Frederic Abergel
Since April 1st, 2015, Frederic Abergel is Deputy Chief Executive Officer of the CIUSSS North-of-Montreal, one of the 5 integrated health and social services center in the island of Montreal (Quebec, Canada). He is responsible for coordinating clinical care as well as quality and performance initiatives, in addition to directing corporate support services (quality-performance, facilities management and IT). From 2008 to 2015, he was responsible for coordinating primary, acute and rehabilitation care in Montreal at the Montreal Health And Social Services Agency, as well as planning medical manpower.

Trained as an occupational therapist, he holds a master’s degree in healthcare administration and a Ph.D. in public health (healthcare administration). He is a Certified Healthcare Executive from the Canadian College of Health Leaders, and member of peer-review committees at the Canadian Institute for Health Research (CIHR).

Sonia Angell
Dr. Sonia Angell is a Deputy Commissioner at the New York City Department of Health and Mental Hygiene, overseeing the newly created Division of Prevention and Primary Care. This Division works to advance population health by improving access to high-quality health services and health insurance and introducing innovative system changes that promote disease prevention and control. It builds upon a history of innovative policy and programming in primary health care delivery systems and communities by bringing together the existing bureaus of Chronic Disease Prevention and Tobacco Control, Primary Care Information Project, and Primary Care Access and Planning. Prior to rejoining the NYC DOHMH in August 2014, Dr. Angell was a Senior Advisor for Global Noncommunicable Diseases at the Centers for Disease Control and Prevention (CDC) in Atlanta. Dr. Angell is board certified in internal medicine and is an Assistant Clinical Professor of Medicine at the College of Physicians and Surgeons of Columbia University and an Assistant Attending Physician at New York Presbyterian Hospital. She received her medical degree from the University of California San Francisco and completed her residency in Internal Medicine at Brigham Women’s Hospital in Boston. She has a Diploma in Tropical Medicine and Hygiene from the London School of Hygiene and Tropical Medicine, and a Masters in Public Health, Epidemiology from the University of Michigan. She is a former Robert Wood Johnson Clinical Scholar and is a Fellow of the American College of Physicians.

Nancy Berlinger
Nancy Berlinger is a research scholar at The Hastings Center since 2002, studying ethical challenges arising in health care work, encompassing health care ethics, public policy concerning health care access, and problems of safety and harm in health care systems. She is a graduate of Smith College (1984) and earned her doctorate in English Literature from the University of Glasgow (1988). She also received a MDiv, with a focus on ethics, from Union Theological Seminary (2002).

Lawrence Brown
Lawrence D. Brown served as former chair of the Mailman School’s Department of Health Policy and Management for 10 years and Columbia University’s Public Policy Consortium for three years. A political scientist, he served on the faculty of Harvard University and the University of Michigan, and held positions at the Brookings Institution before joining the Columbia faculty in 1988. Dr. Brown is the author of Politics and Health Care Organizations: HMOs as Federal Policy (Brookings Institution, 1983) and of articles on the political dimensions of community cost containment, expansion of coverage for the uninsured, national health reform,
the role of analysis in the formation of health policy, and cross-national health policy. Dr. Brown edited the Journal of Health Politics and Policy and Law for five years, and has served on several national advisory committees for the Robert Wood Johnson (RWJ) Foundation. He is a recipient of a RWJ Investigators in Health Policy award and a member of the Institute of Medicine.

Pierre Gerlier (PG) Forest
Dr. PG Forest is the new Dean of the School of Public Policy at the University of Calgary and Palmer Chair in Policy. He joined the university of Calgary after serving as director of the Johns Hopkins' Institute for Health and Social Policy since 2013. Prior to that, he served as president and CEO of the Pierre Elliott Trudeau Foundation, where he was engaged in policy research in areas such as urban policy, immigration, democratic reform, and Canada's energy future. Earlier in his career, PG Forest held prominent positions with Health Canada, where he was accountable for the quality and integrity of the ministry’s scientific and regulatory research. He also served as research director for the Royal Commission on the Future of Health Care in Canada. PG Forest is a fellow of the Canadian Academy of Health Sciences.

Michael K. Gusmano
Michael K. Gusmano is Associate Professor in the Rutgers School of Public Health and a Research Scholar at the Hastings Center. His research focuses on health policy and comparative health systems, with a particular emphasis on inequities in health and health care. He co-directs the “World Cities Project” with Victor Rodwin and the “Undocumented Patients Project” with Nancy Berlinger. Dr. Gusmano serves as the International Editor for the Journal of Aging and Social Policy and an Associated Editor for Health Economics, Policy and Law.

