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*Putting the public back in public health

UNDERSTANDING THE HEALTHCARE SYSTEM

a manual for CABs and CBOs

revised April 2024

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Introduction

Welcome to the introduction to *Understanding the Health Care System*.

What we would like to accomplish with this manual: The healthcare/medical care system is quite complicated – some think it is deliberately so that those not in it won't understand it. But we feel that it is important for all of us to understand this critical system that affects so much of our lives. We also believe very strongly that all of us should play an important role in planning and shaping what the system looks like, who it serves, and how services are provided. For us to play a role, it is important to understand what it is, and how it works, and for whom.

For thirty years, CPHS has played an important role in advocating for communities to have a seat at the table where healthcare is being planned, discussed, and evaluated. Having information available can lead to more comfort in sitting at the table. Rather than creating an even larger document, we will try to provide you with the links and means to access additional information that you might be interested in gathering.

There are opportunities to participate in the health care system at this time and there may be more coming up when, and if, the federal government approves the state Medicaid waiver amendment which, as written, had several ways for community organizations and community residents to participate. There are many problems in the current way that health care services are delivered in this state. We have an opportunity to raise our concerns and recommend changes in several ways and several places. Taking this opportunity after you have a better understanding of how things work could be a major contribution to your community.

Some current ways of participating:

- The Federally Qualified Health Centers (FQHCs) are required to have at least 51% of the board members be consumers of care. Each of the FQHCs have their own way of selecting board members so check their web sites or go to the office and ask for this information. You can locate an FQHC in your community on the web site of the statewide organization: Community Health Care Association of New York State (CHCANYS). FQHCs, like public hospitals, have a mandate to serve everyone in their community, regardless of the person's ability to pay.

- In New York City, each of the public hospitals, nursing homes, and ambulatory care centers are required to have a Community Advisory Board (CAB) that meets regularly. The CAB must have a majority of members be consumers of services at that facility or parents/guardians of patients. The CAB members are appointed by: the Community Boards; the Borough President; the Executive Director of the facility; and Hand the President of Health and Hospitals, the large operation responsible for all of the public facilities.

- The Community Boards, the planning bodies in each of the 59 districts in the city. Each of the boards have responsibility for planning and review in their communities. Most of the boards have a Health and/or Health and Social Services committee.

- Some private hospitals have advisory boards. Check the hospital's website or ask the community relations office.

- There are community-based organizations that have contracts or relationships with the hospital in the community so ask around in your community.

- In 2024, with approval of the state Medicaid 1115 waiver amendment New York Health Equity Reform, community-based organizations have the opportunity to contract with the newly designated Health Related Social Needs (HRSN) organizations to provide social support for Medicaid patients. See **The Section 1115 Medicaid Waiver Amendment** chapter of this document for more information.

Our hope is that if you are already involved by sitting on a board, serving on an advisory committee, or volunteering in some other way, this document will be helpful to you in understanding and using the information we provide. If you are not yet involved or do not have a seat at the table, we would encourage you to decide to play a role in the healthcare system. The goal is to arm you with enough information to offer you confidence and an understanding that the complexity of the system can be unwrapped and made available to you and others in the community.

What is the system?

This section will provide an overview of the different types of healthcare facilities in NYC; the city and state Departments of Health; major healthcare systems and networks in New York City, including Academic Medical Centers; and how hospitals and hospital systems are classified.

Healthcare facilities

Various kinds of healthcare facilities make up the landscape of healthcare in New York City. These include the following:

* *Federally Qualified Health Centers, or FQHCs.* These are community-based providers that care for uninsured, underinsured, or otherwise underserved populations. They are funded by the federal government's Health Resources and Services Administration (HRSA) Health Center Program.

* *Home Health Care and Hospice.* Home Health Care refers to care for an illness, injury, or medical condition in the patient's home; services can range from speech therapy to nursing services to support for daily activities of living. The New York DOH offers a Medicaid-funded Home Care program for older individuals or individuals with a disability, which includes options for personal care such as housekeeping and managed long-term care for health conditions. Hospice refers to at-home end-of-life palliative care for the terminally ill.

* *Nursing Homes and Long-Term Care Centers.* These provide long-term residential services to adults whose medical needs may require regular clinical care but not hospital-level services. There are also short-term rehabilitation beds in hospitals and nursing homes for people who need additional care before going home.

* *Adult Care Facilities (ACF)/Assisted Living.* These facilities provide long-term residential services to adults who are unable to live independently but do not have significant medical needs that require continual, in-patient level care.

* *School-Based Health Centers (SBHC).* Run by local hospitals, community organizations, and medical centers and overseen by NYCDOH and NYSDOH, SBHCs can be found in 387 NYC schools. They provide free primary and preventive care services to students. They are supported by Medicaid and other insurance billing. In addition to SBHCs, the city health department is required by city charter to provide nursing services in all public and private schools.

* *Substance abuse treatment programs.* Programs can either be in-patient/residential, offering a safe place to live and receive care, or outpatient, enabling greater flexibility.

* *Overdose Prevention Centers (OPCs) and Syringe Service/Exchange Programs (SSPs/SEPs).* These facilities provide harm reduction services to people who use drugs (PWUDs), including a safe space to consume previously acquired drugs under the supervision of trained staff, needle exchange, and Narcan training and distribution, among other services.

* *Behavioral and mental health treatment centers.* These encompass both inpatient and outpatient options for behavioral health, mental health, and substance abuse treatment.

* *Urgent care centers.* Urgent care centers are ambulatory care centers for patients who have pressing medical needs but may not need to or be able to access an emergency department within a hospital.

* *Primary care/preventive care clinics.* Primary care providers are the first point of contact for many health needs and are especially valuable for preventing, diagnosing, and managing chronic conditions; providing check-ups, screenings, and immunizations; and generally supporting health and wellness goals.

* *Private medical practices.* Though many physicians operate out of solo office-based practices, these are becoming increasingly rare. Larger multispecialty groups are more common.

* *Hospitals.* Hospitals are either public or private and can be further classified as Critical Access (New York's 13 critical access hospitals are in rural areas of the state), Safety Net (see "**How is the system funded**?" for a discussion of Safety Net hospital criteria), Community (which typically provides more short-term and preventive care), or Specialty (focusing on a particular subset of patients or services) hospitals.

The role of the city's Department of Health and Mental Hygiene

New York City is also unique in that it has one of the nation's oldest and largest health departments. The City DOH, known as the Department of Health and Mental Hygiene, is a part of the city government. It is a regulatory body overseeing and supporting public health in NYC. Their scope is wide-ranging and wide-reaching, spanning mental health care; HIV/AIDS treatment and prevention; environmental health; maternal, infant, and reproductive health; and oversight

of health equity initiatives. The City DOH has the major responsibility to collect and report data that paints the public health picture of the population. There is a Board of Health, whose members are appointed by the Mayor, that has oversight of the department.

The State DOH is a part of the state government. Similar to the City DOH, it is a regulatory body that responds to pressing public health challenges, but its oversight and regulations affect the entire state of New York, not just NYC. These regulations can be found in Title 10 of New York Codes, Rules and Regulations. You can also learn more in the **"What is available to protect patients and promote equitable access?"** section of this document. Importantly, is responsible for monitoring the institutions that provide health services. The state DOH is also responsible for Medicaid, and the state Medicaid director is on the staff of the department. The growth or reduction in services is regulated by the State DOH under the Certificate of Need (CON) program. The State DOH is also responsible for program development and determination of distribution of dollars under these programs. Health equity has become an important component of the work of State DOH. The Public Health division has major oversight of the health of the state's population.

In New York State, as in 25 other states in the US, public health is decentralized, meaning that local governments and local health departments have more authority in carrying out public health programs and initiatives.[1] Federal and state bodies set regulations and provide guidelines, but it is the responsibility of the local governments and local public health departments to operationalize public health protocols and serve the needs of their specific communities. The City and State DOHs are just two players in New York's public health system, which also includes public and private organizations, providers and insurers, and community organizations.

Institutions and networks in New York City

New York City is home to multiple medical schools and other health professions training programs, including SUNY Downstate College of Medicine in Brooklyn; Albert Einstein College of Medicine in the Bronx; and CUNY School of Medicine, Touro College of Osteopathic Medicine, Columbia University Vagelos College of Physicians and Surgeons, Weill Medical College, Icahn School of Medicine at Mount Sinai, and New York University School of Medicine in Manhattan. These are each associated with Academic Medical Centers (AMCs), which combine

[1] "Strengthening New York's Public Health System for the 21st Century," New York State Department of Health, August, 2004, https://www.health.ny.gov/press/reports/century/phc_nyssystem.htm.

health professions schools or training centers with teaching hospitals and/or larger health systems.

The landscape of hospitals and healthcare institutions in New York City has changed over time. Over a period of many years, hospitals have closed and/or discontinued certain services, often maternity service and psychiatric beds. The state changed the bed to population ratio, lowering the numbers of beds per hospital needed across the state. The governor agreed, setting up a private commission to determine which hospitals could be closed, reduced, or merged with other hospitals. Attached to the proposed report to come from this commission was the governor's proposal to apply for a Medicaid waiver amendment to ensure that dollars would be available to accomplish these proposals, and more. The state legislature was left with the position of approving the total report or the governor would not apply for the added federal dollars to come from the Medicaid waiver (the Federal-State Health Reform Proposal, F-SHRP). The commission's report was submitted and, because of its intent to reduce the number of hospital beds and hospitals, it was the impetus following that further reduced and closed hospitals.

