



Greater New York Hospital Association

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TESTIMONY OF
GREATER NEW YORK HOSPITAL ASSOCIATION
BEFORE THE
NEW YORK CITY COUNCIL
COMMITTEE ON HEALTH
AT A
HEARING ON
HOSPITAL CLOSURES
JUNE 15, 2005

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Good afternoon, and thank you for the opportunity to appear before you today. I am Susan C. Waltman, Senior Vice President and General Counsel of the Greater New York Hospital Association, which represents the interests of over 250 hospitals and continuing care facilities that are concentrated in the New York City region, but that are also located throughout New York, New Jersey, Connecticut, and Rhode Island. All of GNYHA's members are either not-for-profit, charitable organizations or publicly-sponsored institutions. Together, they provide services that range from state-of-the-art, tertiary care to the most basic primary care, given their roles as safety net providers for many of the communities that they serve.

The issue of hospital closures is of critical importance to all of us and raises some of the most difficult and sometimes the most emotional questions facing the health care system today. The closures that have taken place to date in the New York City region have been caused in great part by the extreme financial pressures facing the hospital system in New York State. And no one has been more committed to trying to keep the hospitals open than those who manage and govern the institutions as well as those that work every day to support the health care system, including GNYHA, the State of New York, local officials, the health care workforce and in particular 1199 SEIU, and most importantly, the communities that the hospitals serve.

But the financial problems that plague the hospital system are taking their toll, as evidenced by the large number of hospital closures that have taken place in recent years and the additional closures that have been threatened. As a result, we have come to a point where it is essential to look at ways to strengthen and improve the health care system for the long term. Some say the solution is to close more hospitals in order to strengthen those hospitals that remain. Others say that the system is inefficient and needs restructuring to ensure that care is delivered in the most

appropriate settings. Aspects of each of these views may be correct, but in the end, GNYHA and its members are committed to looking at solutions that will ensure access to high quality health care for all of our communities. In order to accomplish this, however, we need significant financial and structural support. We also need the support of our communities and elected officials to ensure that equitable and reasonable solutions that benefit the entire health care system can be implemented.

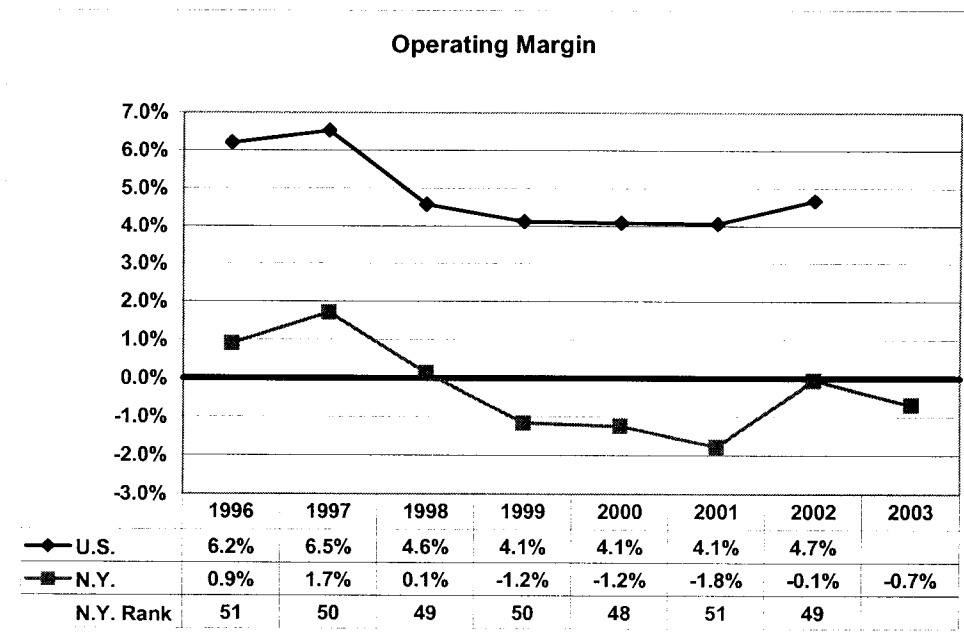
For the purposes of today's hearing, I will describe 1) the severe financial problems facing hospitals in New York State; 2) in general terms, the hospital closures that have resulted from these financial pressures; 3) the tools that we need to improve the system for all of us; and 4) the potential role of the State's new Commission on Health Care Facilities in the 21st Century.

