part of the continuum of care needed to prevent complications of chronic diseases and other acute episodes of illness.

II. Challenges Accessing Specialty Care at Community Health Centers

Through a network of ninety-six satellite sites located statewide, New Jersey’s nineteen Federally Qualified Health Centers (FQHCs) provide high quality preventive, primary, and acute care medical services for its medically underserved population. In addition, community-based health centers, such as Volunteers in Medicine, family planning centers, and the like provide similarly necessary services.

While the FQHCs and community health clinics are models for providing high quality primary and preventive care services, most of these sites are not equipped to provide specialty care services for a wide range of specialty care needs of their patient population. At present, for example, most FQHCs provide specialty care services through referrals to specialists affiliated with local hospitals or specialty care clinics as needed. These referrals generally require payment on the part of patients to the specialty provider. Only a handful of these health centers have on-site specialty care services for selected specialties.

Since many of the medically underserved areas also suffer from severe shortages in health care providers, in many instances, the current referral system fails to provide timely treatment for the health center patients often resulting in harmful health effects, high number of emergency department visits, and costly hospitalizations.¹²⁴ It should be noted that federal legislation

¹²¹July 10, 2007; Cleveland, OH: <http://www.whitehouse.gov/news/releases/2007/07/20070710-6.html>

¹²²Institute of Medicine. *Hidden Costs, Value Lost: Uninsurance in America*. Washington, DC: National Academies Press, 2003.

¹²³“Hospital Capacity, Patient Flow, and Emergency Department Use in New Jersey,” Derek DeLia, Ph.D., September 2007. Available online at: <http://www.cshp.rutgers.edu/Downloads/7510.pdf>

¹²⁴For additional discussion of recommendations related to the FQHCs’ role in New Jersey, go to: <http://www.njpc.org/Medical%20Home%20Document.pdf>

increasing the number of FQHCs across the country would provide a meaningful impact on the medically underserved community.

Recommendation:

Increase the primary care infrastructure and supply of specialty care to patients served by FQHCs and community-based clinics. This effort will require identifying willing providers and financing such care.

One solution proffered to pursue this recommendation was to encourage the New Jersey Primary Care Association (NJPCA), in collaboration with the Medical Society of New Jersey (MSNJ) and New Jersey Hospital Association (NJHA), to work to establish an expanded network of specialty care providers and hospitals to provide additional specialty care support for the health centers. By negotiating letters of agreement with specialists and participating specialty care clinics and hospitals, health centers could refer their patients as needed.

A related solution would encourage FQHCs and other clinics to provide on-site specialty care along with primary care. The NJPCA has identified three approaches to providing on-site specialty care. Since case overload is a major reason for backlog in the existing system of specialty networks, the first approach would be to recruit retired specialists to provide volunteer specialty care services on-site at the health centers. Costs associated with this approach include the cost of maintaining a valid license, the cost of Continuing Medical Education (CME) credits and the cost of malpractice liability coverage. Legislative support at the national level is also needed to extend medical malpractice liability protections to volunteer physicians at community health centers. (H.R. 1313, the “Community Health Center Volunteer Physician Protection Act of 2005” was introduced in November 2005 to amend the existing Public Health Service Act to provide liability protections for volunteer practitioners at health centers.) A New Jersey alternative to this Federal legislation was introduced in 2003. While these bills would act as a catalyst to help bolster the infrastructure of physicians who volunteer service, both have been stalled in the process.

A second option would be to hire retired specialty care physicians on a part-time basis at the health care centers. Once employed, these physicians would be eligible for malpractice coverage under the Federal Tort Claims Act of 1992.

Under a third approach, health centers would contract with practicing specialists to provide on-site services for a few hours each week in high priority specialty areas. Physicians from FQHCs and community clinics should also be encouraged to join the medical staff of a single local hospital – in order to encourage patient care through a team approach.