Antoine Groulx
Antoine Groulx, MD, MSc, FCMF has been a family physician since 2004. During and after his studies, he has presided in many medical unions and occupied several medical-administrative hospital functions. He has also presided over the Quebec College of Family Physicians, and serves as an associate clinical professor at Laval University. Since 2013, he has served as the director of integrated primary health care organization at the Ministry of Health in Quebec while maintaining his clinical and teaching activities. He has been active in piloting primary care reform in the hope of improving Quebecers’ access to timely, high quality, local health care.

Jill Huck
Jill Huck is the Director of the Project Management Office for the DSRIP Program at The Mount Sinai Health System. In this role, she is responsible for all operational aspects of the DSRIP Performing Provider System, including project management, human resources, communications and PR, stakeholder engagement, network development, and data analysis. The Mount Sinai PPS, LLC links The Mount Sinai Health System to over 150 health partners and community-based organization with the goal of reducing avoidable hospital re-admissions through strengthening community partnerships and investing in technology to improve care delivery and patient access. Jill has worked in multiple sectors of the inpatient hospital including; rehabilitation medicine, information technology, project management, and strategic planning. She has been at Mount Sinai for over a decade. Prior to her role in DSRIP she worked for the Office of the President to further the successful integration of the Mount Sinai Hospital and Continuum Health Partners after the two hospital systems merged in 2013.
**Ronda Kotelchuck**

Ronda Kotelchuck is the founding and now retired CEO of the Primary Care Development Corporation (PCDC), a unique public-private partnership with a mission of expanding access and improving primary care in underserved communities. Since its inception in 1993, PCDC’s Capital Program has financed 120 primary care projects totaling $670 million in investment and providing new capacity to care for 860,000 low income Americans. PCDC has also worked with 900 health care organization and 7,000 health care workers to cut waiting times, create same-day access, reduce no-shows, develop team-based, coordinated care, create patient-centered processes, increase productivity, adopt and use electronic health records and implement the patient centered medical home model of primary care.

Ms. Kotelchuck served on the original workgroup that conceptualized, designed and established PCDC and has served as its CEO from 1993 when it commenced operations to 2015, when she retired. Prior to PCDC, she worked for the NYC Health and Hospitals Corporation where, as Vice President for Corporate Planning and Intergovernmental Relations, she spearheaded HHC’s 1989 strategic plan which focused in part on the need for primary and preventive care. Ms. Kotelchuck previously worked for the NYC Financial Control Board, the Greater Boston Health Systems Agency and the Health Policy Advisory Center. Ms. Kotelchuck received her Masters in Regional Planning from Cornell University and her Bachelor of Arts from Lewis and Clark College in Portland, Oregon.

**Steven Newmark**

Steven Newmark is the Senior Health Policy Advisor in the Office of the New York City Mayor, where he works directly with the City’s Health Department and municipal hospital system (NYC Health + Hospitals), and spearheads mayoral initiatives aimed at expanding access to primary care. Steven previously served as General Counsel to then Public Advocate Bill de Blasio, and as a health law litigator at the law firm Orrick, Herrington & Sutcliffe, where his team successfully argued over a dozen cases before various appellate courts, including the U.S. Supreme Court. Steven is also an adjunct professor in health care policy at CUNY Baruch.

**Raynald Pineault**

Dr. Raynald Pineault holds a PhD in medical care organization from the University of Michigan (Ann Arbor). He was Director of the Department of Social and Preventive Medicine from 1981 to 1992 and Vice Dean of Public Health from 1993 to 1995 in the Faculty of Medicine at Université de Montréal. From 1997 to 2001 he was Director of the Health Interdisciplinary Research Group and Deputy Director of the CHUM Research Center. His research interests have more recently focused on the problems of primary care as well as knowledge transfer and dissemination of research results to managers and decision makers. He is the author of numerous scientific articles and has directed more than thirty master’s and doctorate students. He was named professor emeritus at Université de Montréal in September 2003. The Québec Population Health Research Network in 2006 awarded him the prize for "distinguished scholar." He is currently consulting physician to the Public Health Department of Montreal and the National Public Health Institute of Quebec.

