A Plan to Stabilize and Strengthen New York's Health Care System

Final Report *of the* Commission on Health Care Facilities in the 21st Century

December 2006

Commission on Health Care Facilities in the 21st Century
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PROLOGUE

The Commission on Health Care Facilities in the 21st Century was created to review and strengthen New York State's acute and long term care delivery systems. Systems, by definition, are comprised of multiple parts that form a unified whole. Such definition does not apply to New York's health care industry where we confront a fragmented patchwork of health care resources. Some areas of our state have excess health care resources while others have shortages. We have widespread and unnecessary duplication of services. We have too much institution-focused care and not enough home and community based options. We have too few primary care resources to keep people well and out of the hospital. We spend extravagantly on health care and yet still leave too many without adequate access to the health care they need. We have yet to come to grips with changes in medicine that render parts of a massive bricks-and-mortar infrastructure obsolete.

Our hospitals and nursing homes, as described in this report, are in dangerously unstable condition. Years of chronic losses and growing numbers of empty beds have led some hospitals to close their doors and others are on the brink of collapse. Even the relatively "successful" hospitals that manage to break-even or eke out a modestly positive margin do not have sufficient resources to reinvest and maintain the high-quality, modern health care that New Yorkers deserve. A growing percentage of nursing homes are losing money from operations. It is not in the best interests of patients to rely on health care providers in such financial straits, and closures due to market forces alone threaten ongoing access to quality care, especially for the State's most vulnerable residents.

Hovering over the instability of our hospital and nursing home providers is a growing problem of affordability. New York should be proud of having one of the largest and most generous Medicaid programs in the nation. It is a very costly program to maintain, however, and its costs are rising at an unsustainable rate. The total cost of the Medicaid program has nearly doubled over the last decade to approximately $45 billion per year. Medicaid is a crippling budget item for the state and many counties. Upstate counties, which lack broad tax bases but have growing Medicaid populations, are particularly struggling under these cost burdens. We must regain control over Medicaid costs and spend more wisely to maintain health care services without crowding out our ability to finance other important social needs.

In fulfilling its mandate, the Commission had to face difficult choices. Decisions to reconfigure or close health care institutions are never simple or without controversy. Even when a closure will have no adverse impact on health care delivery and makes enormous economic sense, history has shown that opposition may arise. Such feelings of institutional loyalty are understandable. There are many groups, organizations, and individuals with personal, and often financial, interests in local hospitals. The Commission carefully considered community issues in its deliberations. The Commission also recognizes that our current predicament is in part a result of past failures to make honest and hard choices. We will not get to a better place until we confront our problems head-on and take action that is in the best interests of the entire system and its patients. An orderly transition that respects the needs of health care workers and communities affected by the recommendations in this report is required.

The work of this Commission is a start, not an end, to the facility rightsizing process. Additional opportunities to remove excess capacity exist but cannot be realized absent changes in reimbursement, reductions in length-of-stay, broader availability of non-institutional services, and removal of other obstacles. The Commission made responsible choices given real-world constraints. More can and should be done if circumstances change.

The recommendations in this report are a step in what must be a broader process to reconfigure our health care system. It is beyond the practical scope of a single Commission to address or resolve all of the state's health care issues. Yet, we are impressed by the various important agendas that have been presented to the Commission and which must be addressed in future initiatives. Structured decisions about health care resource allocations must be continuous rather than a one-shot phenomenon. Issues of the uninsured, mental health, and primary care development should be at the forefront of an ongoing reform agenda.

It has been a privilege to examine New York State's health care system and develop immediate and long-term agendas for change. We are grateful to the members of the Commission and the regional advisory committees who volunteered their time and talents to this important work. The Commission's staff worked with great dedication and professionalism. The Department of Health, Dormitory Authority of the State of New York, Division of the Budget, and other agencies provided tremendous support. Our thanks go to the numerous members of the public, providers, and organizations that engaged in this process, provided vital information, and helped shape our thinking. By working together, we are confident that New York will seize the

opportunity to build a health care system that is stronger, better, fairer, more affordable and that meets the needs of communities.