III. Mental Health and Substance Abuse Services

Local hospitals are an integral part of the community mental health and substance abuse systems with much of the emphasis placed on meeting the most acute, serious needs of these populations. Many hospitals offer a continuum of psychiatric and substance abuse services, which function as acute care diversion services, as well as step-down options from more intensive services. These hospitals, embedded in the community, are critical in responding to the needs of the community members. Users of mental health services depend on local hospitals that provide mental health treatment in addition to other services. It is worth noting that an estimated one in five people in New Jersey will experience a diagnosable mental illness, and that the National Association of Mental Health Program Directors estimates that people with mental illness live, on average, 25 fewer years than do persons not so afflicted. When hospitals close, it is imperative that these critical services remain available to the community at the same level of accessibility and clinical intensity.

While hospitals serve as an important part of the mental health and substance abuse treatment system, many patients seeking medical treatment in emergency rooms present with signs of mental health or substance abuse problems. According to the 2007 Rutgers Study, New Jersey hospitals have increasingly become providers of care for mental health and substance abuse patients, particularly through the emergency department. A number of emergency department physicians have attributed this rise to a decrease in the number of

psychiatric beds and detoxification services and insufficient funding for community-based mental health and substance abuse care. Many admissions to emergency rooms are often related to drug or alcohol misuse. Substance abuse-related emergency room visits represent an opportune moment for screening, brief intervention, and referral to treatment services. Currently, this practice is not widely implemented.

The continuum of preventive, non-acute care provided by community-based and hospital providers is less expensive, effective, and preferable to costly emergency-based care. Available services and funding sources from hospital closures could be transitioned to replacement community or hospital-based services, and when possible, to more wellness and recovery-oriented services.

Recommendation:

State health policy should expand mental health and substance abuse capacity in the community, prioritize funding for mental health and substance abuse services, and insist on tailoring services to patients' wellness and recovery needs. In addition, it is also critical that acute psychiatric and detoxification services, emergency and acute hospital inpatient care continue to be available in a hospital setting.

As noted above, this could be funded through a reallocation of resources available once a hospital closes. Similar resource shifts should likewise occur for substance abuse services, now available on an inpatient basis in only limited parts of the State.

IV. Disconnect between community needs and the Certificate of Need process

The Subcommittee noted that the existing Certificate of Need (CN) process, which, in relevant part, examines availability and continuity of community resources when a hospital is considering closure, is ripe for examination and can be strengthened.

Recommendation:

Institute a community-based health planning process that encourages partnerships and includes community resources so that access to basic and essential healthcare services is a proactive, rather than a reactive endeavor.

V. Historically Low Medicaid Reimbursement Rates Limit Access

New Jersey's historically low provider reimbursement rates for fee-for-service Medicaid are well documented. A comparison of all states in 2003 found that New Jersey had the lowest reimbursement rates in the nation. Low rates have been directly associated with adversely impacting access to a variety of healthcare services.¹²⁵ Indeed, the abysmally low reimbursement rates have severely impacted the availability of healthcare professionals who are willing and/or financially able to offer services to Medicaid patients.

Recommendation:

To improve the availability of quality care, the Commission recommends that New Jersey set provider reimbursement rates for Medicaid and other state-funded health care services at 75% or more of current Medicare rates.

The Commission did note that Governor Corzine's 2008 Budget Initiative to include \$5 million (a \$20 million figure once annualized and matched with federal dollars) to increase Medicaid rates for services to children was a first and meaningful step to address this long-standing concern.

VI. High Prices for the Uninsured

Uninsured patients seeking care at New Jersey hospitals and elsewhere often face the highest prices for services of any patients entering the door. In nearly all cases, they are least able to afford it and receive extremely high bills following discharge. While they often can't and don't pay the entire bill and can frequently negotiate a discount, this sometimes only happens after facing collection procedures such as wage garnishment, levies on bank accounts, and property liens.