**Victor Rodwin**

Victor G. Rodwin is Professor of Health Policy and Management, Wagner School of Public Service, New York University. He is co-director (with Michael K. Gusmano) of the World Cities Project. His research focuses on health planning and policy, comparative analysis of health care systems, and urban health with special attention to health system performance and aging in world cities. Some recent publications include a book (with M. Gusmano and D. Weisz) Health Care in World Cities: New York, London and Paris (Johns Hopkins U. Press, 2010; Disparities in access to health care among three French regions (Health Policy), Dimensions

Denis A. Roy
Dr. Denis A. Roy holds a community medicine specialty and is a Harkness Fellow of the Commonwealth Fund in Health Policy. Since May 2015, he serves as Vice-President, Science and Clinical Governance at Institut national d’excellence en santé et services sociaux. He is also Acting President of the Canadian Association of Health Services and Policy Research (CAHSPR / ACRSPS). From 2009 to 2015, as Vice-President, Scientific Affairs, he has been responsible of the Institut National de Santé Publique du Québec comprehensive scientific program on the determinants of population health. Dr. Roy has also been president of the Board of l'Initiative sur le Partage des Connaissances et le Développement des Compétences, a province-wide capacity building consortium aimed at health system improvement. He is the proud co-author of a reference book on health networks’ management and governance. Previously, Dr. Roy has occupied three other executive leadership positions at l’Agence de la Santé et des Services Sociaux de la Montérégie, at the Quebec Health and Social Services Ministry and at the Montreal Public Health Department.

Sam Solomon
Sam Solomon is an attorney and the Deputy Director of Policy for the New York City Mayor’s Office of Immigrant Affairs. He has served on the steering committee of the Mayor’s Task Force on Immigrant Health Care Access and has published works on the implementation of the Affordable Care Act, among other topics. From 2006 to 2010, he served as the associate editor of the National Review of Medicine, in Montreal, where he reported on Canadian health policy.

Rishi Sood
Rishi Sood is Deputy Director of Policy in the New York City Health Department’s Bureau of Primary Care Access and Planning. In this role he works on various policy initiatives to improve access to quality primary care for New York City’s low-income and immigrant populations. He was the Department’s lead representative on the recent Mayor’s Task Force on Immigrant Health Care Access and in this capacity led the Task Force’s subgroup focused on care and coverage options for the uninsured. Rishi has a Master’s degree in Public Health and an undergraduate degree in medical anthropology, both from Case Western Reserve University. His previous work experience includes work at the Prevention Research Center for Healthy Neighborhoods in Cleveland, OH and at the Nassau County Department of Health in New York.

Erin Strumpf
Erin Strumpf is an Associate Professor in the Department of Economics and the Department of Epidemiology, Biostatistics and Occupational Health at McGill University. She received her Ph.D. in Health Policy from Harvard University and was awarded a Research Scholar Career Award from the Fonds de recherche du Québec – Santé and the Ministère de la Santé et des Services sociaux du Québec. Dr. Strumpf’s research in health economics focuses on measuring the impacts of policies designed to improve the delivery of health care services and improve health outcomes. She examines the effects on health care spending and health outcomes overall, and on inequalities across groups. She has presented her work to provincial ministries of health and of finance in Canada, and to policymakers in France and the United States.
Anne Lemay
Anne Lemay is a health economist who serves as associate executive director at the CIUSSS Centre Ouest in Montreal. She has a doctorate degree in public health and health care organization. She has held many positions responsible for performance and quality evaluation in academic hospitals in Quebec and Ontario, and has also held positions in provincial associations of hospitals and other health care facilities. She is adjunct professor at the Public Health School of Montreal University, and served as director of Health Care Safer Now Campaign in Quebec for 4 years, as well as an accreditation surveyor for Accreditation Canada for 10 years.

Ram Raju
Dr. Ramanathan (Ram) Raju, is the President and Chief Executive Officer (CEO) of NYC Health + Hospitals Corporation, the largest municipal healthcare system in the nation. Dr. Raju was appointed by Mayor Bill de Blasio in January 2014 to lead the 42,000 employees of this $7.2 billion health system, providing essential services to 1.4 million New Yorkers, including more than 425,000 uninsured, every year in more than 70 locations across the City’s five boroughs.