I. Financial Pressures Facing Hospitals

Hospitals in New York State have faced extraordinary financial pressures for many years. For the purposes of today's hearing, I will outline four trends that have had a significant negative impact on New York's health care system: 1) the under funding of New York's hospital system; 2) the imbalance between the profits of health plans and other industries that derive their revenues from hospitals on the one hand, and the losses of hospitals on the other; 3) the impact of niche providers on the financial situation of hospitals; and 4) the ever-increasing costs of delivering health care.

The Under Funding of Hospitals in New York State—Hospitals in New York State are dangerously under funded, particularly compared to their counterparts across the country. The figure below demonstrates that New York State hospitals' bottom line continues to be well below that of hospitals nationally.

Figure 1. With the U.S. Operating Margin, NY Hospitals Would Have Made \$2 Billion in 2003 Instead of Losing \$300 Million



Source: *Medicare Cost Reports*. National data for 2003 are not sufficiently complete.

New York hospitals' poor profitability is manifested by poor cash flow, limited ability to meet current operating and capital obligations, and over-reliance on debt, rather than equity, to pay for capital improvements and upgrades. The table below compares New York hospitals' key financial ratios to the national average and ranks the State in comparison to the rest of the country. New York State is among the worst on all of these critical financial measures.

Table 1. The Financial Condition of New York Hospitals is Among the Worst in the United States

	U.S.	New York	NY Rank
Profitability			
Total Margin	2.6%	-1.1%	2d lowest
Liquidity			
Current ratio	2.00	1.30	3d lowest
Days in average payment period	55	77	2d lowest
Capital structure			
Equity financing ratio	55%	32%	2d lowest
Debt service coverage ratio	2.9	1.7	3d lowest

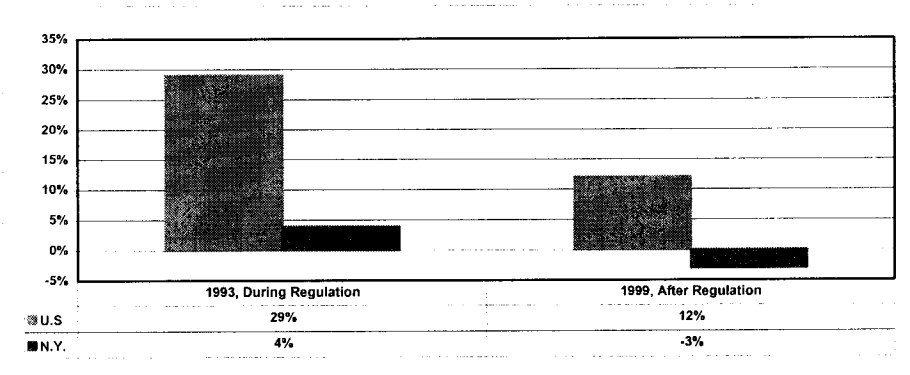
Source: *Almanac of Hospital Financial and Operating Indicators, 2004* (Salt Lake City: Ingenix, 2003).

The causes for this negative financial situation are complex and include the loss of critically important Medicare reimbursement over time, most recently Medicare’s disappointing decision to dilute hospital payments in the metropolitan New York City area by deeming three counties in New Jersey to be in our labor market. While we are vigorously challenging this decision in the Federal courts, the Medicare program’s decision has a negative impact of nearly \$900 million on New York City area hospitals over the next ten years.

The financial distress that faces many New York State hospitals is also rooted in the State’s unique history of inpatient rate regulation. The State’s regulated payment system, which ended in 1996, essentially required Medicaid and Blue Cross to pay hospitals cost-based inpatient rates, with a fixed “mark-up” for other private insurance companies. This effectively yielded breakeven profitability for hospitals for many years until the State enacted its current reimbursement system, called the Health Care Reform Act or HCRA, which brought about the deregulation of inpatient rates. Under HCRA, the State was no longer able to adjust hospital payments through special rate appeals or enhancements to ensure that needed community providers remained financially stable.