Stephen Berger
Chairman

David Sandman, Ph.D.
Executive Director

EXECUTIVE SUMMARY

A System in Crisis

The Commission on Health Care Facilities is a nonpartisan panel established to review New York State's acute and long-term care systems. New York is home to some of the world's finest and most sophisticated hospitals. We have superb nursing homes that provide advanced and humane care to our sickest and most frail residents. We have a strong and growing foundation of non-institutional care providers. Our health care providers employ a skilled and dedicated workforce. The State has a historic commitment to ensuring access to care for its most vulnerable citizens and we expend vast sums of public resources on health care. Public and private initiatives are underway to further improve access, improve quality of care, and produce greater value for the dollars spent on health care services.

Despite these strengths, the Governor and Legislature recognized the need for improvements and thus established the Commission. The challenges facing our system developed over a long period and cannot be linked to a single time or policy. Similarly, these problems will not be solved overnight; solutions will require sustained efforts.

The Commission reaches a stark and basic conclusion: our state's health care system is broken and in need of fundamental repairs. Today, New York is struggling to maintain a 20th century institutional infrastructure in the face of mounting costs, excess capacity, and unmet needs for community-based alternatives. Weaknesses in our system are readily apparent:

- Turbulence afflicts our health care providers; facility closures and declarations of bankruptcy are too common. Since 1983, 70 hospitals and over 63 nursing homes have closed in New York State. Some of our oldest and proudest names in health care struggle under the unintended consequences of bankruptcy proceedings. Patient access to stable health care services is at risk.
- Our health care providers are in weak financial condition. For the past eight years, the state's hospitals as a group have lost money. A majority of the state's nursing homes, even some that are fully occupied, operate at a loss. Such losses cannot be sustained indefinitely.

- Negative or inadequate fiscal margins limit the ability of providers to reinvest in their systems, obtain the latest technologies, access capital, and upgrade their physical plants. Many of our hospitals and nursing homes are outdated and in need of capital improvements.
- Hospital average lengths of stay have decreased but remain unacceptably and unjustifiably long in many parts of the state.
- Too many New Yorkers – almost one in five nonelderly residents – continue to lack health insurance coverage and face barriers to care and worse health outcomes as a result.
- Virtually every region of the state has an unmet need for additional home and community-based services. As consumer preferences change and technology advances, this gap could widen.
- Primary care capacity is insufficient, so that some patients go without preventive and basic services. Inadequate primary care worsens health care status, allows chronic conditions to go unmanaged, and results in back-end care that is more costly and less beneficial than front-end services.
- Our Medicaid program, already the largest and most expensive in the nation, is growing at an unsustainable rate.
- Reimbursement mechanisms distort patterns of service delivery and induce facilities to pursue high margin services, sometimes at the expense of more essential community needs. The current rate paradigm is encouraging a medical arms race for duplicative provision of high-end services and discouraging the provision of preventive, primary, and other baseline services.

Why We Must Act Now

From crisis arises opportunity. It is not too late to restructure New York's health care delivery system. The time to act, however, is now. Absent intervention, the Commission believes that the future of our state's health care system is bleak. Unless we act decisively, further facility closures and bankruptcies are almost certain to occur. Moreover, the facilities that close due to market forces alone may be the ones most critical to preserving access.

Without intervention, our providers will spiral further into debt and be forced to make difficult decisions to cut services and lay off workers. Without change, our providers will lack the financial stability needed to invest in new technologies and remain on the cutting edge of modern health care. Unless we shift course, health care expenditures will rise at unsustainable rates, further burden our taxpayers, and cripple our ability to devote resources to the full array of public needs including education, housing, and transportation.

Confronting and solving these problems will require difficult, perhaps unpopular, decisions and strong leadership from our elected officials and others. There is no other responsible choice. We cannot deny reality, bury our heads in the sand, or cling to established patterns. We must overcome our reliance on outdated institutions and strengthen those that remain. New Yorkers deserve and demand a 21st century health system that is more flexible, leaner, stronger and more affordable than the one we have today.

Excess Capacity Weakens Our System

A fundamental driver of the crisis in our health care delivery system is excess capacity. New York State is over-bedded and many hospital beds lie empty on any given day. The statewide hospital occupancy rate has fallen from 82.8% of certified beds in 1983 to 65.3% in 2004, a decrease of 17.5%. On a staffed bed basis, approximately one quarter of hospital beds are currently unoccupied. Occupancy rates vary by region and are especially low in Western, Northern, and Central regions. Some individual hospitals are more than half empty. Certain pockets of the state have too many nursing home beds while others have too few. The statewide average nursing home occupancy rate has been in decline since 1994 despite a gradually aging population.

