HFMA briefing
September 2023

The New York health system

Lessons from across the pond

Introduction

The major challenges facing the healthcare system in the United Kingdom – such as an increase in demand, workforce shortages, health inequalities, financial sustainability and information management – are common across the world. Despite different structures and funding arrangements in place, there is a lot to be learnt from countries with similar challenges and aspirations.

Caroline Clarke, NHS England's new London regional director, took up her new role earlier this year with the aim of trying to make London's health and care services the best they can possibly be. Wanting to visit a city comparable with London to see what works well elsewhere, New York was an obvious choice – both are large western cities with a population of almost nine million people and large disparities in life expectancy as you move from east to west[1].

Caroline's visit to New York in June 2023 was supported by a bursary from the HFMA and she was accompanied by Lisa Robertson, HFMA senior policy manager. The visit included discussions with the Greater New York Hospital Association, Department of Health and Mental Hygiene, New York Health and Hospitals Association and the Coalition for Behavioural Health, as well as visits to health systems and sites in Staten Island, Montefiore and East Brooklyn. These visits provided a fantastic wealth of insight and we would like to thank all of those we met in New York who were so generous with their time.

This paper sets out the insights from the visit. Further reflections can be heard on the HFMAtalk episode, *Across the pond: comparative healthcare systems in the US*[2].

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[1] The population of New York city was 8,804,00 in 2021 based on the US census (U.S Census Bureau, *QuickFacts: New York city*, April 2020) and the population of London was 8,600,000 based on the UK census 2021 (ONS, *Census 2021*, June 2022)

[2] HFMA, *HFMAtalk episode 54 – Across the pond: comparative healthcare systems in the US*, July 2023

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Overview of the New York city healthcare system

Funding

The biggest difference between healthcare in the United States and the United Kingdom is the way it is funded. Under the insurance-based model there are three ways care is paid for:

- commercial payer with reimbursement through private insurance
- government payer:
  - Medicaid for those on low income with 50% funded by the federal government and 50% funded by the relevant state
  - Medicare for those over 65 mainly funded by the federal government
- uninsured.

In New York the payer mix is just under one third each across private insurance, Medicaid and Medicare with the remaining 5% uninsured.

Providing an overview of the funding arrangements, the Greater New York Hospitals Association (see **box 1**) shared the financial context, noting the differences in the amount of costs recovered (cost ratio) depending on the type of payer.

In 2021 cost ratios were approximately 150 to175% for commercial payers; 84% for Medicare; and 61% for Medicaid. Based on the difference in recovery rates between types of payers, cost shifting between commercial and government payers is a common approach. The payer mix therefore has a significant impact on financial sustainability.

Costs and charges vary significantly between hospitals and with no price controls in place, different hospitals will charge different amounts for the same procedures. Commercial insurances are variable, both in terms of which hospitals it covers and levels of excess payments for individuals. A patient will also use specialist hospitals for different things. For example, if you want a knee operation you will go to a hospital known for that and then somewhere else for neurology.

With an insurance model coding is clearly important. Some 25% of commercial claims are initially denied with approximately 60% of these subsequently paid in part or full. State and federal governments prevent billing the patient for surprise bills. There are conditions of service that must be met for Medicaid and Medicare and although it is largely a fee for service model, there is a movement towards value based care with the requirement to demonstrate some level of quality outcomes. Litigation also forms a significant aspect of the health system.

Other funding includes:

- grant funding (government or foundations): for many programmes (such as social prescribers or school programmes) start with seed funding from government grants or money from foundations
- fundraising: the scale varies significantly from large capital campaigns at academic medical centres to local community events for voluntary hospitals
- behavioural health (referred to as mental health in the NHS) and substance use programmes: largely funded by government contracts
- capital: Medicaid has a capital component largely based on historic spending and further funding is sought from federal grants, banks and community lending groups.

Box 1: Greater New York Hospital Association (GNYHA)

The GNYHA is a trade association of nearly 280 member hospitals, health systems and continuing care facilities in New York. It provides support, technical assistance and guidance to members on issues facing hospitals and health systems covering topics such as finance, government, workforce, health equity, legal and emergency preparedness.
For more information see *Greater New York Hospital Association website*

Structure

There are a range of health care providers in New York city covering the five places of Manhattan, The Bronx, Brooklyn, Queens and Staten Island.