Perhaps more significantly, under HCRA and its deregulated system, the private payers negotiated new rates with the hospitals, with the old cost-based rates being used as the ceiling, not the floor. The result was that, while private payers paid hospitals 4% above their costs under the regulated system, their payments fell below hospital costs after deregulation.

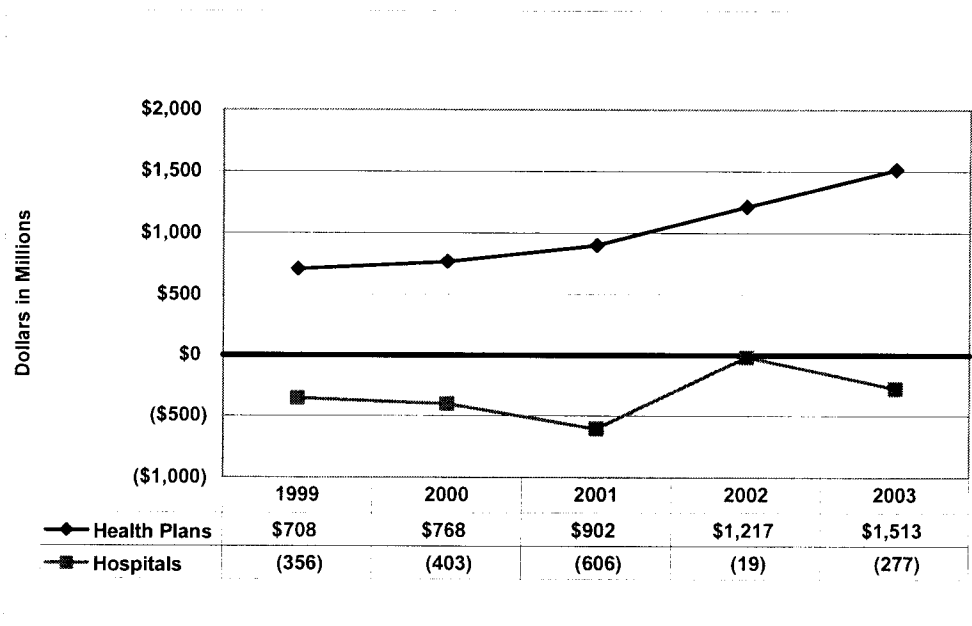
Figure 2. Private Payer Payments in Relation to Cost, Pre- and Post-Deregulation



Source: Medicare Payment Assessment Commission (MedPAC).

The High Profitability of Industries “Derivative” of Hospitals—The phenomenon of private payers paying rates below costs undoubtedly contributed to the unprecedented growth in private health plan profits since deregulation occurred. According to Weiss Ratings, in 2002, health plans in New York State recorded the highest amount of net profits, \$1.2 billion, of any state in the country. California health plans, the second highest group, had profits of \$878.3 million. The following chart depicts the vast disparity between the profits of health plans and the losses of hospitals in New York State.

Figure 3. Profitability of NY Health Plans Versus NY Hospitals



Source: *New York State Insurance Department and Medicare Cost Reports.*

Other industries, such as pharmaceutical companies, device manufacturers, and medical-surgical product companies, similarly derive their immense profitability from hospitals, with each of those industries making significant sums of money by “doing business” with hospitals.

The Additional Destabilization Caused by Niche Providers—Over the last decade, medical advances and changes in reimbursement have shifted services traditionally provided in the inpatient hospital setting to ambulatory settings, including physician offices and freestanding ambulatory service centers. The proliferation of what are referred to as “niche providers,”

particularly ambulatory surgery centers, have had a significant negative impact on the operations and financial stability of New York State hospitals. Niche providers siphon off profitable procedures involving insured patients, leaving hospitals with many of the less profitable procedures as well as with the continuing responsibilities of caring for the uninsured, maintaining round-the-clock emergency and trauma services, and covering the full array of operating and capital costs. In essence, niche providers add to the cost of the health care system by creating new providers, but leave hospital costs stranded. Moreover, these niche providers do not provide community benefits nor are they subject to the same quality and regulatory oversight as are hospitals.

There has been an explosive growth of niche providers in New York State since 1998. Given the significant damage they have caused to hospitals, GNYHA has called for a moratorium on the establishment of additional niche providers in the State. GNYHA has also urged the State Legislature to require oversight of the quality of care provided by office-based surgery practices.