Declining occupancy rates are driven in part by shifts in the venues in which health care is provided. Health care services are migrating rapidly out of large institutional settings into ambulatory, home and community-based settings. Hospitals face increasing competition from niche providers such as ambulatory surgery centers, who often provide services that are well reimbursed and deprive hospitals of revenues that were historically used to cross-subsidize less profitable services. Similarly, long term care

is evolving towards shorter sub-acute stays in nursing homes, increased resident turnover in nursing homes, and the provision of long term care in non-institutional settings.

Excess capacity has negative consequences for our health care system:

- **Quality of Care is Jeopardized**: In health care, there is a direct positive relationship between volume and quality of care. The more cases or procedures performed, the better the outcome. Excess capacity disperses volume and expertise, potentially diminishing quality. It is a public health imperative to concentrate volumes at fewer institutions and create Centers of Excellence. Excess capacity also subsidizes inferior quality by blocking investments in equipment and staff.
- **Unnecessary Utilization Occurs**: Hospitalizations expand in relation to the number of available beds. Supply induces demand and unused capacity creates pressure to admit patients solely in order to generate revenue. Similarly, greater numbers of expensive tests and procedures are performed when resources like imaging machines, diagnostic labs and surgical suites are available and need to generate revenue. Areas with excess capacity repeatedly demonstrate higher rates of hospital admission and services that cannot be explained by differences in rates of illness or age.
- **Duplication Fuels a Medical Arms Race**: New York's hospitals compete for the most expensive and sophisticated technologies that produce higher financial margins. The result in unnecessary duplication of high-end services like magnetic resonance imaging and cardiac catheterization labs and too little integration of regional service delivery. Eliminating these redundancies will save money without compromising access to care.
- **The Safety Net is Endangered**: Low occupancy rates and associated financial pressures can lessen hospitals' commitment to provide care for vulnerable populations. As fiscal pressures increase, facilities may feel forced to close or shrink their less financially viable services in inner city neighborhoods or rural communities.
- **Costs Increase**: Excess capacity is expensive. Maintaining a "bricks and mortar" based system carries enormous costs. Even empty beds, wards, and buildings that

are unused and unstaffed have fixed costs that must be paid and which are spread over a diminishing number of patients. Additionally, dollars are diverted from other productive uses and reinvestment opportunities are thwarted.

The Commission Process: Public and Local Participation

The Commission is a broad-based, nonpartisan panel established by Governor Pataki and the New York State Legislature to undertake a rational, independent review of health care capacity and resources. It was created to ensure that the regional and local supply of hospital and nursing home facilities is best configured to respond to community needs for high-quality, affordable and accessible care, with meaningful efficiencies in delivery and financing that promote infrastructure stability.

The Commission was specifically charged with rightsizing institutions. Rightsizing includes the possible consolidation, closure, conversion, and restructuring of institutions. Over the course of 18 months, the Commission evaluated each hospital and nursing home in the state to develop its final recommendations. The Commission's process balanced "science" and "art." Its deliberations were informed and driven by extensive review of objective data and quantitative analysis. However, its deliberations were more than a "numbers game" and its final recommendations are not solely the product of mathematical algorithms. Public input, understandings of local market conditions, professional judgment, and factual information were combined to form the basis of the Commission's work.

The Commission operated independently of any existing agency or entity. Given the size and diversity of New York State, the structure of the Commission had a strong focus on regional concerns and issues. The state was formally divided into six regions by its enabling statute. In addition to eighteen statewide voting members, the Commission had up to six regional members for each of the six regions. The regional members had voting authority on matters related solely to their region.

Furthermore, each of the six regions had Regional Advisory Committee (RAC) consisting of up to twelve members. The RACs provided essential community knowledge and insights into local conditions. They played vital information-gathering roles by fostering discussions with and among local stakeholders. Each of the RACs held

extensive meetings with hospital and nursing leaders and representatives from trade groups, organized labor, patient advocates, insurers, researchers, and public health officials. The final advisory reports of the RACs are included as appendices to this report.

The Commission and RACs held public hearings across the state to further solicit input from a wide array of interested parties including patients and consumers, providers, payors, labor, elected officials, and the business community. In total, nineteen hearings were held throughout the regions. The Commission heard from hundreds of witnesses and reviewed thousands of pages of testimony.