Unlike many parts of the United States, New York does not allow investor-owned private companies to own hospitals. Instead, privately owned not for profit hospitals exist (known as voluntary hospitals). There is a competitive market in New York and the five major voluntary systems are academically based, for example, Montefiore Health System is the university hospital for Albert Einstein College of Medicine. In addition, public hospitals (known as safety net hospitals) are run by New York City Health and Hospitals (see **box 2**). New York regulations do allow for primary care profit companies and as such there is an increasing trend of large networks (such as a CVS pharmacy chain and Amazon) to employ a large number primary care physicians.

Box 2: New York City Health and Hospitals (NYH&H)

NYH&H operates the public hospitals and clinics in New York city as a public benefit corporation. It is the largest municipal healthcare system in the United States and provides an integrated network of hospitals, community-based health centres, long-term care and rehabilitation facilities, home care services, and correctional health services. Its funding is unique with city budget critical, particularly to capital support and it is committed to provide care regardless of the ability to pay.

Its focus is on being one system, rather than a disjointed set of organisations. This was a driver of its Epic implementation to provide a single system view, its single biggest capital programme across acute hospitals. Epic provides medical records software for over 70% of patients in the United States. The recognising of the clinical cost of being disjointed was a key selling point for investment in the new system. The last of its hospitals went live with Epic in March 2022, having a significant impact on managing the Covid-19 pandemic such as identifying surge opportunities. Empowered leadership and involvement of clinicians were key learning points.

For more information see *NYC Health and Hospitals website*

There are many layers of healthcare regulation including federal, state and city. The federal government has a Center for Medicaid and Medicare Services (CMS) which sets the conditions of participation[3], with a list of various measures and star ratings awarded this is a significant tool in driving quality. Similar to the UK, the Covid-19 pandemic brought health equity to the fore and this has been reflected in the CMS domains. The New York City Department of Health and Mental Hygiene (DoHMH) undertakes a range of roles (see **box 3**) including state oversight of providers.

Ambulance dispatch is run by the fire department (via 911) and hospitals often have their own ambulances advertised within the community. A new mental health number, 988, is used to dispatch ambulances with a social worker. There is not a national equivalent to the UK's 111 for advice, although private payers do have insurance numbers to provide similar assistance.

In terms of information, Healthix[4] is mandated in New York, providing overnight patient data. Information is collated without permission, but doctors can only see it if patients have opted in. It provides electronic alerts to physicians when a patient contact is made such as emergency room admission. All hospitals in New York have an electronic medical record now, with 70% using Epic, although there is variation in what they do. New York City Health and Hospitals (**box 2**) completed their Epic implementation across all their publicly owned hospitals in March 2020, impacting significantly on their ability to respond to the Covid-19 pandemic.

Many of the workforce issues in New York are the same as in the United Kingdom, such as vacancy levels, particularly in mental health, wage pressures with competition particularly from the retail

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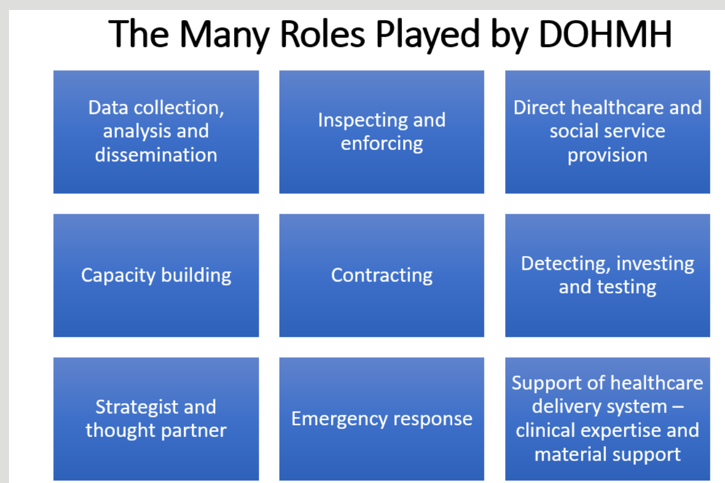
[3] CMS, *Centers for Medicaid and medicare services*, website
[4] Healthix, *What we do*, website

sector and preference for specialisms over primary care. There has been some recent industrial action but this tends to be one system at time. One tool used to encourage nurses and doctors to practice in under-served areas is the payment of loans accrued at medical school. This is called the loan forgiveness programme.