One problem, among many, is the lack of focus on equity issues in the work of the commission. Following a pattern, many of the hospitals that closed were located in low-income, often communities of color without regard to community need. In addition, the commission's report recommended consolidation of hospitals into larger hospitals, a pattern that is continuing to this day. The commission also had a subcommittee that focused on the hospitals in Central Brooklyn, with recommendations for specific consolidations – e.g., that Interfaith and Wyckoff Hospitals become part of the Brooklyn Hospital Center. A description of the commission report and the implementation of the recommendations can be found here.

NYC Health + Hospitals

New York City had public hospitals run under a city agency, the Department of Hospitals, for many years. The system was always underfunded, and probably mismanaged. It was the subject of commissions and legislative oversight hearings, as well as the subject of much negative media attention. Despite all of the piled on bad news, it is also true that there were 20 public hospitals that were available, accessible, and free of charge to the patient. This was before the passage of Medicaid and Medicare and thus there were many uninsured residents in the city, so this access to care was important. Some of the private, non-profit hospitals also provided care for the uninsured, but it would never have been anywhere near enough for low-income residents. A decision was made to ask the state to pass legislation setting up a public benefit corporation to

run these facilities. After much debate and negotiations, the state enacted McKinney's Unconsolidated Law in 1969, in which the Health and Hospitals Corporation was to be in operation by July 1970. Although this action meant a partial privatization of the system, the language was very clear that patients were to be provided care regardless of their ability to pay.

Of particular interest for community residents and organizations, Harlem CORE fought for language that would allow a sub-corporation run by the community, for a hospital to be developed, though this has never happened. Also of note, there is language in this legislation that requires a community advisory board to be set up at each of the public facilities. There was specific language that required each community advisory board to consider and advise the facility about any plans or programs. Over the years since HHC's creation, this provision has been the subject of lawsuits by CABs. In one particular lawsuit, Greenpoint Hospital CAB v. HHC, a judge wrote out what consultation with CABs was required by the corporation in the circumstances. Despite the outcome in this case, there are still some disagreements - and much discussion between CABs and HHC - about what kind of consultation is required by the statute.[2]

As of February 2023, there are 60 hospitals in NYC across the five boroughs. As of March 2024, there are current proposals to close two hospitals: one in Manhattan and one in Brooklyn.

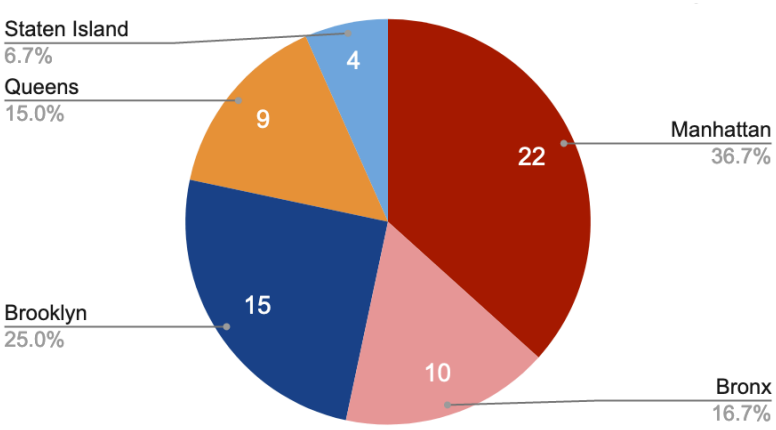

Figure (right): Distribution of Hospitals in New York City

NYC hospitals that are members of the Greater New York Hospital Association (GNYHA) and their associated networks can be found in the **Appendix section** of this document.

[2] Judy Wessler and Linda Ostreicher, *Executive Summary: Sinking to the Bottom Line* (New York: Commission on the Public's Health System, 2001). http://www.cphsnyc.org/cphs/reports/may_2001-_sinking_to_the_bottom/http__cphsnyc_org_pdf_sinking.pdf.

On New York City hospitals' nonprofit status

A 2022 report from the AHA indicated that 84% of hospitals in the US are community hospitals, and among those community hospitals, 58% are not-for-profit, 24% are investor-owned and for-profit, and 19% are run by state and local governments. Compared to the US at large, NYC has created a stronger safety net and developed an immense nexus of public and private non-profit community health centers and hospitals.[3] Most hospitals in New York City are privately owned, or "voluntary," hospitals, but in New York State, all hospitals, including private hospitals, must operate as nonprofits.[4] This is required by the state's Certificate of Need (CON) process, in which the Character and Competence of all board members must be reviewed, a requirement which is not possible with for-profit corporations. Nonprofit hospitals are exempt from paying taxes—including all corporate income, sales, and property taxes.[5] This includes exemption from paying taxes on contributions from donors and taxes on bonds for capital projects.[6]

Nonprofit status saves organizations a significant amount of money: tax exemptions for private hospitals in New York State average around $10 million per hospital per year.[7] It can be quite lucrative to operate as a private nonprofit hospital. To justify their tax exemption, the IRS mandates that nonprofit hospitals provide "community benefit," such as charity care. However, hospitals have some leeway in their interpretation of "community benefit": while hospitals and the IRS include health professionals training and research activities in their definition of community benefit, many are concerned that some of the current permissible categories of community benefit do not actually result in tangible benefits to local communities and taxpayers. Savings from hospitals' tax exempt status–a gift from taxpayers–aren't necessarily being funneled back into the community and don't necessarily translate to medical benefits for community members. Additionally, the state does not dictate a minimum level of charity care or community benefits.

Though it is expected that the value of community benefits should meet or exceed the value of the tax exemption, many NYC hospitals are falling short. The Lown

[3] Michael K. Gusmano and Victor G. Rodwin, "New York's Health System," n.p., March 2016.
[4] Roosa Tikkanen, Steffie Woodhandler, and David Himmelstein, *Funding Charity Care in New York: An Examination of Indigent Care Pool Allocations* (New York: NYS Health Foundation, 2017).
[5] Entities can apply to be recognized as nonprofits, and granted tax exempt status, by the IRS. Once they are granted tax exempt status, they are designated section 501(c)(3) organizations. Nonprofits must make their application to tax exempt status (Form 1023) and their recent annual returns (Form 990 or Form 990-PF) accessible to the public. You can find resources to locate these documents for a given nonprofit here.
[6] Danielle Ofri, "Why Are Nonprofit Hospitals So Highly Profitable?" *New York Times*, February 20, 2020, https://www.nytimes.com/2020/02/20/opinion/nonprofit-hospitals.html.
[7] Tikkanen, Woodhandler, and Himmelstein, *Funding Charity Care in New York*.

Institute indexes nonprofit hospitals across the US based on its evaluation of what it calls “fair share spending,” a comparison of hospitals’ spending on charity care to the value of their tax exemptions. In seven states, including New York, the total fair share deficit for all hospitals exceeded $1 billion (CA, PA, NY, OH, IL, MI, MA). Within NYC, Lown estimates that in 2019 the NewYork-Presbyterian Health System received $319 million more in tax breaks than it spent on meaningful community care, which is the 12th largest deficit in the nation. Similarly, NYU Langone’s estimated “fair share” deficit was $167 million, and Mount Sinai’s deficit was $98 million. In New York State, the total fair share deficit for all hospitals exceeded $1 billion in 2019. You can find the Lown Institute Hospitals Index and key takeaways here.

An issue related to the interpretation of “community benefit” is the issue of the criteria for a hospital to be recognized as a “safety net” hospital. You can read more about the importance of the “safety net” criteria in “**How is the system funded?**”.

While NYC’s healthcare system has admirably exemplified what one study calls a “deep sense of mission in support of the care of vulnerable populations that has been bolstered by a traditionally supportive public policy environment,”[8] despite the efforts of policymakers and providers, the system has produced stark disparities in healthcare access and outcomes. These disparities will be discussed in the following section, **“Who does it treat?”**.

[8] Joel Cantor et al., *Health Care in New York City: Providers' Response to an Emerging Market* (Washington D.C.: Urban Institute, 1998).

Who does it treat?

New York City is the most populous city in the United States with more than 8 million residents. It is one of the most diverse cities in the nation consisting of 31.9% white (not Hispanic), 23.8% black, 14.3% Asian, 28.9% Hispanic/Latino people. New York City is also unique in that it has one of the highest percentages of immigrants living there (at 36.4%) and high rates of income disparities. While it is home to the most billionaires in the world, NYC has 17.1% of its population who live below the poverty line.[9]

The diversity and inequities are not limited to demographics or income, but also bleed into health care and health care policy. For decades the NYC health care system has failed to meet the needs of underserved, black and brown communities either through willful neglect or due to negligence. The effects of this are still prevalent today and can be seen through the lens of health care outcomes. The mortality rate of black infants remains three times higher than that of white infants. Not only that, in 2015, the mortality rate for non-Hispanic black people younger than 65 was 51% higher than that of non-Hispanic white people in New York City.[10]

Why does insurance status matter?