Summary of Policy Recommendations

The Commission's direct mandate to rightsize and reconfigure facilities was a vast and necessary endeavor. Nevertheless, the work of the Commission is only one element in a comprehensive reform agenda. No single Commission can address or resolve all of the State's health care issues. The work of this Commission is one step in what must be an ongoing and wide-ranging process to modernize and reshape New York's health care system. The Commission makes the following recommendations to provide a blueprint for additional work necessary to more fully reconfigure our system:

- New York should undertake a comprehensive review of reimbursement policy and develop new payment systems that support a realignment of health services delivery.
- New York should strive for health coverage that is universal, continuous, affordable to individuals and families, and affordable and sustainable for society at large. New York should study coverage expansion efforts in other states and adopt additional strategies to sustain its recent progress in reducing the number of uninsured New Yorkers. While guarding against fraud, New York should lower administrative barriers to enrollment to help ensure that all uninsured but eligible persons are placed in the appropriate program and make it easier for eligible persons to retain coverage.
- New York should expand primary care capacity, including facilities, equipment, information technology and workforce.

- New York should develop and test “hybrid” delivery and financing models that are less than a hospital and more than a primary care center.
- New York should undertake a comprehensive analysis of the feasibility and advisability of privatizing the State University of New York (SUNY) teaching hospitals at Stony Brook, Syracuse, and Brooklyn.
- New York should cultivate its health care workforce by implementing strategies to address persistent shortages in a variety of occupations and to educate and retrain workers to prepare them for increasing uses of heath technologies in their jobs. Workers displaced by Commission recommendations should receive assistance in obtaining employment in other healthcare settings.
- New York should promote the increased use of health information technologies and ensure that these systems are able to communicate, using open architecture and embracing the principle of interoperability.
- New York should undertake a comprehensive review of the future role of county-owned and operated nursing homes. A clear policy should be developed to guide decision-making about county nursing homes and to protect indigent residents.
- New York should develop a mechanism whereby niche providers share in the burden of paying for public goods and charity care. New York should also consider the possible need for quality-of-care monitoring and reporting in non-regulated and private settings.
- New York should implement an ongoing process to sustain the efforts initiated by this Commission.

Summary of Facility Recommendations

Per its statutory obligation, the Commission makes the following recommendations to rightsize and reconfigure health care facilities in each region of the state. The recommendations apply equitably across all regions. The acute care recommendations address 57 hospitals, or one-quarter of all hospitals in the state. The acute care recommendations include 48 reconfiguration, affiliation, and conversion

schemes, and 9 facility closures. Collectively, the recommendations will reduce inpatient capacity by approximately 4,200 beds, or 7 percent of the states' supply. The long-term recommendations for downsizing or closing nursing homes will make highly-targeted nursing bed reductions of approximately 3,000, or 2.6 percent of the state's supply. Twice as many nursing homes will be downsized as closed. In addition, the long-term care recommendations will create more than 1,000 new non-institutional slots.

Central:

- Crouse Hospital and SUNY Upstate Medical Center should be joined under a single unified governance structure under the control of an entity other than the State University of New York, and the joined facility should be licensed for approximately 500 to 600 beds.
- Auburn Hospital should downsize by approximately 100 beds and discontinue its obstetrical services.
- Arnot Ogden Hospital and St. Joseph's Hospital should participate in discussions supervised by the Commissioner of Health to explore the affiliation of such facilities.
- Albert Lindley Lee Hospital should close all of its 67 beds and convert to an outpatient/urgent care center with Article 28 diagnostic and treatment center licensure.
- Van Duyn Home and Hospital and Community General Hospital's skilled nursing facility should be joined under a single unified governance structure under the control of Community General Hospital and downsize their combined number of beds by approximately 75.
- Mercy of Northern New York should downsize 76 nursing home beds, add assisted living, adult care, and possibly other non-institutional services.
- Willow Point should downsize by between 83 and 103 nursing home beds, rebuild its facility in an appropriate configuration, and add adult day care.
- Lakeside Nursing Home should close and assisted living, adult day care, and possibly other non-institutional services should be added in Tompkins County by another sponsor.

- United Helpers, Canton should downsize by approximately 64 nursing home beds, rebuild its facility, and add assisted living and possibly other non-institutional services.