Box 3: New York City Department of Health and Mental Hygiene (NYC DOHMH)
With an annual budget of $1.6 billion and more than 6,000 employees, NYC DOHMH is one of the largest public health agencies in the world. Positioned as the city health strategist, focusing on population health and public health, its key roles are set out below. It does not allocate funding or undertake performance management.



For more information see NYC health website

What we saw

As set out above, our conversations with the GNYHA, DoHMH and NYH&H provided a helpful overview on the way the New York health system is set-up, the key challenges and the policy direction.

Each of the sites we visited provided specific examples of how healthcare organisations and systems are working with local people to improve healthcare for their populations. Common to each of these visits, we saw strong leadership, dedication and teamwork; a focus on the social determinants of health; and the role of charitable and faith foundations in providing essential support.

As well as our formal visits to healthcare institutions, we were fortunate to be able to travel around New York city during our week there. What we found striking was the visible level of opiod use, as well as a large number of people both physically and mentally frail on the streets. It felt very different to walking around equivalent areas in London.

Montefiore Health System

The Montefiore system is an academic health system covering a population of 3.5 million and comprising 11 hospitals and more than 200 outpatient ambulatory care sites. It owns the Albert Einstein College of Medicine and is nationally recognised for its clinical excellence (see **box 4**).

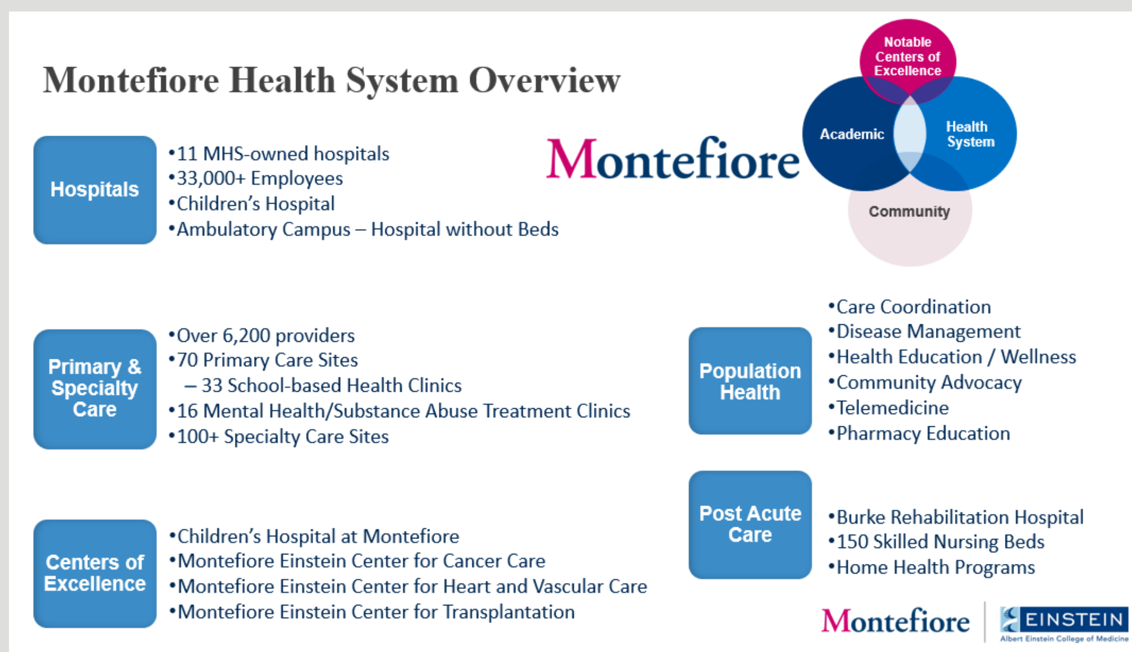
Montefiore is particularly proud of its whole person model providing an integrated approach, wrapped around what the patient needs from primary care, hospital stays, transitions to the community and behaviour health. Its journey of integration is set out in the King's Fund paper, *The Montefiore Health System in New York: integrated care and the fight for social justice*[5].