There is inequity still present in the system that begs the question, why is that? Health insurance is one of the key markers for health care access and delivery. This can be seen in a patient's decision to get medical attention and their access to preventative care.

In NYC, uninsured patients were four times more likely to forgo medical care for a health problem due to costs and twice as likely to not fill drug prescriptions when compared to adults with insurance. This disparity is also seen when comparing those with public insurance vs private insurance, adults less than 65 years old with Medicaid were twice as likely to forgo care than privately insured adults.[11]

[9] U.S. Census Bureau, "QuickFacts," accessed March 5, 2023, https://www.census.gov/quickfacts/newyorkcitynewyork.
[10] NYC Health, "Race to Justice," accessed March 5, 2023, https://www.nyc.gov/site/doh/health/health-topics/race-to-justice.page.
[11] *Health Care Access Among Adults in New York City* (New York: New York City Department of Health and Mental Hygiene, May 2007).

When looking at preventative care, adults over 65 with insurance and a regular provider were nine times more likely to get pneumonia vaccination than people with neither. They were also 3 times more likely to get a colonoscopy, twice as likely to get a mammogram and forty percent more likely to get a pap test than patients who had neither.[12]

Having health insurance thus serves as the bare minimum for equity in access to care for patients. It has important implications on when patients choose to get care and how adherent they are to these care. This will later also play a factor in what type of patients are seen at private vs public hospital systems. Public hospitals who generally have a population who have public insurance or are uninsured.

But having health insurance is not a guarantee of access to quality care. One hospital, NYU Langone, does not typically provide services for Medicaid patients. Other hospitals maintain different locations of care in clinics for Medicaid and uninsured patients, whereas private patients are treated in what is commonly called faculty or private practice sites with different standards of care.

Insurance rates in NYS and NYC

Insurance rates in New York state and NYC are improving; however, there seems to be a persistent number of people who are uninsured.

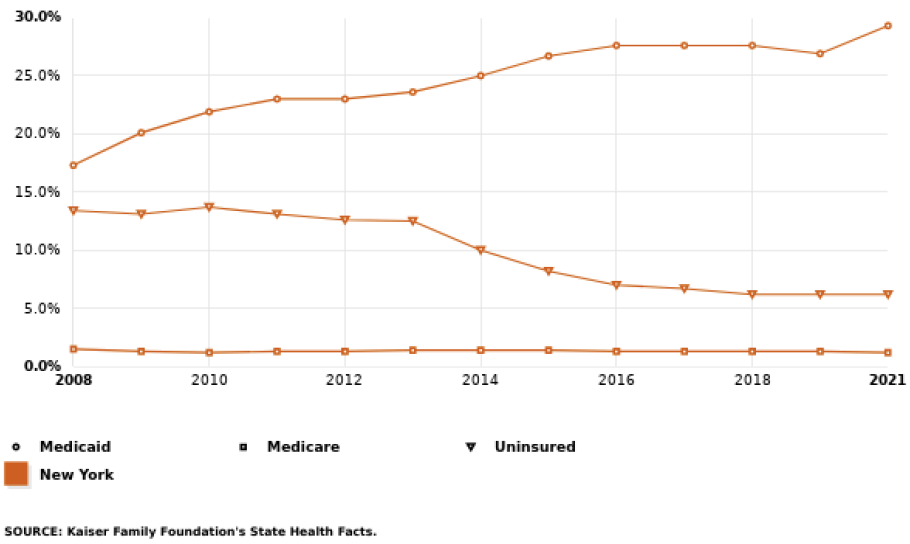

Figure (right): Health Insurance Rates of the Nonelderly in NY State from 2008 to 2021[13]

[12] NYCDOHMH, *Health Care Access.*
[13] Kaiser Family Foundation, "Health Insurance Coverage of Nonelderly 0-64," accessed March 5, 2023, https://www.kff.org/other/state-indicator/nonelderly-0-64/?activeTab=graph&currentTimeframe=0&startTimeframe=12&selectedDistributions=medicaid--medicare--uninsured&selectedRows=%7B

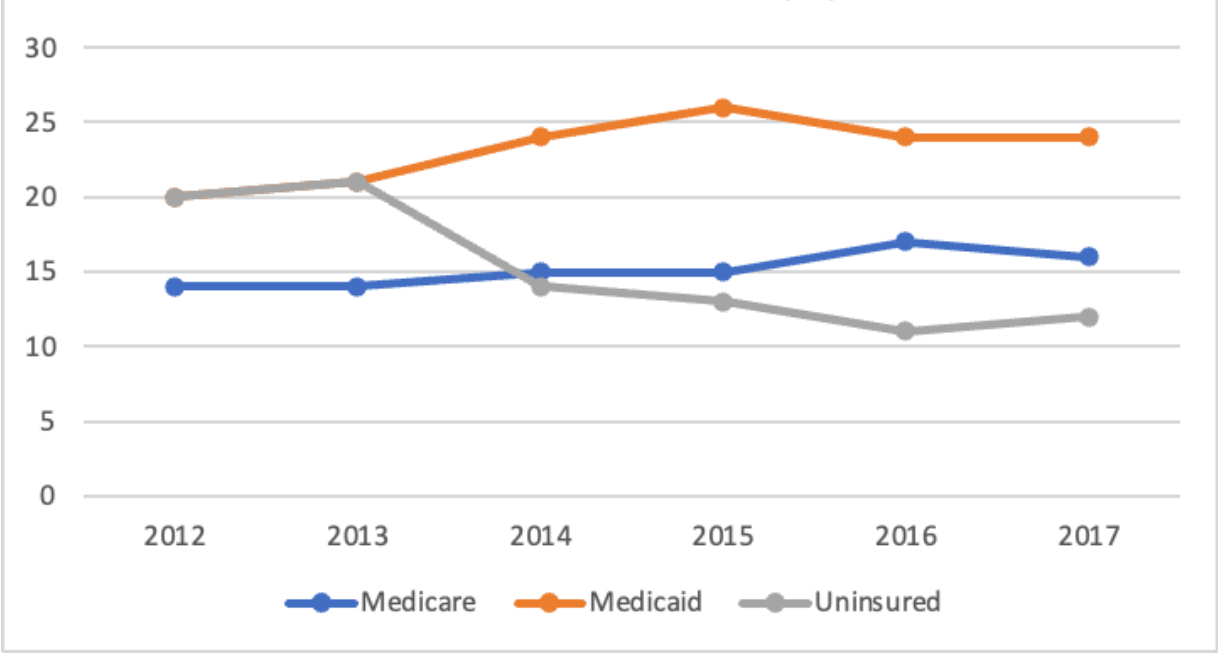

Figure (above): Community Health Survey, Overall NYC Insurance Rates[14]

The increase in Medicaid enrollment has seen an uptick due to the COVID-19 pandemic. The government implemented emergency measures that allowed for more people to be eligible for Medicaid, however the measure has ended thus there is a risk for the additional people to not qualify for Medicaid.[15]

%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[14] NYC Health, "Health Care Access and Use," accessed March 5, 2023, https://a816-health.nyc.gov/hdi/epiquery/visualizations?PageType=ts&PopulationSource=CHS&Topic=2&Subtopic=15.

[15] Jennifer Tolbert, "Medicaid Pandemic Enrollment Policies Helped Drive a Drop in the Uninsured Rate in 2021, but the Coverage Gains Are at Risk," Kaiser Family Foundation, September 16, 2022, https://www.kff.org/policy-watch/medicaid-pandemic-enrollment-policies-helped-drive-a-drop-in-the-uninsured-rate-in-2021-but-the-coverage-gains-are-at-risk/.

Insurance rates, race and ethnicity

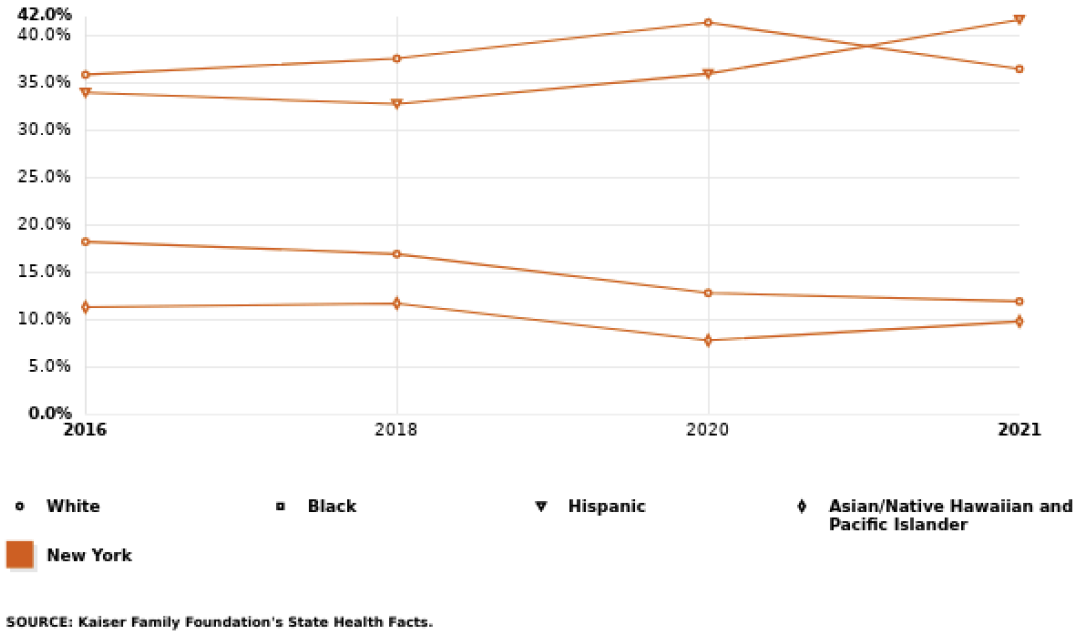

Figure (above): Uninsurance Rates of the Nonelderly By Racial/Ethnic Demographic in New York State[16]