The Ever-Increasing Costs of Delivering Care—At the same time that hospital payments are decreasing, the cost of delivering care continues to skyrocket as the cost of pharmaceuticals, hospital supplies, and new treatment and diagnostic modalities have risen dramatically. The cost of new health care information technology, which has become an important tool for improving the quality and efficiency of care, is significant and often beyond the means of many New York State hospitals. Hospitals have also spent increased sums on preparedness since the World Trade Center attack, with relatively little reimbursement being made available for their efforts.

The nursing shortage also adds to hospital operating costs. GNYHA's most recent survey of its members' nurse vacancy and turnover rates, released in 2004, indicates that 39.2% of responding hospitals have nurse vacancy rates of 10% or higher. Hospitals also have significant difficulty recruiting nurses for critical care and emergency services, with over 60% of responding hospitals taking longer than three months to fill positions in these specialty areas. As a result, hospitals are required to use supplemental staffing strategies, including paying overtime and reliance on agency nurses, all at an increased cost to the hospitals.

Finally, the spiraling cost of professional liability coverage has caused many hospitals to consider discontinuing high risk services. According to GNYHA's study of professional liability insurance costs released in November 2004, hospitals in the downstate area have experienced average annual increases of 17% per year from 1999 through 2004. The cumulative percentage increase in premiums over that period was 147%, a percentage that stands in stark contrast to the cumulative growth in inflation increases recognized by the Medicare and Medicaid programs of 17% and 16%, respectively. New York is also one of 20 professional liability crisis states for physicians designated by the American Medical Association, and the crisis appears to be affecting patients' access to services given that obstetricians/gynecologists report that they have stopped or decreased the amount or nature of obstetrical care they perform because they fear malpractice exposure.

II. Hospital Closures in the Wake of Financial Pressures

The convergence of the foregoing factors has placed a significant strain on hospitals throughout the State, forcing many hospitals to curtail services and some to close. The list of acute care hospital closings is long and growing, and its length surprises even those who are knowledgeable about New York State's health care system. A working list of acute care hospital closures appears as an attachment to this testimony.

Preludes to a Closure—While GNYHA is not familiar with the circumstances surrounding many of the upstate closures, GNYHA has been involved in a number of the efforts undertaken to rescue downstate hospitals that have eventually been forced to close their doors. In general terms, many of the downstate hospitals went through prolonged periods of financial distress and vigorously pursued multiple alternatives for improving their revenue, reducing their costs, and potentially restructuring their operations. They also went through lengthy periods during which they consistently worried about meeting payroll, funding their professional liability and pension plans, and making debt service payments on their outstanding capital indebtedness. They also saw their patient volume drop, their physicians leave, and their workforce grow restless as word of their financial situation became public. Many curtailed services in the interest of keeping the institution as a whole alive.

During these preludes to a closure, there were typically extensive efforts by multiple stakeholders—public officials, local communities, unions, creditors, and others—to put the hospital on firmer financial footing and to keep the hospital open. GNYHA, often in coordination with 1199 SEIU, has undertaken exhaustive efforts on behalf of the industry as a whole as well as specific hospitals in particular to try to improve their financial circumstances through increased reimbursement, special infusions of cash, and other initiatives. Indeed, many hospitals have been able to meet their payrolls and other obligations only as a result of these special interventions on their behalf. And, as stated earlier, no one has devoted more effort to keeping the hospitals open than has their management and governing bodies, who at all times have been committed to meeting the charitable missions of their organizations.

But, as we see from the chart attached to this testimony, many closures occurred notwithstanding these efforts. Hospitals found that they could not sustain the losses associated with continuing in operation or that they could not afford the capital improvements needed to provide quality care, and thus they ultimately closed their doors. Others found that they just could not continue their charitable mission in their current form and concluded that they needed to convert to other uses, e.g., to behavioral health or a diagnostic and treatment center.