[5] The King's Fund, *The Montefiore Health System in New York: integrated care and the fight for social justice*, April 2018

Its focus on the social determinants of health is integral to its work – directly working in the community with schools, housing and community groups. The schools programme was particularly impressive. With a mission to achieve health and well-being for all Bronx public school students through full access to high quality comprehensive primary and preventative health services, the Montefiore school health programme is the largest and most comprehensive in the country. It started with government seed funding. It serves about 98 schools, has 32 full service health centres and one stand-alone mental health clinic – providing both critical health services and building trust and relationships within the local community to last throughout their lives. The theme of trust and relationships was also a key feature of their successful peer support workers programme.

Another area of focus for the team was the effective role of information. Dr Andrew Raccine, system senior vice president and chief medical officer, made the point that information management is at the core of their business, critical to supporting physicians to manage their workload and to direct resources effectively. The importance of communicating both medical and non-medical information was also emphasised, ensuring that key information is well communicated during handovers.

Box 4: Montefiore Health System



For more information see Montefiore Health System website

Staten Island Performing Provider System

Staten Island Performing Provider System (SIPPS) is an integrated network of medical, behavioural and social services agencies (see **box 5**). Its goal is to make change via collaboration and it works across over 55 organisations including hospitals, primary care, community-based organisations and higher education. As an island it is a good example of how integration can work in one place, demonstrated in the case study, *A case study in effective integration: the Staten Island PPS.*[6]

[6] Integrated Care Journal, *A case study in effective integration: the Staten Island PPS*, August 2022

Box 5: Staten Island Performing Provider System (SIPPS)

'In 2014, Staten Island Performing Provider System (SIPPS) formed an integrated network of medical, behavioral, and social services agencies under the New York State Department of Health Delivery System Reform Incentive Payment Program (DSRIP). Our founding goals included improving the quality of care, reducing costs and improving health outcomes for Staten Island's Medicaid and uninsured populations. By the end of the DSRIP Program, we exceeded our goals and maintained our network to continue enhancing and refining the transformative work built in the Staten Island Community.

Today, we continue to work with our partners to improve population health outcomes, address social determinants of health, grow our network and reduce health disparities. We are dedicated to improving health equity by holding conversations with our community, creating educational and workforce opportunities for youth, and bridging connections with non-traditional service providers to meet people where they are in the community.'

For more information see Staten Island Performing Provider System website

SIPPS recognises that comprehensive data analytics are essential in transitioning from volume to value – both in terms of population management decisions and active individual patient management. It brings real time data together from primary and secondary care with the aim to push care upstream into prevention and primary care. We heard from one of the more advanced primary care practices in the community using this data to identify trends (such as whether annual checks are up to date) and engage individuals (such as having conversations when patients are admitted to the emergency department). A number of indicators, such as cancer screenings, are earning based indicators and the use of data analytics has been used to improve performance against these indicators.

Co-ordination across several data sources to turn data into useful information requires dedicated data analyst resource. We heard more on this from Dr Salvatore Volpe, emphasising the importance of a team-based information technology approach to improve healthcare[7].

Another key area of focus at SIPPS is the approach to screening for social determinants of health (SDOH). Partnering with a number of organisations such as schools, law enforcement and peers/faith-based organisations in the community, it uses a SDOH survey to look for triggers for early intervention on areas such as substance misuse, diabetes and asthma. Surveys cover a large number of areas such as hospital, housing, food, workforce, social services, clothing, health literacy, legal, safety, transportation and behavioural health. The care management approach uses these to see the distribution of SDOH needs by zip code and inform the referral management system.

A visit to Richmond University Medical Centre, one of the SIPPS organisations, demonstrated how doctors, hospitals and other health care providers come together voluntarily to give co-ordinated health care to their Medicare patients. This centred around the four pillars of financial, clinical care, patient experience and analytics, with improvement in maternal health being particularly impressive.