Prior to becoming President and CEO of NYC Health + Hospitals, Dr. Raju served as Chief Executive Officer for Cook County Health & Hospitals System (CCHHS) in Chicago, Illinois. Dr. Raju spent 25 years as a practicing vascular and trauma surgeon in Brooklyn, before going on to serve as the Chief Operating Officer and Medical Director at NYC Health + Hospitals/Coney Island. In 2006 he became NYC Health + Hospitals Chief Medical Officer, Corporate Chief Operating Officer and Executive Vice President. During his tenure, the system achieved great successes in quality, patient safety, and healthcare data transparency. Dr. Raju has published widely in academic medical journals, such as, Epidemiology, The Heart Surgery Forum, Annals of Royal College of Physicians and Surgeons of Canada, and The Joint Commission Journal on Quality and Patient Safety. He serves on the Boards of Trustees of the American Hospital Association, where he chairs the Equity of Care committee, and the Healthcare Association of New York State. He is a member of the Board of Directors of America's Essential Hospitals as well as the Board of Directors of the Greater New York Hospital Association, where he serves as Vice Chair.
Access to Health Services and Care Coordination in New York and Montreal: An Invitational Meeting to Compare and Learn

Friday, March 11, 2016
Robert F. Wagner School of Public Service
Puck Bldg. 2nd Fl.
295 Lafayette St. (corner of Houston)
New York

7:30 – Registration and Breakfast

8:00 – Welcome and Introduction to Conference Themes and Panel Discussions
Jean-Claude Lauzon, Québec Delegate General
Victor G. Rodwin, NYU, Wagner School of Public Service
Michael K. Gusmano, Rutgers University School of Public Health
Erin Strumpf, McGill University

8:40 – 10:00: Current Health Care System Organization and Challenges: Montreal and New York City
Panel Chair: Michael K. Gusmano

1. Anne Lemay, Assistant Executive Director for the Support, Administration and Performance Programs, CIUSSS Centre-West-Montreal
2. Dr. Raynald Pineault, Advising Physician, CIUSSS Centre-South-Montreal and Montreal Department of Public Health
3. Sam Solomon, Deputy Director of Policy, NYC Mayor’s Office of Immigrant Affairs
4. Dr. Sonia Angell, Deputy Commissioner, New York City Department for Health and Mental Hygiene

10:00-10:15 Break
10:15 – 12:00: Innovations to Improve Access and Care Coordination: Montreal and New York,
Panel Chair: Victor G. Rodwin

1. Dr. Antoine Groulx, Director of Integrated Primary Care Services, Quebec Ministry of Health and Social Services
2. Frédéric Abergel, Deputy CEO, CIUSSS North-Montreal
3. Ronda Kottelchuck, former CEO, Primary Care Development Corporation
4. Jill Huck, Director, DSRIP Project Management Office at The Mount Sinai Health System
5. Direct Access Program for Undocumented:  
   - Rishi Sood, Deputy Director of Policy, Bureau of Primary Care Access and Planning, NYC Department of Health and Mental Hygiene  
   - Nancy Berlinger, Research Scholar, the Hastings Center

12:00-12:10 Break

Dr. Ram Raju, CEO and president, New York Health and Hospitals Corporation

12:45-2:00: Lunch and informal discussion

2:00-3:45: Wrap up/General Discussion
Panel Chair: Erin Strumpf

1. Dr. Denis Roy, Vice President, Science and Clinical Governance, Quebec National Institute of Excellence in Health and Social Services
2. Mr. Steven Newmark, Senior Health Policy Advisor and Counsel to Deputy Mayor for Health and Human Services
3. Professor Lawrence Brown, Columbia University
4. Pierre Gerlier Forest, Dean, School of Public Policy, University of Calgary
Montreal’s Health Care System (Quebec, Canada)

Raynald Pineault, Alexandre Prud’homme, Julie Fiset-Laniel, and Erin Strumpf
Prepared for the conference Access to Health Services and Care Coordination in New York and Montreal
sponsored by the Délégation générale du Québec à New York, March 2016

List of acronyms

Regional governance entities:

CISSS  Centre intégré de santé et de services sociaux
       (Integrated University Health and Social Services Center)
CIUSSS Centre intégré universitaire de santé et de services sociaux
           (Integrated University Health and Social Services Center)
CSSS  Centre de santé et de services sociaux
      (Health and Social Services Center)
MSSS  Ministère de la santé et des services sociaux
      (Ministry of Health and Social Services)
RAMQ  Régie de l’assurance maladie du Québec
       (Quebec Health Insurance Board)
RLS   Réseaux locaux de services de santé et de services sociaux
      (Local (Health and Social) Services Network)
RTS   Réseaux territoriaux de services de santé et de services sociaux
      (Territorial (Health and Social) Services Network)