Hudson Valley:

- Kingston and Benedictine Hospitals should be joined under a single unified governance structure, contingent upon Kingston Hospital continuing to provide access to reproductive services in a location proximate to the hospital. The joined facility should be licensed for approximately 250 to 300 beds.
- Mt. Vernon Hospital should downsize approximately 32 medical/surgical beds, convert approximately 20 additional medical/surgical beds into a transitional care unit, convert approximately an additional 24 medical/surgical beds into mentally impaired chemical abusers unit.
- Sound Shore Medical Center should decertify approximately 9 pediatrics and 60 medical/surgical beds and convert additional medical/surgical and obstetrics beds into level III NICU beds and detoxification beds.
- Contingent upon financing, Orange Regional Medical Center should close its existing campuses and consolidate operations at a new, smaller replacement facility that is licensed for approximately 350 beds.
- Community Hospital at Dobbs Ferry should close in an orderly fashion.
- Westchester Medical Center should evaluate establishing the Children's Hospital as an independent entity and review its clinical service mix to identify opportunities for reconfiguration that is non-duplicative of services in community hospitals.
- Valley View Center for Nursing Care and Rehab should downsize by approximately 160 nursing home beds and add assisted living, adult day care and possibly other non-institutional services. The facility should also convert 50 nursing home beds to ventilator-dependent and behavioral step-down units.
- Andrus on Hudson should downsize all 247 nursing home beds and add assisted living and possibly other non-institutional services.
- Taylor Care Center should downsize by approximately 140 nursing home beds.

- Achieve Rehabilitation should downsize by approximately 40 nursing home beds.
- Sky View Rehabilitation and Health care Center should close, downsize, or convert pending a review by the Commissioner of Health

Long Island:

- Eastern Long Island Hospital, Southampton Hospital, Peconic Medical Center should be joined in a single unified governance structure. The new entity should develop an affiliation with University Hospital at Stony Brook. Brookhaven Hospital should continue joint planning with these hospitals and explore joining the new entity. All of these hospitals should implement the bed reconfiguration scheme described in the complete recommendation.
- University Hospital at Stony Brook should be given operational freedom to affiliate with other hospitals and create a regional health care delivery system.
- St. Charles Hospital should downsize 77 medical/surgical beds, convert the remaining 37 medical/surgical beds to psychiatric and alcohol detoxification beds, and discontinue its emergency department.
- J.T. Mather Memorial Hospital should convert all 37 of its psychiatric and alcohol detoxification beds to medical/surgical beds.
- Nassau University Medical Center should downsize by 101 beds and revise its bed configuration across service lines.
- Long Beach Medical Center should downsize by approximately 55 beds. Contingent on other developments, Long Beach should reconfigure as a smaller facility focused on emergency and ambulatory services.
- A. Holly Patterson should downsize by approximately 589 nursing home beds and transfer its subacute services to Nassau University Medical Center. A. Holly Patterson should also rebuild a smaller facility on its existing campus and add assisted living and possibly other non-institutional services.
- Cold Spring Hills Center for Nursing and Rehabilitation should downsize by approximately 90 nursing home beds an d add a ventilator unit, and evening adult program, and a hemo-dialysis center.

- Brunswick Hospital Skilled Nursing Facility should close and assisted living and possibly other non-institutional services should be added in Suffolk County by another sponsor.

New York City:

- New York Methodist Hospital and New York Community Hospital of Brooklyn should merge into a single entity with two campuses, downsize by an approximate total of 100 beds, and expand ambulatory services.
- Victory Memorial Hospital should close in an orderly fashion and the site should be converted to a diagnostic and treatment center and/or a facility offering a continuum of long term care services.
- Peninsula Hospital should downsize by approximately 99 beds and St. John's Episcopal Hospital should downsize by approximately 81 beds. Contingent upon financing, the two facilities should merge and rebuild a single facility with approximately 400 beds.
- Queens Hospital Center should add approximately 40 medical/surgical beds.
- Parkway Hospital should close in an orderly fashion,
- Westchester Square Medical Center should close in an orderly fashion.
- Cabrini Medical Center should close in an orderly fashion.
- Beth Israel Medical Center – Petrie Campus should convert approximately 80 detoxification beds to 80 psychiatric beds.
- North General Hospital should enter into a stronger corporate relationship with Mount Sinai Medical Center.
- St. Vincent's Midtown Hospital should close in an orderly fashion. The psychiatric beds and ambulatory services operated by St. Vincent's Midtown should be transferred and operated by St. Vincent's Manhattan or other sponsors.
- New York Downtown Hospital should decertify approximately 74 medical/surgical beds and 4 pediatric beds, discontinue inpatient pediatric services, and reorganize its outpatient clinics under new sponsorship.
- Manhattan Eye Ear and Throat Hospital should downsize all 150 beds.