One of the things the SIPPS also shared was their 'warm hand-off programme', emphasising that while technology is key to much of their work, this must go together with a human touch for all patients.

Coalition for Behavioural Health

David Woodlock, a leader in behavioural healthcare, along with the Coalition of Behavioural Health brought together a number advocates for behavioural health to share their experiences. In his own book, *Emotional dimensions of healthcare*[8], David sets out a holistic approach to healthcare in which the patient's emotional history is paramount.

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[7] Volpe Salvatore, *Health informatics: multidisciplinary approaches for current and future professionals*, 2022
[8] David Woodlock, *Emotional dimensions of healthcare*, May 2017

The group noted it is important to recognise that behavioural health patients have a higher cost to the system and that by enabling people to do the right thing to support them through greater integration also saves money. This realisation has been accelerating progress to integrate primary care and behavioural health transformation. Examples include:

- Primary care development corporation case study – *Closing the behavioural health integration gap: a New York case study*[9] including recommendations on financing to build primary care on site
- *The Meadowlark initiative*[10] – an example of deep integration bringing together clinical and community teams to provide support healthy pregnancies and secure families
- *The comprehensive healthcare integration framework*[11] – a framework of eight domains of integration used to implement the integration of physical health and behavioural health.

These examples are helpful to understand how the partnerships work and the issues facing the city in providing integrated services. To bring this to life, we then visited the East New York Health Hub (see **box 6**). Primary care and integrated behavioural health are brought together on one site combining the Institute for Community Living (ICL) and the Community Healthcare Network (CHN) to provide assessment and evaluation, psychotherapy, education, health monitoring, care co-ordination, peer support, employment support and crisis support – all with no insurance required. The only limit for the centre is that you need to live in the local community. They work closely to provide supporting housing beds and provide a wellness programme including yoga, an art studio, a food pantry and more. Bi-directional integration is used to refer both from primary care to behavioural health and vice versa.

Perhaps the best measure of the success of the Hub is the newly built similar and competing facility across the street.

Box 6: The Coalition for Behavioural Health

The Coalition for Behavioural Health provides policy, advocacy, training and technical assistance to more than 100 community-based behavioural health providers.

During our visit they brought together a number of experts working across the city to share examples of good practice and took us to East New York Health Hub.

For more information see The Coalition for Behavioural Health website

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[9] Primary Care Development Corporation, *Closing the behavioural health integration gap: a New York case study*, December 2019
[10] The Meadowlark Initiative, *The Meadowlark initiative evaluation 2022*, January 2023
[11] National Council for Mental Wellbeing, *The Comprehensive healthcare integration framework*, April 2022

What we learned

Despite the differences in structure and funding, many of the challenges, opportunities and aspirations we saw in New York are similar to those faced in the United Kingdom today. Many of the examples demonstrate what integrated care systems in England are aiming to achieve as they bring partner organisations together to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

We saw some inspiring examples of how to manage services by wrapping them around the patient. Reflecting on the visit the key factors that can have the most positive impact are set out below.

Trust: One of the common themes from all those we talked to was the importance of building good relationships and trust within the community such as the Montefiore schools programme, the Staten Island faith groups and the encouragement to talk to a primary care physician when coming into the East New York Hub at a time of crisis. This also provided a renewed understanding of the importance connecting with school children now in order to engage the workforce and patients of the future.

Integration: In terms of integration it is helpful to think about what level it is best to integrate at – for many of the examples we saw this was at a local neighbourhood level. Bi-directional integration was also effective, particularly in communities with limited contact with a health or care provider. Proactive, community based screening of the social determinants of health in order to provide early intervention was a common feature with the work of Professor Michael Marmot and the Institute of Health Equity[12] quoted several times. The holistic approach incorporated the full range of health factors such as social services, housing, education etc.