Health and social service providers:

CLSC  Centre local de services communautaires
      (Local Community Services Center)
CR    Clinique réseau
      (Network Clinic (NC))
GMF   Groupe de médecine de famille
      (Family Medicine Group (FMG))
Canadian health care system at a glance

- Provision of health care and social services are under provincial jurisdiction in Canada
- Federal government contributes to financing according to contractual agreements with the provinces (<25%)
- Canada Health Act requires public administration of provincial health insurance

| Services covered by the Quebec public health insurance plan for permanent or temporary residents |
| Hospital Insurance (1961), Physician Services Insurance (1970) |
| - Hospital-based Medical (including mental health) services (including outpatient departments and ER) |
| - Medical services (including mental health) provided by physicians, in and outside hospitals |
| - Most radiology services offered in private clinics |
| - Dental care (aged < 10) |
| - Optometry services (aged < 18 and ≥ 65) |

Some services are not covered outside of hospitals, e.g. specialized imaging (Ultrasound, CAT, CT scan, MRI), laboratory tests analyses done by private labs, services provided by non-MD professionals (e.g., psychologists, physical therapists) unless provided in public establishments (e.g., CLSCs).
Quebec's Prescription Drug Insurance Program (1997)

Universal and mandatory coverage for prescribed drugs is provided in three different ways:

1. Private insurance through employment and membership in professional orders (e.g., physicians, pharmacists, lawyers): compulsory if offered
2. Public insurance (limited to RAMQ formulary) based on eligibility:
   - For those aged < 65 years and not eligible for a private plan (active enrollment or default enrollment through tax system)
   - For those aged ≥65 years
   - For recipients of social assistance
     Premium is adjusted based on ability to pay.
3. Blended: public insurance as basic, private insurance as complementary (aged ≥ 65)

Governance of health care in Montreal

In April 2015, Law 10 changed the governance model in place since the early 2000s. The current model reflects a two-level system, with informal networks at the local level.

<table>
<thead>
<tr>
<th>Levels</th>
<th>Governing entities</th>
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</thead>
<tbody>
<tr>
<td>Provincial</td>
<td>Quebec MSSS oversees 13 Integrated health and social services centers (CISSS) and 9 Integrated University health and social services centers (CIUSSS)</td>
</tr>
<tr>
<td>Territorial health and social services</td>
<td>Montreal: 5 CIUSSS + 5 independent institutions</td>
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<tr>
<td>networks (RTS)</td>
<td>• 2 university-affiliated hospital networks: CHUM &amp; MUHC</td>
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<tr>
<td></td>
<td>• St. Justine Children's Hospital</td>
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<tr>
<td></td>
<td>• Montreal Heart Institute</td>
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<tr>
<td></td>
<td>• Phillipe Pinel Institute (psychiatric hospital)</td>
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<tr>
<td>Local services networks (RLS)</td>
<td>No governing entity (collaboration and local initiatives)</td>
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In each RTS, the CIUSSS are responsible for “ensuring the development and proper functioning of all local health (including mental health) and social service networks that operate within its territorial service network in order to fulfil their population-based responsibility” (Adapted from MSSS, 2015). To do so, each CIUSSS must develop collaborations and partnerships with primary health care clinics, community groups and pharmacies, non-merged hospitals and other partners (e.g. schools). Among all CIUSSS partners, only GMF clinics receive direct financial support (nurses and nutritionists paid by the CIUSSS).
Primary health care organization in Montreal
Montreal has about 5,500 full-time equivalent physicians among which almost half (2,500) are family physicians. Types of primary care clinics vary by their ownership status, source of financing and method of payment to physicians. The vast majority of physicians (primary care as well as specialists) receive most of their income from fee-for-service billing. Since 2002, the MSSS has developed GMFs, groups of 6 to 12 full-time equivalent physicians working together and with other health professionals (mainly nurses), in order to strengthen primary care delivery in Quebec. Compared to the rest of Quebec, Montreal has a higher concentration of specialist physicians, and access to primary care doctors is particularly challenging. The number of Montrealers without a regular source of primary care, as well as waiting times for appointments, are higher than in other regions.