When looking at NYC, in 2012, the uninsured rate by race were: White 12%, Black 19%, Hispanic 31% and Asian/Pacific Islander 20%.[17] These disparities persist to this day where an investigation found that "7% of Black and Asian New Yorkers are uninsured, more than double the amount of white people. For Latinos, that number's even higher at 14%."[18]

[16] Kaiser Family Foundation, "Distribution of the Nonelderly Uninsured by Race/Ethnicity (CPS)," accessed March 5, 2023, https://www.kff.org/other/state-indicator/distribution-of-the-nonelderly-uninsured-by-race-ethnicity-cps/?activeTab=graph&currentTimeframe=0&startTimeframe=3&selectedDistributions=white--black--hispanic--asiannative-hawaiian-and-pacific-islander&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[17] New York City Department of Health and Mental Hygiene, "Uninsured Adults in New York City," *Epi Data Brief* no. 43 (March 2014): 1-3.

[18] Dan Krauth, "Equity Report: Racial gaps in health insurance in New York City," ABC7NY, September 29, 2021, https://abc7ny.com/our-america-equity-report-health-insurance-new-york-city/11057416/.

Where do patients go to get treated?

Most hospitals with higher percentages of uninsured or Medicaid patients served than the citywide average were public hospitals. With only four private hospitals meeting this average. And only one hospital in NYC provided for a higher percentage of uninsured patients than the citywide average.[19]

Low-income areas often consist of historically marginalized communities where health and infrastructure investment are lacking.[20] In many low-income and communities of color, hospitals have been closed over the years and access to care became more difficult.

Due to the lack of access to healthcare there is a need for the public health system to step in. However, due to persistent under funding of public hospitals, there is a significant burden on these hospitals. The problem of underfunding is especially apparent for community safety net hospitals where at least 50% of the patient population is either uninsured or on Medicaid.[21] Additionally, Medicaid is the single largest payer for the community safety net hospitals and it only pays 67 cents on the dollar for care provided by hospitals and even less when it comes to inpatient psychiatric care. This leads to the chronic underfunding of safety net hospitals. You can read more about hospital funding and safety net hospitals in the "**How is the system funded?**" section of this document.

Hospital patient population characteristics and outcomes

Large private academic medical centers dominate the charts on "best" patient outcomes, or they are the "leader" in a variety of conditions ranging from heart disease to rare cancers. However, the picture is more complex than this. Private hospitals take only a subset of the population under their care. Public hospital systems, and especially the safety net designated hospitals, provide for the most vulnerable and sick. This is an unintended consequence of "value-based care"

[19] The Institute for Family Health, "Neil Calman, MD: Structural Racism in the Healthcare System and its Impact on Health Disparities," YouTube, May 16, 2018, educational video, 14:29, https://www.youtube.com/watch?v=Cj_8BG5Yoa8&t=869s.
[20] Primary Care Development Corporation, "Today's Health Inequities in New York City Driven By Historic Redlining Practices," *Points on Care* no. 5 (September 2020).
[21] Carrie Tracy, Elisabeth R. Benjamin, and Amanda Dunker, *Unintended Consequences: How New York State Patients and Safety-Net Hospitals Are Shortchanged* (New York: Community Service Society, January 2018).

models,[22] which incentivize providers to cut costs while focusing on patient outcomes, often leaving the most vulnerable and sick patients behind.[23,24]

The problem is further exacerbated when looking at the model of payments for hospitals. The larger private hospital's patient population is often people with commercial insurance who are able to pay more. These people have better access to primary care and health follow-up and generally see doctors earlier on in their disease progression. Thus, they are more likely to be well taken care of and their private insurance is welcomed by these hospitals as it pays the hospital for what it provides while it also helps offset the cost of Medicaid patients this hospital might be serving. Additionally, the Medicaid and uninsured patients are treated in clinic settings (with all that implies) while private patients are seen in private and faculty practice.[25]

On the other hand, public hospitals and specifically safety net hospitals, serve patient populations that are either on Medicaid, public insurance or uninsured. These patients often forgo medical treatment till they are unable to forgo it any longer. Thus their care is more complex and their outcomes more adverse. Because these public hospitals do not have a large patient population with private insurance, they cannot offset the price through them.[26]

In addition to disparities in patient populations, there are many issues related to public vs. private hospital status and their commitment to underserved communities. You can read more about these other issues in the "**On NYC Hospitals' Nonprofit Status**" section of this document.

Though Manhattan has many hospitals with segregated patient populations, the Lown Institute identified several NYC hospitals that were amongst the top in the

[22] Value-based care is a healthcare reimbursement model which aims to cut unnecessary costs that might exist under a fee-for-service model. Fee-for-service model paid providers based on amount of healthcare delivery. While value-based care payments are based on measuring health outcomes against the cost of delivering the outcome.
[23] Suhas Gondi, Karen Joynt Maddox, and Rishi K. Wadhera, "'REACHing' for Equity -- Moving from Regressive toward Progressive Value-Based Payment," *New England Journal of Medicine* 2022, no. 387 (July 14, 2022): 97-99, https://www.nejm.org/doi/full/10.1056/NEJMp2204749.
[24] Lown Institute, "Are NYC Hospitals Earning Their Tax Breaks?," accessed March 5, 2023, https://lowninstitute.org/projects/are-nyc-hospitals-earning-their-tax-breaks/.
[25] Lindsay Clark et al., "Medical Student-Driven Efforts to Incorporate Segregated Care Education Into Their Curriculum," *AMA Journal of Ethics* 25, no. 1 (January 2023): 31-36, https://journalofethics.ama-assn.org/article/medical-student-driven-efforts-incorporate-segregated-care-education-their-curriculum/2023-01.
[26] William L. Schpero and Paula Chatterjee, "Structural Racial Disparities in the Allocation of Disproportionate Share Hospital Payments," *JAMA Network Open* 5, no. 11 (November 4, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2798157.

country with regards to racial inclusivity[27] of their patient population. Manhattan was ranked #10 with the most Racially Segregated Hospitals in the United States, meaning the community served does not reflect the community that *could* be served based on the demographic in the area.[28]

Conversely, a report looking at the top 50 racially inclusive hospitals included four NYC hospitals,[29] all of which were affiliated with NYC H&H Corporation.[30] Furthermore, when looking at which hospitals serve the highest proportion of Medicaid patients, 8 out of the top 10 US hospitals were located in NYC; all of these were also part of the NYC H&H Corporation.[31] These hospitals are all-in low-income neighborhoods and in communities of color, making it imperative to invest in these institutions and communities so that they can have the same access as patients who reside in high-income neighborhoods.

There are several structural factors and inequities that contribute to racial segregation in hospitals and communities, including hospital location, institutional and interpersonal racism, insurance status, and other barriers to care such as insufficient language/translation services. The connection between hospital racial segregation and hospital funding and insurance status is further discussed in the "**What are the forms of insurance coverage?**" section of the document.

Conclusion

NYC consists of a diverse set of patient population that is diverse in race, ethnicity, socioeconomic levels, and immigration status. Each of these groups has a special set of healthcare disparities associated with them that needs to be targeted. The system as it stands now serves those who are wealthier more so, rather than all groups equally. There are additional barriers that patients face

[27] The Lown Institute's racial inclusivity score reflects how well the demographics of the hospital's "community area" (containing people who the hospital could serve) compare to the demographics of the patient population (who the hospital does serve). The community area is determined using the zip codes from which a hospital's Medicare patients come and includes a travel time adjustment. More on their methodology can be found here.
[28] Lown Institute Hospitals Index, "2022 Winning Hospitals: Racial Inclusivity," accessed March 5, 2023, https://lownhospitalsindex.org/2022-winning-hospitals-racial-inclusivity/.
[29] The following NYC hospitals were listed amongst the top in the country when it comes to racial inclusivity in their patient population: Metropolitan Hospital Center, Harlem Hospital Center, Queens Hospital Center, and Lincoln Medical and Mental Health Center.
[30] Lown Institute, "Racial Inclusivity."
[31] Jakob Emerson, "US Hospitals with the Highest Share of Patients on Medicaid," *Becker's Hospital CFO Report*, April 15, 2022, https://www.beckershospitalreview.com/finance/us-hospitals-with-the-highest-share-of-patients-on-medicaid.html#:~:text=(1)%20Queens%20Hospital%20Center%20%E2%80%94%2096%20percent&text=System%3A%20New%20York%20City%20Health%20and%20Hospitals%20Corp.

from language difficulties or not knowing how to navigate the complicated, convoluted health care system. Some community studies where patients are surveyed, including open-ended questions, have documented the inequities that patients face in accessing care and in the care that they receive when they go for care. The city has been continuing to improve healthcare outcomes; however, the disparities still stand. This manual, as a guide to CBOs, hopes to tackle these disparities for a more equitable system. The newly approved Medicaid waiver 1115 demonstration, New York Health Equity Reform, is meant to address these disparities.