Impact of Closures on Access—Like the members of the City Council and other community leaders, GNYHA and its members are concerned about the potential impact of closures on access to care. However, we note that most hospitals that close experience a significant drop in demand for their services before they get to the point of closure. As indicated previously, troubled hospitals often curtail services in the interest of keeping the institution afloat. In addition, when possible, hospitals that are part of multi-hospital systems and that are facing financial problems often transfer and consolidate services to other sites in order to enhance the efficiencies of their operations.

As word of a hospital's financial troubles are made public, many of the hospital's patients also begin to seek care elsewhere, and the hospital's medical staff begin to obtain privileges at other hospitals. Thus, by the time a hospital closes, its occupancy rate is typically already low, and many patients have already begun to seek care from other providers. Nevertheless, when a

closure eventually occurs, hospitals try to identify key services they can sustain at the closing location by, for example, creating urgent care centers or offering other key services in order to ensure access post-closure.

In summary, the negative impact on access related to the closure of a hospital is typically a gradual process that tracks the pace of the financial deterioration of the hospital rather than occurring suddenly as the institution physically closes its doors.

The Role of the Media in Terms of Closures—I would like to comment on the role of the media in hastening hospital closures. I have noted that most hospitals that eventually close go through a period of financial turmoil, accompanied by drops in patient visits and sometimes defections of staff. The recent media pastime of creating lists of hospitals that might be candidates for closure only serves to fulfill the media's prophesy. The public listing of a hospital as one that should or could close causes many patients to seek care elsewhere because they think the hospital it is about to close or that its quality is suffering. It causes more staff to seek other jobs or privileges at other facilities. It causes creditors to become even more wary, such that they insist that already stressed hospitals pay down their payables before more supplies can be delivered. In this manner, the downward spiral accelerates.

We note that there is currently no official State list of hospitals recommended for closure. The Commission charged with creating such a list, which is described in more detail below, has not even met yet and will conduct an 18-month process before a final list is made public. Therefore, the publication of a list by news organizations is irresponsible and has very real consequences.

I ask the City Council to join us in requesting that the media act responsibly and refrain from “making the news” by creating such lists. Access to care is at stake, and the media should not compound the already acute financial problems facing our area's hospitals.

III. The Need for Tools to Restructure the Hospital System

What has become obvious to GNYHA and others is that the current financial pressures facing hospitals cannot be sustained and cannot be permitted to continue. Notwithstanding the significant efforts being devoted to keeping hospitals open, many are closing in any event. Thus, GNYHA has been advocating for tools that can help restructure and strengthen the health care system. And on the specific issue of closures, GNYHA has advocated that, if closures must take place, they should be undertaken in a more planful, supportive way so that access to care, the workforce, and critical providers of hospital capital can be protected.

HEAL NY Capital Grant Program—Commensurate with this game plan, in early 2004, GNYHA, together with 1199 SEIU, requested the State to provide funding for hospital restructuring and health care information technology on the basis that these two applications of funding have the best chance of strengthening the system in the long term. They also represent applications that hospitals caring for under-served communities can rarely afford. From these efforts came what is referred to as the Healthcare Efficiency and Affordability Law for New Yorkers or HEAL NY, which will provide \$1 billion in capital grants to be used for encouraging “improvements in the operation and efficiency of the health care delivery system of the state” over a four year period. During the current State fiscal year, HEAL NY provides for \$185 million in bonding authority and \$65 million in capital appropriations for a total of \$250 million.

GNYHA very much appreciates the HEAL NY funding that has been made available for hospital restructuring and health care information technology. However, GNYHA emphasizes that there are several notable limits on the availability and applicability of this funding. First, it will take some time for the grant program to be developed and for the State to be in a position to award these grants. The New York State Department of Health (DOH), which will administer the program, is currently working with the Dormitory Authority of the State of New York to develop guidelines for the program. Depending on the level of “process” that must be incorporated in awarding the grants, the program will probably not make its first award until sometime this fall at the earliest and potentially as late as the end of the first quarter of 2006.

Secondly, HEAL NY funds are to be used for capital projects, which would include projects such as construction associated with restructuring buildings and services as well as the acquisition of health care information technology. However, HEAL NY grant funds cannot be used to cover many of the basic operating costs that troubled hospitals are typically unable to cover, such as payroll expenses, supply costs, and other costs of running a health care facility. GNYHA has also been informed that HEAL NY proceeds may not be able to be used to pay pre-existing capital obligations such as outstanding debt service although that particular interpretation is being reviewed.