- Split Rock Rehabilitation and Health Care Center should close, downsize or convert pending a review by the Commissioner of Health.

Northern:

- Bellevue Woman's Hospital should close in an orderly fashion and its maternity, neonatal, eating disorders, and mobile outpatient services should be added to another hospital in Schenectady County.
- St. Clare's Hospital and Ellis Hospital should be joined under a single unified governance structure and the resulting entity should be licensed for 300 to 400 beds.
- Ann Lee Infirmary and Albany County Home should merge, downsize by at least 345 nursing home beds, rebuild a unified facility, and simultaneously add or provide financial support for non-institutional services.
- The Avenue and Dutch manor should merge and downsize by approximately 200 nursing home beds in a rebuilt Avenue facility and should add assisted living, adult day care and possibly other non-institutional services.
- The Glendale Home should downsize by approximately 192 beds.

Western:

- Millard Fillmore Hospital – Gates Circle should close in an orderly fashion.
- St. Joseph Hospital should close in an orderly fashion.
- DeGraff Memorial Hospital should downsize all 70 medical/surgical beds. It should convert to a long term care facility encompassing its current 80 nursing home beds and the 75 nursing home beds currently at Millard Fillmore Hospital - Gates Circle.
- Sheehan Memorial Hospital should downsize 69 medical/surgical beds. The 22 inpatient detoxification beds currently at Erie County Medical Center should be added to Sheehan, and Sheehan should add ambulatory care services, methadone maintenance, and outpatient psychiatric services.
- The facilities controlled by Erie County Medical Center Corporation and Kaleida Health should be joined under a single unified governance structure under the

control of an entity other than Erie County Medical Center Corporation, Kaleida Health, or any public benefit corporation. The new entity should have a single unified board with powers sufficient to consolidate services into centers of excellence.

- Lockport Memorial Hospital and Inter-Community Memorial Hospital at Newfane should engage in a full asset merger and reconfiguration of services.
- Bertrand Chaffee Hospital should downsize by at least 25 beds, seek designation as a critical access hospital, and affiliate with TLC Tri-County and TLC Lake Shore.
- Brooks Memorial Hospital should seek designation as a sole community provider.
- TLC Tri-County should downsize 28 medical /surgical beds and convert the remaining 10 medical/surgical beds to detoxification beds.
- TLC Lake Shore should downsize all 42 medical/surgical beds and 40 nursing home beds and convert to an Article 28 diagnostic and treatment center. At its option, Lake Shore should continue to operate approximately 20 psychiatric beds or these beds should be added by another local sponsor.
- Westfield Memorial Hospital should downsize all 32 inpatient beds and convert to an Article 28 diagnostic and treatment center.
- Mount St. Mary's Hospital and Health Center or its sponsoring entity and Niagara Falls Memorial Medical center should participate in discussions supervised by the Commissioner of Health to explore the affiliation of such facilities.
- Mount View Health Facility should downsize all 172 nursing home beds, rebuild a new facility on its existing campus, add assisted living, adult day services and possibly other non-institutional services.
- Nazareth Nursing Home should downsize all 125 nursing home beds and convert the facility for use in the PACE program at the former Our Lady of Victory Hospital.
- Mercy Hospital Skilled Nursing facility should add 10 beds and transfer all of its beds to the former Our Lady of Victory Hospital
- St. Elizabeth's Home should covert its adult home beds to an assisted living program.

- Williamsville Suburban should close.

Financing

The Commission's recommendations will benefit New Yorkers and the health care system. First, they will promote stability of health care providers thereby ensuring access to care and the provision of public goods. Second, they will reduce unnecessary public and private spending and produce overall cost savings for all payors. Third, they will produce numerous opportunities for reinvestment in the system thereby providing substantial financial benefits to providers and the patients served by them.

System restructuring also provides many savings for payors, both in terms of actual reductions in current expenditures and avoided future costs. Such opportunities for savings include reductions in inappropriate utilization, avoided capital investment and leveraged savings. The total estimated savings for payors is around $806 million annually or $8 billion over ten years. This includes an annual savings to Medicaid of around $249 million, or $2.5 billion over ten years, and an annual savings to Medicare of around $322 million, or $3.2 billion over ten years. The total estimated benefit to providers is around $721 million annually or $7.2 billion over ten years. Together, these calculations yield a total benefit to payors and providers of over $1.5 billion annually, or $15 billion over ten years.