What are the forms of insurance coverage?

Health insurance in New York City is provided by a mix of public and private insurers. Insurance coverage can be employer-sponsored (meaning that companies select and subsidize plans for their employees), public (meaning it is funded by the federal, state, or local government), or private (meaning the plan is chosen by an individual or family and provided by a private insurance company). Insurance can cover individuals or families.[32] Though insurance coverage and rates have been improving over time, there are still stark racial and ethnic disparities in insurance coverage, with implications for where and how people receive care. This is discussed in the "**Who does it treat?**" section of this manual.

How do people get or choose insurance?

Some people receive health insurance for themselves or for their families as an employment benefit: their employer shops for and selects the insurance plan, and splits the cost of the premium with the employee. Some people shop for and enroll in private insurance, affording them more flexibility and autonomy in terms of the details of the plan, the deductible, and the covered services and providers, but are solely responsible for the cost of the premium.

Under the Affordable Care Act (ACA), or Obamacare, the federal government introduced the Health Insurance Marketplace, a federal initiative where individuals, families, and small businesses can access insurance coverage. Many states also introduced their own insurance marketplaces, New York included. These marketplaces are required to offer insurance options that provide a basic, standardized level of coverage: plans must cover a set of 10 key categories of services, termed Essential Health Benefits. This standard ensures that people with a marketplace plan are more easily able to access vital care like primary care, emergency care, mental health care, and prescription drugs.

New York launched New York State of Health, a health insurance marketplace which enables New Yorkers to compare and enroll in health insurance plans. Within NY State of Health, New Yorkers can also apply for and receive financial assistance to help offset the cost of insurance premiums. There are several restrictions on who can access and use this marketplace: you must live in New York, be a legal resident or US citizen, and not be currently incarcerated. More on the NY State of Health as well as answers to frequently asked questions about insurance in New York can be found here.

[32] NYC Health, "Health Care Access and Use."

What is Medicare? What is Medicaid?

Medicare is a federal health insurance program for people who are 65 and up and people with disabilities, though people with disabilities typically have to wait for two years through their disability to get Medicare coverage. Medicare plans include Traditional Medicare or Fee-for-Service (FFS) Medicare as well as Medicare Advantage. Medicare comprises four parts: Part A, Part B, Part C, and Part D. Part A refers to inpatient hospital coverage. Part B refers to coverage for outpatient care. Part C refers to Medicare Advantage, an alternate way of accessing Medicare benefits. Part D refers to prescription drug coverage.[33] Medicare Advantage plans offer all the benefits of Part A and Part B, often with additional benefits like dental and vision. However, generally speaking, people with Medicare Advantage plans may have more restricted preferred provider networks and higher total out-of-pocket costs.[34]

Managed care refers to insurance plans that coordinate care and restrict individuals' healthcare to a predetermined network of providers. Insurance companies have agreements with particular providers or institutions, such that insurers can offer lower cost of care or decrease the co-pay when people visit these "preferred" or "in-network" providers. "Out-of-network" providers are comparatively more expensive. Both Medicare and Medicaid offer managed care plans. Frequently, people on Medicaid don't have a choice between managed care and traditional fee-for-service plans. Medicare Advantage is an example of managed care within Medicare, though Medicare beneficiaries typically are able to choose between Medicare Advantage and traditional Medicare.

Both HMO (health management organization) and PPO (preferred provider organization) plans are examples of managed care, though HMOs tend to be a bit less expensive; these lower monthly premiums and lower out-of-pocket costs come at the expense of a larger network, better coverage for out-of-network providers, and coverage for specialty care without a referral. HMOs usually do not pay hospitals for the full cost of care, so hospitals don't have the same financial incentive to accept patients on HMO plans as patients with traditional fee-for-service plans or paying out of pocket. Two other examples of managed care plans are POS (point of service) and EPO (exclusive provider organization). More on managed care can be found here.

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[33] Medicare Interactive, "Medicare Advantage Basics," accessed March 5, 2023, https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/medicare-advantage-plan-overview/medicare-advantage-basics?.

[34] Louise Norris, "Medicare in New York," HealthInsurance.gov, March 3, 2023, https://www.healthinsurance.org/medicare/new-york/.

3.7 million people in New York State receive Medicare coverage, as of late 2021.[35] Medicare pays hospitals and providers better than Medicaid, although it pays worse than private insurers and usually does not cover the full cost of care.

Medicaid is a joint federal-state health insurance program for low income people and people with disabilities. In New York, the premium depends on age, living situation, financial situation, and family situation, but generally there is no premium unless your income exceeds a certain value. There are a range of Medicaid plans. Managed care plans for Medicaid often offer health education classes, preventive health programming, and transportation benefits.[36] As of July 2022, Medicaid covers over 7.5 million New Yorkers, including over 4 million in NYC alone.[37] In New York, Medicaid only pays hospitals about 68% of the cost of providing care.

Federal law sets the rules for Medicaid; the state gets to define and set up their program within the confines of federal law. There are exceptions to the federal law in which each state can determine what they apply for and negotiate with the federal agency, the Center for Medicare and Medicaid Services (CMS), to make these adjustments and get funding.

One way for undocumented or otherwise uninsured people to receive health care coverage in an emergency is a special application of Medicaid, Medicaid for the treatment of an emergency medical condition. Undocumented people as well as “temporary non-immigrants” with proof of identity, income, and, if indicated, State residency, can receive “emergency Medicaid” coverage in care for an acute medical condition that puts the individual's life in jeopardy. Notably, organ transplant procedures are not covered by emergency Medicaid. Nor are chronic conditions, or acute conditions arising from discontinuous or insufficient care following a previous precipitating event. Emergency Medicaid also doesn't cover nursing facilities, home care, or rehabilitative services. You can pre-register for emergency Medicaid at any time to be covered for 12 months in case of a future emergency. More on the pre-approval process can be found at nystateofhealth.gov or in this document.

Sometimes people qualify for both Medicare and Medicaid. This is termed “dual eligibility,” and there are several opportunities available to dually eligible people to combine all their benefits under one plan. One example is MetroPlus UltraCare, a plan for people who need to access long-term care services.

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[35] Norris, "Medicare in New York."
[36] New York State Department of Health, "Managed Care," January 2023, https://www.health.ny.gov/health_care/managed_care/.
[37] New York State Department of Health, "NYS Medicaid Enrollment Databook," accessed July 2022, https://www.health.ny.gov/health_care/medicaid/enrollment/.

There are several insurance plans designed to cover people in need who may not qualify for Medicare or Medicaid. Child Health Plus (CHP) is a free or low-cost health insurance option for children under 19 years of age who are not covered by Medicaid or another form of insurance coverage.[38] The Essential Plan is a no-premium, no-deductible plan for low-income New Yorkers who do not qualify for Medicaid or Child Health Plus.[39] Veterans receive a form of healthcare coverage as well, in the form of Veteran Affairs (VA) healthcare benefits. VA healthcare benefits packages are highly tailored to individual Veterans but generally cover care received at VHA facilities and VA-approved urgent care clinics, though not care at any non-VA facility.[40] Exceptions are made for Veterans seeking care for a medical emergency or and Veterans who do not have a viable VA-affiliated facility nearby.

Who is uninsured? Who is uninsurable?

Between 2010 and 2017, the state of New York reduced its overall uninsured rate from 11 percent to 4.7 percent: insurance rates improved under the ACA.[41] However, disparities in insurance status remained across immigration status, neighborhood, race, and ethnicity. This has implications for who can receive care, and where: a 2017 report found that compared to patients with insurance coverage, patients who were uninsured were five times less likely to receive care at academic medical centers.[42] Health systems sort patients, steering them towards different clinics or hospitals based on their insurance status and/or ability to pay. Since, as previously discussed, people of color are more likely to be uninsured or publicly insured, the result is de facto segregation and disparate outcomes. For more on this issue, see the "**Who does it treat?**" section of this document.

While about 4.5 percent of native New Yorkers are uninsured, over a quarter of people without citizenship are uninsured. People who are uninsured often need hospital financial assistance programs or charity care to access healthcare; otherwise they must pay out of pocket.[43] Though hospitals receive funding from the state to provide charity care to uninsured or underinsured patients (and have

[38] NYC Health Insurance Link, "Child Health Plus," accessed March 5, 2023, https://www.nyc.gov/site/ochia/coverage-care/child-health-plus.page.
[39] New York State of Health, "Essenial Plan Information," accessed March 5, 2023, https://info.nystateofhealth.ny.gov/EssentialPlan.
[40] U.S. Department of Veteran Affairs, "About VA Health Benefits," October 12, 2022, https://www.va.gov/health-care/about-va-health-benefits/.
[41] Tracy, Benjamin, and Dunker, *Unintended Consequences*.
[42] Tracy, Benjamin, and Dunker, *Unintended Consequences*.
[43] Tracy, Benjamin, and Dunker, *Unintended Consequences*.

since 1983), hospitals weren't required to provide charity care to uninsured patients until 2007's Hospital Financial Assistance Law (HFAL).[44]

Health insurance in New York can be very complicated, and people who qualify for insurance are often mistakenly denied coverage. For help accessing or understanding insurance in NY, check out the New York Legal Assistance Group (NYLAG).