<table>
<thead>
<tr>
<th>Type of PHC organizations</th>
<th>Ownership</th>
<th>Operating costs</th>
<th>Source and method of payments to MDs</th>
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<tbody>
<tr>
<td>Local community services center (CLSCs)</td>
<td>Public (CIUSSS)</td>
<td>Public</td>
<td>Public (salary)</td>
</tr>
<tr>
<td>Medical clinic (non-GMF or CR)</td>
<td>Private (MDs)</td>
<td>Private (MDs’ revenues)</td>
<td>Public (fee-for-service*)</td>
</tr>
<tr>
<td>Family medicine groups (GMF)</td>
<td>Attached to a CLSC</td>
<td>Public</td>
<td>Public (salary)</td>
</tr>
<tr>
<td></td>
<td>Attached to a medical clinic</td>
<td>Mixed (public funds + MDs)</td>
<td>Public (fee-for-service)</td>
</tr>
<tr>
<td>Network clinic (CR)</td>
<td>Private (MDs)</td>
<td>Mixed (public funds + MDs)</td>
<td>Public (fee-for-service)</td>
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</tbody>
</table>

* Under the fee-for-service payment scheme, the RAMQ pays about 30% more for a service provided in private clinics than the same service provided in a public establishment (CLSC, Outpatient Department)

Tertiary care organization in Montreal
Montreal is home to 75 health care institutions offering services in over 300 establishments: 5 CIUSSS, 14 short-term hospitals, 4 psychiatric hospitals, 12 rehabilitation centers, 2 youth centers and 37 long-term care hospitals (nursing homes). Among these, we find, 2 large university-affiliated hospital networks – the Centre Hospitalier de l’Université de Montreal (CHUM) – Sainte-Justine and the McGill University Health Center (MUHC) – with one children’s specialty hospital in each, 6 university institutes, 8 university-affiliated centers and 4 facilities with mandates beyond the Montreal region (adapted from ASSS, 2013). In 2011, the city had an average of 26.4 beds per 10,000 residents.
Public Health in Montreal

Montreal’s Public Health Department, which was part of the Regional Health and Social services Agency before 2015, has been administratively attached to one of the 5 CIUSSS although it maintains its responsibility for the whole Montreal population. To meet its responsibilities, the Public Health Department establishes and maintains ties not only to the four CIUSSS but also to other partners that influence the social, economic and environmental determinants of population health.

A regional public health plan aims to carry out activities proposed in the National Public Health Program, which focuses around 5 themes:
- Continuous monitoring of the health status of the population and its determinants
- The overall development of children and youth
- The adoption of healthy lifestyles and the creation of safe environments
- Prevention of infectious diseases
- Management of risk and threats to health and preparation for health emergencies
New York City’s Health System

Michael K. Gusmano and Victor G. Rodwin


The New York City (NYC) health care system shares two key characteristics with the health system in the United States. First, it is characterized by fragmented employer-based private health insurance and public health insurance coverage for eligible beneficiary groups such as elderly or severely disabled people (Medicare), very poor people (Medicaid), children whose parents’ income does not meet Medicaid eligibility standards (SCHIP), and veterans (Veterans Health Administration). Since the Patient Protection and Affordable Care Act (Obamacare), there is also the option for all legal residents to purchase subsidized health insurance on regulated markets (Exchanges). Such health insurance must provide a standardized set of “essential benefits” with varying deductibles and co-insurance; but they are characterized by restricted networks of preferred providers, outside of which health care becomes even more expensive.

Second, most primary care physicians and specialists work in private office-based fee-for-service practices. Solo-based practices are becoming rare, large multispeciality groups and hospital-owned practices increasingly dominate the market, and new walk-in centers, e.g. retail clinics and urgent care centers are growing across the city, many in such corporate retail stores as CVS, Duane Reade, Walgreens. All of these practices share complex contracting arrangements with multiple payers. Also, there is a continually changing organization of safety net providers who care for Medicaid beneficiaries, the uninsured and the undocumented through hospital outpatient departments and community health centers rather than by private physicians.