This unfair and objectionable situation arises from the fact that the no organized entity negotiates prices on behalf of the uninsured. This practice has been under

¹²⁵Zuckerman, S., McFeeters, J., Cunningham, P., Nichols, L. Changes in Medicaid physician fees, 1998-2003: implications for physician participation. *Health Affairs*, 2004; W4: 374-84.

scrutiny in recent years but the hospital industry has yet to adopt a uniform solution that could at least bring charges for uninsured patients in line with what most patients pay by way of their insurer.

Recommendation:

Uninsured patients who are residents of New Jersey should be charged on a sliding scale based on income with a maximum set at the price Medicare pays hospitals for the same services. A hospital's sliding scale policy (i.e. prices charged the uninsured) should be publicly available on the hospital's website.

This maximum price would add a small dimension of fairness to current billing practices despite the fact that the uninsured would continue to face bills that would be beyond their financial means. Hospitals should be required to develop a sliding fee schedule based on income where the Medicare rate would be the maximum financial exposure for an uninsured patient from New Jersey. Fairness also dictates that hospitals should make their sliding scale policies publicly available on their website so that patients can know what to reasonably expect when hospitalized at a given institution.

VII. Workforce Issues and Graduate Medical and Dental Education

According to the New Jersey Council of Teaching Hospitals, New Jersey's teaching hospitals provide 70 percent of the medical care to the uninsured and underinsured. Faculty medical staff and physician residents are key care providers to New Jersey's medically underserved. New Jersey ranks 18th in the nation as to the number of physicians in training relative to the State's population. Furthermore, New Jersey has a particularly high percentage (39.7%) of practicing physicians who are International Medical Graduates (IMG), ranking us 2nd in the nation.

According to the Medical Society of New Jersey, our State is currently experiencing a shortage of physicians in the fields of obstetrics and gynecology, pediatric subspecialties, neurosurgery, anesthesiology, family practice, and general surgery. There is a similar shortage of dentists and other oral health practitioners. A September 2000 GAO report, "Factors Contributing to

Low Use of Dental Services by Low-Income Populations," discusses not only the low Medicaid reimbursement rates for dentists but also the short supply of dentists in many areas.¹²⁶

Workforce policy is a critical issue demanding attention as New Jersey attempts to rationalize the health care system. However, the issue is complex and was beyond the scope of this Commission. A study of workforce issues is warranted and should be undertaken as part of a separate commission. Several suggestions arose in this Commission's deliberations that warrant future consideration:

- Provide loan forgiveness and scholarships to professionals willing to serve in medically underserved areas or in professional specialties experiencing workforce shortages. Targeting incentives to areas of greatest need is important for making health care services available where they are needed most. For example, Medicaid could focus its Graduate Medical Education (GME) funding to the specialties experiencing the greatest workforce shortages. This funding would provide relief to practitioners in potentially vulnerable institutions by in essence providing additional funding for uncompensated care.¹²⁷ Advocacy is also needed on the federal level to increase annual awards to physicians by the National Service Corps to encourage more doctors and dentists to practice in underserved areas while addressing rising medical/dental student debt.
- Boost class sizes in existing medical schools and establish new medical schools.
- Advocate increasing the number of residency training positions funded by Medicare to accommodate additional medical/dental school graduates.
- Increase minority recruitment and training in the State's medical schools. The percentage of minority enrollees in medical schools remained

¹²⁶<http://www.gao.gov/archive/2000/he00149.pdf>

¹²⁷Gbadebo, A.L., Reinhardt, U.E. Economists on academic medicine: elephants in a porcelain shop? *Health Affairs*, 2001; 20: 148-52.

essentially unchanged between 1970 and 1996, and continued at a rate lower than minority representation in the general population. Addressing this trend is important because minority physicians most often serve in minority communities and underserved areas. State policy should establish goals to encourage the recruitment and training of health care providers whose race, ethnicity, and language reflect the composition of the state and communities in need.

- Develop telemedicine programs for remote areas. Telemedicine approaches enable the transfer of medical information – including medical images, two-way audio and videoconferences, patient records, and data from medical devices – for diagnosis, therapy and education. New Jersey should make use of currently available technology to develop and support telemedicine systems that provide medical expertise to underserved geographic areas of the State. Specifically, New Jersey could explore exercising Medicaid options for reimbursing telemedicine services and protect patients by requiring out-of-state physicians to be licensed to provide telemedicine services.