[44] NY Health Access, "NYS Hospital Financial Assistance Law: Hospitals Must Provide Charity Care Assistance Program," September 9, 2020, http://health.wnylc.com/health/entry/69/.

How is the system funded?

Hospitals and other healthcare facilities are funded in various ways. In general, hospitals are funded by private insurers, Medicaid, Medicare, and people paying out-of-pocket in part or in full for their healthcare. In New York, Medicaid only pays hospitals about 68% of the cost of providing care. More on Medicaid, Medicare, and other forms of health insurance in New York can be found in "**What are the forms of insurance coverage?**". Additionally, as was discussed in "**What is the system?**", all hospitals in New York City are required to operate as nonprofits and are thus tax-exempt; though it is not income per se, the value of the tax exemption should be considered when considering hospital funding. By federal law, FQHCs get wraparound reimbursement rates (from Medicaid) based on their obligation to treat uninsured people and provide extra-medical services.

In addition to payments from insurers, there are several other avenues through which hospitals can receive funding. At the local, state, and federal levels there are opportunities to receive payments from special pools of money. These special pools include the Disproportionate Share Hospital pool (DSH) and Indigent Care Pool (ICP); the Delivery System Reform Incentive Payment (DSRIP) program (including the Interim Access Assurance Fund, IAAF); the Vital Access Provider Assurance Program (VAPAP); and the Value-Based Payment Quality Improvement Program (VBP-QIP). Some of these pools purportedly target hospitals that are providing the greatest amount of care to underserved populations or "safety net" hospitals, though that intention is not always reflected in the actual allocation of funding.

Special pools—DSH, ICP, and beyond

State Medicaid programs are required by federal law to support hospitals serving large proportions of individuals covered by Medicaid and uninsured individuals with DSH payments.[45] Public hospitals in NYC receive as much DSH funding as is allowed under federal law. A 2018 article reported that DSH payments total approximately $3.6 billion annually in New York State.[46] The process for allocating these payments begins with state hospitals such as mental hospitals and university hospitals and ends with the NYC Health + Hospitals network.

[45] Medicaid.gov, "Medicaid Disproportionate Share Hospital (DSH) Payments," accessed March 5, 2023, https://www.medicaid.gov/medicaid/financial-management/medicaid-disproportionate-share-hospital-dsh-payments/index.html.
[46] Tracy, Benjamin, and Dunker, *Unintended Consequences*.

Under the Affordable Care Act (Obamacare), DSH funding actually decreased because of the assumption that there would be less need for charity care if less people were uninsured and more people had insurance coverage. Due to the allocation formula, cuts to the DSH, which began in 2019 and will continue through at least 2025, disproportionately reduce the funding available to NYC Health + Hospitals, which serves a large percentage of uninsured patients.[47] Strong lobbying efforts in Washington have deferred implementation of these cuts.

One subcategory within DSH funds is the Indigent Care Pool (ICP). These funds are intended to support safety net hospitals that are providing disproportionate care to the insured and Medicaid patients (the definition of "Safety Net" hospitals is discussed **in the next section**). However, New York State distributes these funds to almost every hospital in the state, including hospitals that are not serving a significant proportion of uninsured or underinsured patients, calling into question the rigor of the criteria outlining safety net hospital status.

In addition to the DSH funding and the ICP, hospitals and other facilities could receive financial support from the Vital Access Provider Assistance Program (VAPAP) and Value Based Payment Quality Improvement (VBP-QIP) programs, which assisted struggling healthcare facilities by providing financial support for redesign or reform initiatives and encourage the transition from fee-for-service to value-based care. These pools were supported by both federal and state funds.

Until 2020, another source of funding was the Delivery System Reform Incentive Payment (DSRIP) program, by which the State implemented the Medicaid Redesign Team (MRT) waiver amendment, calling for federal waiver dollars. The waiver amendment was part of a larger multi-year effort in New York State, beginning in 2011, to reduce avoidable hospital use, improve health outcomes, and reduce costs; the DSRIP dollars from federal savings from Medicaid reform were meant to incentivize hospitals to make these changes.[48] Over 200 initiatives were started as a result of this effort.[49] New York State was allocated $8 billion over five years to reinvest from MRT reform savings; of that, $6.42 billion went to DSRIP payments and $500 million went to the Interim Access Assurance Fund (IAAF). The purpose of the IAAF was to support certain hospitals as they developed the infrastructure necessary to be eligible for DSRIP payments. Half of the IAAF was allocated for safety net hospitals, and half was allocated for large public hospitals. Though the DSRIP program yielded some improvements in avoidable hospital usage, it did not meet all of its stated goals, according to an

[47] Tracy, Benjamin, and Dunker, *Unintended Consequences*.
[48] New York State Department of Health, "Delivery System Reform Incentive Payment (DSRIP) Program," October 2022, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/.
[49] New York State Department of Health, "About the Medicaid Redesign Team, " March 2022, https://www.health.ny.gov/health_care/medicaid/redesign/aboutmrt.htm.

independent evaluation by the State University of New York Research Foundation (SUNY RF).

The Medicaid 1115 waiver demonstration, approved in 2024, adds another special category of funding for certain financially troubled hospitals.[50] The Medicaid Global Budgeting program is targeted to 11 downstate financially troubled private hospitals which meet certain financial criteria. This program is a model developed as a federal program by Center for Medicare and Medicaid Innovation (CMMI) States Advancing All-Payer Health Equity Approaches and Development (AHEAD). The state must apply for approval of this component of the waiver which will be funded at $2.2 billion over the more than 3 years of this demonstration. The eligible hospitals will be located in Brooklyn, Queens, the Bronx, and Westchester counties and have Medicaid and uninsured payor mix at 45%. Included also is a Primary Care Delivery System Model funded at $492 million to improve this care with a special focus on children.

In 2022-23, $800 million state dollars were added to the state budget. Under the current distribution guidelines, those dollars were not all directed towards those who need them most: public hospitals.

What is a "safety net hospital"?

The terms Health Care Safety Net Providers (SNP) or Vital Access Providers (VAP) both refer to facilities, institutions, and providers that play a key role in providing care to low-income, underserved communities. Safety net hospitals are an example of an SNP. As patients at these facilities are often covered by Medicaid or uninsured, they receive less reimbursement for their services than, for example, a large academic medical center servicing a large proportion of patients with private insurance and/or patients who can pay out of pocket for their care. This poses an enormous financial strain to these hospitals, an issue which is complicated and exacerbated by the inequitable distribution of DSH funds (see "**Special pools**"). Identifying and appropriately supporting these hospitals with policies that encourage their survival is key to preventing the breakdown of institutions serving the most vulnerable populations.

While the definition of a "Safety Net Hospital" has been debated for many years, it has important implications for funding allocation. The current criteria defining Essential Safety Net Hospitals, according to Section 2807k of New York's Public Health Law, are:

[50] New York State Department of Health, "1115 Medicaid Redesign Team Waiver Webinar," February 2024, health.ny.gov/health_care/medicaid/redesign/med_waiver_1115/docs/2024-02-16_nyher_overview_slides

1. Medicaid and uninsured patients make up at least 50% of their patient population.
2. They have an “open door” policy: they will provide care regardless of patients’ ability to pay.

Section 2807k also details the criteria for “qualified” safety net hospitals, a broader definition that includes sites whose patient populations comprise at least 36% Medicaid and uninsured patients.

There are many safety net hospitals in NYC, including Health + Hospitals-affiliated hospitals, the State’s University Hospital of Brooklyn, One Brooklyn Health System, and several other community hospitals, some of which may be affiliated with academic medical centers. There are also safety net providers in more rural parts of New York state. Oftentimes, these SNPs are the sole healthcare facility in their community.

What is available to protect patients and promote equitable access?

What are patient protections? How are equity and disparities in the system monitored, documented, and addressed?

Many people believe that they have no rights and no protections in the healthcare system. For sure, there are not enough protections, but there are some – though they don't matter if you don't know they exist and how to use them. Below you will not find a full listing of what might be available, although hopefully it is enough to feel some level of comfort in the health care setting. Some of the protections are:

I. **Patient Bill of Rights**. This can be found in law and regulations at: Public Health Law(PHL)2803 (1)(g) Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c).

There are 21 different rights listed for patients in a hospital in New York State, but we will only highlight a few. The rest can be checked in the law or reg. As a patient in a hospital in New York State, you have the right, consistent with law, to:

1. Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age or source of payment.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care if you need it.
5. Be informed of the name and position of the doctor who will be in charge of your care in the hospital.