In short, while HEAL NY funds will serve a valuable role in helping to restructure the hospital system, the timing and limits on the availability and application of the funds are such that they cannot be used to meet many of the most immediate needs of hospitals facing closure today.

Potential Funding for Operating Costs—There are, however, several other possible funding sources for meeting the operating costs of troubled hospitals. Two of them are limited in the amount of funds that are available, and one of them has not yet been finalized. However, for completeness, I outline those sources briefly.

First, the State has had, for a number of years, what is called the New York State **Health Facility Restructuring Program**, which provides loans to hospitals for the purpose of encouraging improvements in the health care delivery system. These funds can be used for, among other things, engaging management consultants to identify strategies for financial stability as well as payment of debt service. However, the pool available for this purpose is limited, and applicant requests far exceed the funds available. Indeed, many hospitals' immediate financial requirements dwarf the amount of the funds available.

Second, the State has developed a grant program called the "**Health Care Stabilization**" program that will provide up to \$28 million in funds to stabilize "critical" health care providers. Applicants must document financial hardship and present a viable remediation plan demonstrating how the funds will provide a critical link to ensure the continued viability and stability of the provider. Again, the pool for this purpose is limited, and it is not intended nor is

it possible for it to solve the ongoing and very large financial problems of many of the State's most financially troubled hospitals.

Third, the State of New York has been working with the Federal government to secure what is referred to as the **“Federal-State Health Reform Partnership Waiver”** (or F-SHRP waiver), which would amend the State's current 1115 waiver governing its participation in the Medicaid program. Should the F-SHRP waiver be granted, it is hoped that additional Federal funding will be made available for strengthening and restructuring the hospital system in the State. However, the terms of the potential waiver are still under negotiation, and thus any potential funding is not yet available and will probably not be available until 2006.

IV. Commission on Health Care Facilities in the 21st Century

A discussion regarding hospital closures must of course address the potential role of the Commission on Health Care Facilities in the 21st Century, which was created as part of this year's State budget agreement. The Commission's purpose is to undertake a “rational, independent review of health care capacity and resources in the state to ensure that the regional and local supply of general hospital and nursing home facilities is best configured to appropriately respond to community needs for quality, affordable and accessible care, with meaningful efficiencies in delivery and financing that promote infrastructure stability.” The legislative findings creating the Commission emphasize that the health care system “must first and foremost provide quality care and be responsive to community health care needs.”

Although the Governor's Task Force on Medicaid Reform had called for a review of the State's health care system, the Federal government has insisted upon a review of the system as part of its F-SHRP waiver discussions with the State of New York. In other words, in order to obtain more Federal funding, the State is required to create a process similar to that which the Commission will pursue. GNYHA notes that it supports the development of mechanisms to strengthen the health care system, provided that the mechanisms, at all times, take into account access to care and quality. GNYHA also notes that when the Commission was initially proposed, the bill language contained a short time frame for the Commission's review and recommendations. In

response, GNYHA strongly urged that the review process be longer, that it allow for community input, and that it take into account a number of important health planning principles. GNYHA is appreciative that the final legislation creating the Commission took into account GNYHA's recommendations.

Structure of the Commission—Under the legislation, the Commission will consist of 18 full commissioners (12 of whom have already been appointed), and 36 regional commissioners, six for each of six defined regions throughout the State. The regional commissioners are to be considered members of the Commission only for the purposes of issues relating specifically to their region.

In addition, the legislation calls for the creation of six regional advisory committees that are charged with developing recommendations for reconfiguring their respective regions' hospitals and nursing home bed supply "to align bed supply with regional and local needs." The regional advisory committees are to foster discussions and hold public hearings in order to solicit input from local stakeholders, including community-based organizations, providers, labor unions, payers, businesses, and consumers.

Currently, DOH and DASNY are collecting data enumerated in the legislation for submission to the Commission. The data include information regarding existing capacity and need in each region, the economic impact of "right sizing actions," the amount of capital debt held by facilities, the existence of services offered by other providers, and the potential for "improved quality of care and the redirection of resources from supporting excess capacity toward reinvestment into productive health care purposes."