VIII. Lack of Practical Transportation Options Hinders Access to Care

For those individuals who are not Medicaid eligible, transportation was noted as a significant barrier to accessing healthcare – especially in more rural communities and other areas where a robust transportation infrastructure for seniors and those with disabilities is unavailable. In addition, the lack of coordination among existing systems which serve specialized populations creates duplication and increased costs.

Transportation needs are best resolved through local planning and should figure prominently in the community and regional planning noted above. The federal government has initiated a “United We Ride” initiative that requires states to enhance access to transportation to improve mobility, employment opportunities, and access to community services for persons who are transportation-disadvantaged, including

seniors, individuals with disabilities, and low income households. (New Jersey’s Department of Human Services manages this initiative.)

Recommendation:

The health care community should be engaged in the “United We Ride” planning initiatives to ensure the transportation needs of the medically underserved are addressed.

When available, transportation for persons who are Medicaid eligible may be coordinated with existing county Para-transit trips. This will increase cost efficiency and reduce duplication of trips routing.

IX. Barriers for Special Needs Populations

Cultural and communication barriers exist for a number of special needs populations, including access for individuals with disabilities, including persons who are deaf, hard of hearing, blind, or visually impaired, or those for whom English is not a primary language.

A. Individuals who are Deaf or Hard of Hearing

Generally speaking, the health care access needs of deaf and hard of hearing populations are similarly affected by the same access and equity issues described for other vulnerable groups. One complicating factor, however, is the ability of health care professionals to meaningfully communicate with persons who are deaf or hard of hearing, such that the quality of care rendered is not compromised. A 2005 study examining health care system accessibility issues of deaf people found communication to be a pervasive problem and barrier.¹²⁸

Technological advancements are increasingly available, as are traditional resources such as American Sign Language interpreters, although in diminishing supply. These resources can provide meaningful communication for those with special needs. Access remains largely dependent, however, upon a healthcare facility’s investment in and commitment to ensuring adequate availability of human or technological resources with those who require such assistance.

¹²⁸Steinberg, A.G et al. Health care system accessibility: experiences and perceptions of deaf people. *J Gen Intern Med.* 2006; 21(3): 260-66.

B. Individuals who are Blind or Visually Impaired

The ability to access health care is often dependent on the ability to complete health forms. Lack of alternative media for medical forms and the availability of staff to read forms creates a major barrier for sight impaired individuals. A 2007 study conducted by the National Council on Disability points to the importance of providing health care forms and information in alternative formats for those with visual impairments.¹²⁹ As with other populations, access to transportation is also an important issue.

C. Individuals with Physical Disabilities

Generally speaking, the health care needs of individuals with physical disabilities are similarly affected by the access and equity issues noted above. Two complications, however, are barrier-free access to the locus of care and meaningful access to transportation. The previously cited National Council on Disability report identified access to transportation as a significant barrier to accessing health care. An example of a substantial barrier for this population is the lack of availability of accessible examination tables for persons who are non-ambulatory.

D. Individuals with Developmental Disabilities

The medical needs of individuals with developmental disabilities range enormously in their complexity. A 2002 Surgeon General's report outlined the challenges in obtaining these services.¹³⁰ For those with a mild to moderate disability, access to traditional hospital venues and/or community care clinics may suffice for routine medical or dental needs. For those with significant developmental disabilities, however, access to specialty medical and dental care, as well as mental health care (if needed) is critical. Additional behavioral supports may

be required for patients with challenging behaviors in order to facilitate the exam and treatment provided by the physician or dentist. A 2005 report by the Special Olympics highlights the gaps in health care for those with developmental disabilities.¹³¹ The issue of transportation, akin to that which was noted for individuals with physical disabilities, is also a barrier to accessing health care services. It should also be noted that the recently-enacted Danielle's Law has rendered some unintended stressors upon hospital emergency rooms, as the frequency of such visits has increased.