II. **EMTALA/EMSRA,** 42 U.S.C. § 1395dd**.** There is a federal law, EMTALA,[51] that requires hospitals that have an emergency room to provide emergency care when it is needed by a patient. The condition is to be determined and immediate care to be provided to stabilize a patient for an emergency condition. The law does not require the hospital to provide inpatient care unless a life-threatening condition would lead to physical harm to the person. If the patient is to be transferred to another hospital, the physician must make these arrangements for

[51] Emergency Treatment and Active Labor Act

a safe transfer. There is a little-known state law, EMSRA,[52] that goes a step further and requires the hospital to provide inpatient care if needed, unless the hospital cannot treat that condition. Click here to access a resource from CPHS for more information.

III. **While in the hospital:** once you are admitted to the hospital as an inpatient you have certain rights in New York through Section 405 of NYS Unconsolidated Laws. There is a right to receive all treatment for your illness or injury. Discharge from the hospital is to be determined only by healthcare needs, NOT by your DRG or insurance.

On being discharged, the patient has the right to a written Discharge Notice and Plan that informs about treatment next steps. If the patient disagrees with the plan, they have the right to appeal the written discharge plan or notice. The notice from the hospital will tell the patient how to appeal the written notice. It helps to have someone assisting, if possible.

IV. **State Agencies to File a Complaint With.** You can report a problem with the quality of care or services provided by any public or private hospital or clinic located in New York State. It's not clear how well-staffed this part of the Health Department is, but they do have the responsibility to follow-up on complaints. Having a community-based organization support you in making this complaint, can often be positive and have the Health Department more responsive to your concerns.

More information, including the complaint form, is available online. You can also request a paper application by phone.

Online

- Get information about patient rights here.
- Make a complaint about a hospital or clinic here.

By Phone

- Agency: New York State Department of Health
- Division: Hospital Complaints Hotline
- Phone Number: (800) 804-5447
- Business Hours: Monday - Friday: 8:30 AM - 4:45 PM

[52] Emergency Medical Services Reform Act

Helping Organizations to Call

As noted above, it is often helpful to have assistance in your efforts to access health care services, get the care that you need, and get help with working out a problem. If you already work with, or involved with, a community-based organization in your neighborhood, go there first to get help. If they are unable to help you with the problem, there are networks of organizations that get funding to provide assistance to help solve issues in the healthcare system. A full list of helping organizations can be found in the **Appendix**.

- *Access Health NYC*: Access Health is a city-council funded project that provides resources and coordinates the efforts of community-based organizations. The CBOs do outreach to, and assist, residents who are uninsured, speak a language other than English, are LGBTQ, are homeless, or are formerly incarcerated. The network provides education and assistance for residents on access to care and health insurance coverage. The network is co-lead by the Coalition of Asian American of Children and Families (CACF).

- *CHA*: The Community Health Advocates (CHA) network is state-funded and coordinated by the Community Service Society. There are 28 funded-partners around the state including three specialty organizations that provide training and technical assistance. The organizations below are those located in New York City or serving statewide.

- *MCCAP*: The City Council funded the Community Service Society to coordinate the Managed Care Consumer Assistance Program (MCCAP) Network of community-based organizations. The work of this network is to assist patients with managed care problems. Most Medicaid-covered patients, except for some special populations, are required to choose and enroll in a managed care plan that coordinates their health care services.

The Section 1115 Medicaid Waiver Amendment

The New York State Health Department submitted its 1115 Medicaid waiver amendment for a demonstration project, New York Health Equity Reform (NYHER), for a federal review in September 2022. NYHER was finally approved on January 9th, 2024 as a three-year Medicaid demonstration. This is the fourth Medicaid amended waiver demonstration approved by the federal Center for Medicare and Medicaid Services (CMS). You can access the 1115 Medicaid waiver amendment here.

Waivers #1-3

The Medicaid waivers are meant to demonstrate what can be done differently to improve the health care delivery system and improve health care outcomes. The first (the Community Health Care Conversion Demonstration Project, or CHCCDP) and third (the Delivery System Reform Incentive Payment, or DSRIP) waivers were seen by the informed community as a reward for hospitals and a way of getting added dollars to their coffers. Community evaluations of these proposals told very different stories from the official reviews.

The major goal for DSRIP was the reduction of unnecessary hospitalizations and emergency room visits. These goals were partially met. Twenty-five Preferred Provider Systems (PPS) were organized, in part, by region. Twenty-three of the PPSs were controlled by hospitals; only one was coordinated by a Federally Qualified Health Center and another by an organization of Latino and Asian physicians. The PPSs were meant to be a coalition of all types of healthcare providers and health care organizations. There were projects to be chosen and carried out by the PPS. For the first year and a half of funding, the majority of dollars were not distributed to the coalition partners, but rather were mainly used by the hospitals to develop costly administrative structures. This was discovered by an outside panel written into the legislative agreement for funds to flow. The panel (the Project Approval and Oversight Panel, or PAOP) insisted on public reporting of the funding flow and advocated for distribution of funds out to coalition partners to work on the projects. This part of the story is not reported in the literature or in the evaluation of the waiver. A survey of community-based organizations on their impressions under DSRIP shows concern.

Communities and their organizations were not incorporated well in the PPS's. Several New York city organizations lobbied the state's Medicaid Director for

funding for CBOs to do their own planning. Support from members of the PAOP resulted in funding for three regions of the state to do this planning. The report from Communities Together for Health Equity (CTHE), covering New York City, can be found here. The results were, unfortunately, largely ignored by the State, although the new proposed waiver amendment incorporates a large role for community organizations.

Waiver #4: New York Equity Health Reform

The fourth waiver proposal, New York Health Equity Reform (NYHER), is very different from the preceding three waiver amendments and would better address inequities and community needs. Its approval foreshadows dramatic changes. One big change is that the money will not be going into the hands of the hospitals. Another departure, as the title indicates, is that the state learned a great deal from the COVID-19 pandemic in who was hurt the worst during this epidemic – it was, and is, communities of color, immigrants, and essential workers.[53] The hardest hit populations were low-income and people of color, and the waiver is to have a prominent role in addressing the serious disparities that became more evident during the pandemic. You can read more about the disparities in insurance status and outcomes in the **"Who does it treat?"** section of this document.

Similarly, the NYHER proposal is distinct in its recognition of the Social Determinants of Health (SDH), or Health Related Social Needs (HRSN), as a critical element in overall healthcare design. HRSN, such as housing, food, transportation, and more, have an impact on health status and health care delivery. During the DSRIP funding, the beginnings of funding for SDH/HRSN was initiated but the determination of how and what was basically determined by Managed Care Organizations (MCOs). In NYHER, this funding will fall under a new structure named the Social Care Network (SCN). The network, composed of community organizations and social service providers, will organize the CBOs to provide screening interventions, provide for contracting arrangements, and work on building CBO capacity.

The SCN will receive dollars and fund the CBOs as well as to build the capacity within the network. Funding for services will come through MCOs as Value Based Projects (VBP) contracting arrangements. Five hundred million dollars are allocated for the development of 13 SCNs statewide with the possibility of five in New York City, one for each borough. The SCNs will set up the organization;

[53] Samantha Artiga et al., "Growing Data Underscore that Communities of Color are Being Harder Hit by COVID-19," *Kaiser Family Foundation*, April 21, 2020, https://www.kff.org/policy-watch/growing-data-underscore-communities-color-harder-hit-covid-19/.

contract with a data platform; organize and coordinate networks of CBOs; and collaborate with regional partners. Applications to become an SCN were due in March 2024, and awards will be made in August 2024. Work on Health Related Social Needs, funded at $3.4 billion, is slated to begin in October 2024. The covered services include housing supports, nutrition, transportation, and case management. Medicaid beneficiaries will be screened for eligibility for added services. Targeted high need persons, including high users of services, people with serious conditions, pregnant persons, and children under the age of six, are eligible for enhanced services.

Another important difference between this waiver and earlier waivers is the role of consumer and community organizations – the roles are prominently defined within this waiver. In the former waivers, a role for community was never defined, but rather was reliant on health care providers sponsoring or allowing such participation. Conversely, in the NYHER proposal, the community is given a specific role in components of this waiver.

The NYHER proposal also introduces the Health Equity Regional Organization, or HERO. The HERO would be a statewide planning entity performing data collection, through a $125 million contract by the State, to address health equity issues with a focus on nine regions across NYS. It would be responsible for convening and collaborating with stakeholders to collect and distribute information on outcomes, utilization, and social care needs; work to find health equities and other gaps in the regions; develop Value-Based Payment (VBP) goals and social needs in a region; and perform an evaluation. There will also be a focus on development of Substance Use Disorder (SUD) programs. Unfortunately, regional health planning was eliminated from the funded proposals. It is critical that community based organizations that are anchored in and representative of their communities have a prominent role in this planning *for* their communities. New York City is considered one region, but on the basis of their large populations each borough or county could be funded as its own region.

More details about the waiver can be found on the NYSDOH's 1115 Medicaid Waiver Information Page. You can also review the following three resources from early 2024:

- A webinar by the Health Foundation of Western and Central New York (HFWCNY).
- A webinar by HMA Health Management, a consultant corporation
- A presentation by the State Health Department team responsible for development of the NYHER waiver.

What's next?