New York City’s Unique Challenges

Beyond the characteristics it shares with the United States, NYC’s population has some distinctive characteristics. The rate of its foreign-born residents and immigrants is among the highest across cities in the U.S. Also, NYC has among the highest rates of older people (65 years and over) who, because of their recent immigrant status, have not met the eligibility
qualifications for Medicare. For these reasons, the rate of uninsured residents in NYC was historically twice that of the national average. Since implementation of the ACA, it has declined to less than the national average due largely to New York State’s decision to expand the Medicaid Program and to its efforts to increase enrollments on the Exchange. Along with high rates of undocumented residents (compared to the national average), these population characteristics have contributed, over time, to the creation of a stronger safety net. The city’s response to this need has resulted in the development of a large network of public and private not-for-profit community health centers and public hospitals that distinguish NYC from the nation as a whole.

**Distinctive Health Care System Features**

New York City’s health care delivery system also differs from the U.S. First, the most visible difference is the presence of the largest public hospital system in the United States. The NYC Health and Hospitals Corporation (HHC) was created in 1969 as a public benefit corporation to replace the city’s Department of Hospitals. HHC functions like a city agency, but it has a board of directors and is allowed to accept private revenues and funding. HHC operates 11 of the city’s roughly 60 acute-care hospitals (the remaining acute-care hospitals are private, not-for-profit) and is responsible for almost 20 percent of all admissions to acute hospital beds. HHC also provides an extensive network of primary care, as well as specialist services in its hospital outpatient departments and community care centers (six diagnostic and treatment centers, and more than 70 community-based primary care sites). In addition, HHC is responsible for a large share of the City’s emergency room visits. In Manhattan, HHC’s Bellevue hospital is known for its emergency room and trauma services. All HHC hospitals accept all patients and most have affiliation contracts with NYC’s academic medical centers.

Second, NYC stands out because its academic medical centers have a strong influence over the provision of health care delivery while training the largest number of medical residents in the nation. Also, NYC is the home to one of the earliest and larger health maintenance organizations in the United States, the Health Insurance Plan (HIP) of New York. HIP, along with Group Health Incorporated, (GHI) are now part of Emblem Health, which provides health insurance and a network of services for its members.

Third, NYC is known for its Department of Health and Mental Hygiene (DOHMH), the
oldest, largest, and strongest health department in the nation. Since its establishment in the 1860s in response to a cholera epidemic, much has changed in NYC, but DOHMH’s mission to protect New Yorkers against infectious disease remains strong following the AIDS and tuberculosis epidemics, the West Nile, SARS and Ebola scares, and post-9/11 concerns about the risks of bioterrorism, and more generally emergency preparedness. From the 1990s on, DOHMH has exercised its authority in containing tuberculosis, regulating smoking, more generally integrating its public health surveillance system, and developing community health profiles that have led to targeting high-risk areas of the city. DOHMH also improved its relations with the physician community so that most NYC physicians now communicate reportable diseases directly to the department, most hospital emergency departments participate in monitoring their patients’ diagnoses, and the Emergency Medical System monitors patterns of complaints for a sample of 911 calls.

Since 2000, DOHMH has also adopted new regulations and programs to combat the rise in three chronic diseases: heart disease, colon cancer, and diabetes. In 2003, DOHMH formed the Citywide Colon Cancer Control Coalition to reduce colon cancer deaths through primary and secondary prevention. In 2006, it created a NYC A1C registry to help providers and patients improve diabetes care. Most laboratories in the city now report to DOHMH the results of A1C blood tests. DOHMH issues quarterly reports from the A1C registry to health care providers in an effort to help them manage diabetes and reduce complications associated with it. Finally, DOHMH’s recent bans on smoking in public buildings, restaurants, and bars and on artificial trans fats in city restaurants were both designed to reduce rates of heart disease, the leading cause of death among New Yorkers.

Finally, NYC is an important part of New York State’s Medicaid experiment with Delivery System Reform Incentive Payments (DSRIP). Since 2014, the federal government’s Centers for Medicare and Medicaid Services (CMS) granted Medicaid DSRIP wavers to six states – California, Kansas, Massachusetts, New Jersey, Texas and New York. These wavers provide Medicaid funds to hospitals and certain other providers conditional on their achieving performance gains on an array of metrics linked to such targets as system redesign, clinical improvements, and enhancements of population health. New York State has developed a regional network approach which is led by twenty-five “safety net performing provider systems” within which 15 operate in NYC. The new partnerships among networks of hospitals and community

3
providers are responsible for most or all Medicaid beneficiaries in a given geographic area and will be paid based on measurable progress in reducing rates of avoidable hospitalization by 25%, building infrastructure and programs to improve population health, expanding access to services and more generally shifting the payment system from volume to “value.”