Recommendations By the Commission—The legislation requires the Commission to develop recommendations for reconfiguring the State's hospital and nursing home beds to align the supply with regional needs. For this purpose, the Commission is required to collaborate with the regional advisory committees in order to obtain statewide and regional input. Recommendations may include closures, resizing, consolidation, conversions, or restructuring. In addition, the Commission may recommend needed investments in the system, ways to streamline the

regulatory process to address the provision of needed community health services, and changes to the reimbursement systems to facilitate the transition to a restructured system.

Timeline for Recommendations—The timeline for the Commission’s recommendations is as follows: the regional advisory committees are to submit their reports and recommendations to the Commission by November 15, 2006. The Commission is required to submit its report to the Governor and the Legislature by December 1, 2006, and the Governor is required to submit his written approval of the Commission report to the Legislature by December 5, 2006. By December 31, 2006, the Legislature may reject the recommendations through a majority vote. If the Legislature does not reject the recommendations, the Commissioner of Health is required to implement the recommendations by June 30, 2008.

V. Moving Forward—Hope for a Stronger Health Care System

While there is understandably great apprehension about the potential recommendations of the Commission, GNYHA is hopeful that the Commission’s deliberations will present opportunities for improving and strengthening the health care system, which is indeed its goal. The health care system in New York State has struggled too long. The financial pressures facing the health care system have taken their toll in spite of exhaustive efforts by hospital management, boards, and other stakeholders to rescue troubled institutions. GNYHA and its members are committed to serving their communities, but they require the resources and support to fulfill their purposes and goals. We look forward to working with the Commission, the City Council, and most importantly, our communities to forge a stronger health care system for all of us.

Appendix

Hospital	County	Date Closed or Converted
Bronx-Lebanon Hospital Center -Fulton Pavilion (converted to primarily behavioral health)	Bronx	Early 1990's
Staten Island University Hospital South site/North Shore-LIJ, (converted primarily to a behavioral health clinic - some acute care beds remain)	Richmond	Early 1990's
Medical Arts Center	New York	1994
Mohawk Valley	Herkimer	June 1996
Julia Butterfield	Putnam	June 1996
Jackson Heights – Wyckoff	Queens	December 1996
Little Neck	Queens	December 1996
Leonard Hospital	Rensselaer	April 1997
Samaritan Medical Center – Stone Street Division	Jefferson	December 1997
Union Hospital (now part of St. Barnabas, now a D & T center)	Bronx	January 1998
Salamanca	Cattaraugus	July 1998
Columbus Community Healthcare	Erie	October 1998
Parsons Hospital (Flushing North)	Queens	June 1999
St. Johns Episcopal Community Hospital	Suffolk	June 1999
St. Mary's Hospital	Monroe	November 1999
Massapequa General Hospital Inc.	Nassau	August 2000
Olean General Hospital	Cattaraugus	May 2001
Genesee Hospital (now a clinic)	Monroe	2001
Yonkers General (now part of St. John's Riverside, converted to behavioral health)	Westchester	2002
Brooklyn Jewish Hospital Division of Interfaith Medical Center	Kings	2002
Myers Community Hospital	Wayne	January 2003
Mary McClellan Hospital	Washington	April 2003
Bayley Seton Hospital/Saint Vincent Catholic Medical Centers	Richmond	Announced April 2003
Caledonian Campus/Brooklyn Hospital Center	Kings	2003
Island Medical Center (formerly Hempstead)	Nassau	July 2003
Staten Island University Hospital Concord site/North Shore-LIJ	Richmond	September 2003
St. Agnes Hospital	Westchester	October 2003
Sheehan Memorial Hospital (now a rehab/detox clinic)	Erie	October 2003
Florence D'Urso Pavilion/Our Lady of Mercy Healthcare System	Bronx	January 2004
Herbert and Nell Singer Division/Beth Israel Medical Center	New York	August 2004
St. Joseph's Hospital/ Saint Vincent Catholic Medical Centers	Queens	October 2004
New York United Hospital Medical Center	Westchester	Announced December 2004
St. John's Division/Interfaith Medical Center	Kings	April 2003, announced closing of obstetrics program
St. Mary's Hospital (Brooklyn)	Kings	June 2005, announced closing of hospital October 2003, announced closing of its obstetrics program