The Future: a new federal 1115 waiver amendment that offers hope

New York State applied for a federal amendment demonstration project under its Section 1115 waiver. This was the fourth such demonstration project, this time with tremendous differences in the underlying concepts of this waiver. It also differed in who would directly benefit, how the funds would be spent, and what it was meant to accomplish. Under the first and third waivers, CHCCDP[54] and DSRIP[55] respectively, the bulk of the funding went directly to hospitals. Under the second waiver, F-SHRP,[56] funding was distributed differently, but the bulk of the funding would end up in the coffers of hospitals. This waiver's funding was tied to the state legislative approval of a report developed by the "Berger Commission," appointed by then-Governor Cuomo, with recommendations of how to reduce the number of hospitals and hospital beds in the state.

In this, the fourth waiver request, the funding is more directed toward managed care companies. But there is a more complicated and important direction of the funding.[57] Three main purposes include: a broad-based planning process; a focus on working toward equity; and focus on addressing the social determinants of health through funded regional networks of community-based providers and community-based organizations.

The fourth New York State 1115 waiver amendment was approved on January 9, 2024. Although not as originally proposed by the state, there is still an important role for community-based organizations to play within this new structure. This is critical in a new environment in which working toward health equity is a major objective, it is through CBOs that are of, from, and a major component are the critical vehicles that are culturally to work with the local population. The SCNs will contract with CBOs to screen Medicaid beneficiaries and then to help navigate and provide services to the persons that are special populations and eligible for the more specialized services. The CBOs will be paid for these services through Medicaid.

Following the approval of the 1115 waiver amendment, some important dates to watch for are the following:

- January 2024: NYHER approved - RFA for SCN Released

[54] Community Health Care Conversion Demonstration Project
[55] Delivery System Reform Incentive Payment Program
[56] Federal-State Health Reform Program
[57] New York State Department of Health, "MRT 1115 Waiver Extension Request," February 2023, https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/index.htm.

- March 2024: SCN Applications due
- June 2024: HERO planning work begins
- August 2024: SCN contracts, AHEAD application due
- October 2024: HRSN services begin

Conclusion

In this manual, topics have spanned the key players in the healthcare system to the disparities in insurance coverage and treatment to the new 1115 Medicaid waiver. Our hope is that this document has helped to demystify some of New York City's healthcare system, identify resources, and illuminate pathways for additional learning. Our hope is also that this information is shared, built upon, and used. Some of the ways you can get involved include, but are not limited to, joining the board of an FQHC; participating in the community advisory board of a public hospital, nursing home, or ambulatory care center; or sharing your voice as a district Community Board member.

You're not alone. The system is complex, imperfect, and sometimes unwieldy. It might feel overwhelming to come to terms with all that you still don't know about the system, and to reckon with all its flaws. However, New York City is full of people working tirelessly to improve it. You can join them in imagining a healthcare system that best serves you and your community and advocating for the changes you wish to see in the system. You do not need to know everything to get started. Hopefully, this manual gives you everything you need to take the first steps. What you choose to do with the information provided in this manual could one day influence your health, your family's health, your community's health, and your city's health.

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Appendix

I. Greater New York Hospital Association (GNYHA) Member Directory Networks

This table contains information from the GNYHA Member Directory detailing what health centers, clinics, and/or hospitals within the GNYHA belong to each larger hospital network.

Network name	Hospital name	Location
BronxCare Health System	BronxCare Children's Pavilion	Bronx
	BronxCare Dr. Martin Luther King Jr. Health Center	Bronx
	BronxCare Health and Wellness Center	Bronx
	BronxCare Hospital Center (Concourse)	Bronx
	BronxCare Hospital Center (Fulton)	Bronx
	BronxCare Life Recovery Center	Bronx
	BronxCare Mount Sinai Comprehensive Cancer Care Facility	Bronx
	BronxCare Special Care Center	Bronx
Episcopal Health Services	St. John's Episcopal Hospital	Far Rockaway
Maimonides Health	Maimonides Medical Center	Brooklyn
	Maimonides Midwood Community Hospital	Brooklyn
MediSys Health Network	Flushing Hospital Medical Center	Flushing
	Jamaica Hospital Medical Center	Jamaica
Montefiore Health System, Inc.	Montefiore Medical Center - Einstein Campus	Bronx
	Montefiore Medical Center - Montefiore Westchester Square	Bronx
	Montefiore Medical Center - Moses Campus	Bronx
	Montefiore Medical Center - The Children's Hospital at Montefiore	Bronx
	Montefiore Medical Center - Wakefield Campus	Bronx
Mount Sinai Health System	Mount Sinai Beth Israel	New York
	Mount Sinai Brooklyn	Brooklyn
	Mount Sinai Morningside	New York
	Mount Sinai Queens	Astoria
	Mount Sinai West	New York

	New York Ear and Eye Infirmary of Mount Sinai	New York
	The Mount Sinai Hospital	New York
NewYork-Presbyterian	NewYork-Presbyterian Allen Hospital	New York
	NewYork-Presbyterian Brooklyn Methodist Hospital	Brooklyn
	NewYork-Presbyterian Lower Manhattan Hospital	New York
	NewYork-Presbyterian Morgan Stanley Children's Hospital	New York
	NewYork-Presbyterian Queens	Flushing
	NewYork-Presbyterian/Columbia University Irving Medical Center	New York
	NewYork-Presbyterian/Weill Cornell Medical Center	New York
Northwell Health	Lenox Hill Hospital	New York
	Staten Island University Hospital	Staten Island
NYC Health + Hospitals	Bellevue	New York
	Carter	New York
	Coney Island	Brooklyn
	Elmhurst	Elmhurst
	Harlem	New York
	Jacobi	Bronx
	Kings County	Brooklyn
	Lincoln	Bronx
	Metropolitan	New York
	North Central Bronx	Bronx
	Queens	Jamaica
	Woodhull	Brooklyn
NYU Langone Health	NYU Langone Hospital--Brooklyn	Brooklyn
	NYU Langone Hospitals--Tisch Hospital/Kimmel Pavilion/Hassenfeld Children's Hospital	New York
	NYU Langone Orthopedic Hospital	New York
One Brooklyn Health System	One Brooklyn Health: Brookdale Hospital Medical Center	Brooklyn
	One Brooklyn Health: Interfaith Medical Center	Brooklyn
	One Brooklyn Health: Kingsbrook Jewish Medical Center	Brooklyn
SBH Health System	Saint Barnabas Hospital	Bronx
Veterans Health Administration	Brooklyn VA Medical Center	Brooklyn
	James J. Peters VA Medical Center	Bronx

	Margaret Cochran Corbin Campus	New York
	St. Albans VA Medical Center	Jamaica
No network given	Calvary Hospital	Bronx
	Hospital for Special Surgery	New York
	Memorial Hospital for Cancer and Allied Diseases	New York
	SUNY Downstate Health Sciences University / University Hospital of Brooklyn	Brooklyn
	The Brooklyn Hospital Center	Brooklyn
	The New Jewish Home	New York
	The Rockefeller University Hospital	New York
	Wyckoff Heights Medical Center	Brooklyn
	Richmond University Medical Center	Staten Island

II. Helping Organizations

This table details the CBO networks of Access Health NYC, CHA, and MCCAP. You can click on any of these organizations to be directed to their website.

Network	Organizations
Access Health NYC	APICHA Community Health Center
	Arab-American Family Support Center
	Bedford Stuyvesant Family Health Center
	BOOM!Health
	Callen Lorde Community Health Center
	Care for the Homeless
	Charles B. Wang Community Health Center
	Chinese American Planning Council
	Commission on the Public's Health System
	Community Healthcare Network
	Community Health Center of Richmond
	Community Service Society of New York
	Council of Peoples Organizations

	Dominican Sunday
	Elmy's Special Services
	Emerald Isle Immigration Center
	Fort Greene Strategic Neighborhood Action Partnership
	HANAC, Inc.
	Health People
	Henry Street Settlement
	Japanese American Social Services, Inc.
	Korean Community Services of Metropolitan New York
	Make the Road New York
	Mary Mitchell Family and Youth Center
	Mekong NYC
	New York Immigration Coalition
	Northern Manhattan Improvement Corporation
	Polonians Organized to Minister to Our Community, Inc.
	Public Health Solutions
	Sapna NYC
	South Asian Council for Social Services
	Sunset Park Family Health Center at NYU Langone
	Adapt Community Network (formerly United Cerebral Palsy of New York City)
	United Chinese Association of Brooklyn
	Urban Health Plan, Inc.
	Voces Latinas
	Young Women's Christian Association of Queens
CHA	Asian Americans For Equality
	BronxWorks
	Brooklyn Perinatal Network
	Center for Independence of the Disabled, New York
	Emerald Isle Immigration Center
	Empire Justice Center*
	The Legal Aid Society*
	Make the Road New York

	Medicare Rights Center*
	South Asian Council for Social Services
	United Jewish Organizations of Williamsburg and North Brooklyn
	Urban Health Plan
	**CHA Specialist Agencies*
MCCAP	Community Service Society
	Council of Peoples Organization
	Jewish Community Center of Staten Island
	Jewish Community Center of Rockaway Peninsula
	Korean Community Services of Metropolitan New York
	LGBT Network
	Make the Road New York
	Northern Manhattan Improvement Corporation
	Northern Manhattan Perinatal Partnership
	Polonians Organized to Minister to Our Community
	South Asian Council for Social Services
	Urban Justice Center