Workforce: There were many examples that demonstrated the importance of teams uniting under a common goal alongside good relationships helping to make organisations a good place to work. There was evidence of people using different roles to tackle workforce shortages and achieve better outcomes such as the use of community peers. Investment in teams was also demonstrated, such as the use of data analysts, reflecting the recommendations set out in *The Topol review*[13]. The need for ‘whole person’ training was emphasised, different to usual training in either residency, social work, nursing school etc.

Quality: Since the pandemic, quality can be redefined to encompass access and equity. The accreditation metric, CMS, demonstrate the importance of aligning metrics and incentives around outcomes.

Leadership: Another common feature among those organisations we visited was the strength of leadership and the involvement of clinicians. In many cases long term relationships and the involvement of clinicians was integral. The leadership team in Staten Island recognised a key part of their role was ‘to take obstacles away so everyone can do their job’.

Information: Described by Montefiore as ‘an information business’, it was clear throughout our visit that the use of real time data that is easy to understand and use, is the aspiration. This includes sharing data between primary and secondary care to be used for population management and individual proactive patient management.

Communication: The concept of the warm hand-off was referred to at both Staten Island and Montefiore, recognising the importance of communicating patient needs. This recognised that there is so much more information about a patient that that included on an electronic record and some of this is best shared quickly at the handover stage. There was a real focus on patient needs, such as the primary care centre focusing on behavioural health (Staten Island).

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[12] Institute of health equity, *The UCL Institute of Health Equity*, website

[13] NHS England, *The Topol review: preparing the healthcare workforce to deliver the digital future*, February 2019

As well as insights from New York, this visit was a helpful reminder about what we should be proud of in the United Kingdom. Despite the current challenges, many we spoke to in New York were keen to point out the advantages of our one NHS system, the lack of a need for an army of people for billing and the potential access to system wide data. The task at hand it to make the most of these opportunities.

As Caroline Clarke commented, ‘In a period of austerity we need to be our most creative selves.’ Taking time to reflect on what we can learn from excellent work being carried out both here and abroad is a good starting point.

Acknowledgements

This visit was made possible by those in New York so generously willing to share their experiences and time. We would like to thank everyone listed below.

Coalition for Behavioural Health

- Amy Dorin, The Coalition for Behavioural Health
- David Cohen, Maimonide Medical Center
- Henry Chung, Montefiore Health System and Albert Einstein College of Medicine
- Louise Cohen, Primary Care Development Corporation (PCDC)
- Jody Rudin, ICL
- Joan King, National Council for Mental Wellbeing
- John Coppola, New York Association of Alcoholism and Substance Abuse Providers
- All the team at the East New York Health Hub
- David Woodlock, Woodlock and Associates

Department of Health and Mental Hygiene

- Ashwin Vasan
- Jenna Mandel-Ricci
- Emiko Otsubo
- Aaron Anderson
- Simran Chaudri
- Madeline Barasso
- Calaine Hemans-Henry

Greater New York Hospital Association

- Barbara Green
- Elizabeth Wynn
- Emily Leish
- Laura Alfredo
- Tim Johnson
- Erin Dupree
- Lloyd Bishop
- Alison Burke
- Andrew Dahl
- Puja Khare

Helgerson Solutions Group

- Jason Helgerson
- Sarah Crick

New York Health and Hospitals Association

- Dr Kim Medez
- Matthew Siegler
- Michael Bouton
- David Silverstri,
- David Mancher
- Jeremy Segall
- Komai Lodaria
- Rachel Larkin

Montefiore Health System

- Colleen Blye
- Dr Andrew Racine
- Matthew McDonough
- Dr Sybil Hodgson
- Dr Kevin Fiori
- John Williford
- Stephen Rosenthal
- Rosy Chhabra

Staten Island

- Joseph Conte
- Ashley Restaino
- Salvatore Volpe
- Anyi Chen
- Jolani de la Porte
- Mindy Mannarino
- Susan Beane
- Richard Salhany
- Humroy Mendez
- David Wortman
- Rosemarie Signorile
- Vivienne Destafano
- Harold del Pino
- All the team at the Richmon University Medical Care Clinic
- All the team at the Community Health Center of Richmond

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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HFMA is also a limited company registered in England and Wales, no 5787972. Registered office: 110 Rochester Row, Victoria, London SW1P 1JP

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