Recommendations:

While it is difficult to generalize the accessibility concerns of special needs populations, basic accommodations such as communication support, barrier-free access, and specialized care are not always costly and should be prioritized.

One example of an important and low-cost effort towards effective communication is the Communication Picture Board, prepared through a collaboration of the New Jersey Department of Health and Senior Services/Office of Minority and Multicultural Health and the New Jersey Hospital Association. This board utilizes a variety of pictures to enhance one's expression of needs, and is designed for use by emergency service personnel and frontline intake staff to better enable effective communication with the public.

The establishment of Centers of Excellence for medical, mental health and dental care for individuals with developmental disabilities should be explored.

For individuals with developmental disabilities, the dearth of medical and dental specialists is particularly acute. Accessibility and communication are significant barriers to medical and dental services.¹³²

¹²⁹National Council on Disability. Implementation of the Americans with Disabilities Act: Challenges, Best Practices, and New Opportunities for Success. 2007. Available at: http://www.ncd.gov/newsroom/publications/2007/implementation_07-26-07.htm

¹³⁰U.S. Surgeon General. Closing the Gap: A National Blueprint to Improve the Health of Persons with Disabilities. 2002. Available at: <http://www.surgeongeneral.gov/topics/mentalretardation/retardation.pdf>

¹³¹Special Olympics. The Health and Health Care of People with Intellectual Disabilities. 2005. Available at: http://www.specialolympics.org/NR/rdonlyres/e75okatixbkeht-trnuutheossutueniq7hsd6ev6bg3astpgwfmabbzfwy5ph2tbjoiz3gnjuzum6hhbjgljh6nl36d/CACW_Health.pdf

¹³²See <http://rtc.umn.edu/nhis/> & <http://www.Pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1783697&blobtype=pdf>

X. Language

The increase in immigrant groups in New Jersey, coupled with higher incidence of chronic health care conditions requiring regular health care monitoring, argues strongly for health care services that can adequately serve linguistically, ethnically and culturally diverse families.

Recommendation:

New Jersey's health care system must provide appropriate *professional* interpretation and translation services along with outreach and educational materials in the language of patient populations and should be reimbursed for such services by all payers.

The health care system too often relies on makeshift methods to overcome language barriers, compromising quality and equity. Translation services and language appropriate outreach and education should be a priority. Title VI of the Civil Rights Act and U.S. Department of Health and Human Services regulations prohibit all recipients of federal funding, either directly or indirectly, from discriminating on the basis of national origin to provide equal access to services and activities. All such entities are obligated to take steps to provide meaningful access to services for people with limited English proficiency, with specific guidance for healthcare organizations issued by DHSS through the Office of Minority and Multicultural Health. This guidance reiterates the various methods and criteria for satisfying this obligation through professional interpreters (not patients' family members) and translated materials.

Since most health care providers (hospitals, doctor's offices, health maintenance organizations, nursing homes, community health centers, etc.) receive some federal funding, virtually all health care providers are obligated to provide appropriate language access to patients with limited English. In 2000, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) stated that federal Medicaid and SCHIP funds can be used for language services and activities for Medicaid beneficiaries. Several states have taken advantage of this method to maximize federal funding in this area and reimburse providers for this service. Since language access is a significant barrier to health care and relevant to racial and ethnic health disparities, this method for reimbursement should be adopted by New Jersey.

XI. Conclusion

Vulnerable populations are profoundly affected by the problems in our State's health care system. Low-income patients struggle to access specialty care in community health centers, poor reimbursement rates impose barriers for Medicaid beneficiaries, uninsured patients seeking hospital-based care are charged the highest prices, deficiencies of the mental health care system manifest in crowded hospital emergency rooms, and special-needs populations face unique barriers to accessing care. The Commission has put forth a range of recommendations aimed at reducing these barriers and improving health equity.