The realization of these savings will also entail costs. Broad systemic changes must be supported with appropriate resources and investments are required to implement these recommendations. Potential costs are associated with closures, new construction, and affiliations. Not all of these costs will be borne by the State. It is estimated that implementation will entail a total cost of approximately $1.2 billion, including approximately $350 million in closure costs, $1.1 billion in construction costs, $11 million in affiliation planning costs, and $300 million in offsets from the sale of facility real property. Almost $606 million of these costs are attributable to two contingent projects that the Commissioner will not be required to implement absent available funding.

Vast and unprecedented sums are available to support the restructuring of New York's health care system and cover costs associated with implementing the

Commission's recommendations. The Health Care Efficiency and Affordability Law for New Yorkers (HEAL-NY) allocates $1 billion over four years for capital grant funds to finance physical reconfiguration, conversion, downsizing, or closure of hospitals and nursing homes. Additionally, the Federal-State Health Reform Partnership (F-SHRP) allocates an additional $1.5 billion for similar purposes.

Although HEAL-NY and F-SHRP and critical to financing the Commission's recommendations, they are not and should not be the only sources of funding. Indeed, public funds should be used in the most prudent possible manner. Insofar as facilities are capable of funding their own closure, conversion, affiliation, or rightsizing, they should be expected to do so. The Commission believes it to be appropriate that costs will be shared among all interested parties. Taxpayer dollars should be used judiciously and equitably.

I. Dynamism of New York's Health Care System

Little remains static in New York's health care system. Regulatory changes, technological and clinical innovations, patient preferences, and varying business models contribute to this constant transformation. Rapid and broad scale change is inevitable; it requires adaptive strategies. Yet today, New York is struggling to maintain a 20th century institutional infrastructure in the face of mounting costs, excess capacity, and unmet need for community-based alternatives. To strengthen our system, New York must overcome its over-reliance on outdated institutions and improve the fiscal stability of its health care providers to guarantee the ongoing provision of important safety-net functions, public goods, and world-class quality of care.

Catching Up to Change

The past decade was a period of especially dramatic change for NY's health care system and its financing mechanisms. Under the regime of New York's Prospective Hospital Reimbursement Methodology (NYPHRM), established in 1983, the New York State Department of Health set hospital reimbursement rates. Only health maintenance organizations and similar managed-care entities were allowed to negotiate fees with hospitals. Essentially, NYPHRM established cost-based inpatient rates for Medicaid and Blue Cross. Other private insurance companies were required to pay a fixed "mark-up" of 11% above the Blue Cross rate.[1]

The Health Care Reform Act of 1996 (HCRA) replaced NYPHRM. HCRA deregulated hospital rate negotiation so that insurers, employers, and other health care payers now directly negotiate rates with hospitals. The State continues to establish Medicaid fee-for-service reimbursement rates. The federal government sets Medicare rates.

Under NYPHRM, NY's hospitals generally experienced modest or break-even financial margins. The artificial margins created by NYPHRM were exposed by HCRA. Hospital industry leaders have argued that providers were disadvantaged in their ability to thrive in the newly competitive environment. According to the Greater New York Hospital Association (GNYHA),

[1] Raske, K.E. (2006, February 7). Testimony Of Kenneth E. Raske, President of Greater New York Hospital Association on the Executive Budget Proposal for 2006–07 Before the New York State Senate Finance And Assembly Ways and Means Committees. Retrieved July 21, 2006, from Greater New York Hospital Association Web site: http://www.gnyha.org/testimony/2006/pt20060207.pdf

"[a]fter deregulation in 1997, hospitals' precariously balanced financial well-being collapsed because health insurers were able to establish negotiated rates by using the old NYPHRM payments as the ceiling. That is, plans negotiated down from a State-set, cost-based rate rather than from market-set, charge-based payments, as had been the case in other states. In addition, the State was no longer able to rescue ailing hospitals through special rate appeals or revenue enhancements because it no longer controlled most of hospital revenue."[2]

Concomitant to the change in state regulation, the federal government reduced Medicare's hospital reimbursement rates in 1997. The Balanced Budget Act of 1997 (BBA) resulted in major revenue losses for New York hospitals. Due to New York City's heavy concentration of academic medical centers and its large medically indigent population, the BBA's sharp reductions in general medical education (GME) and disproportionate share hospital (DSH) payments resulted in an especially considerable drop of New York City hospitals' collective revenue.[3]

Hospital and Nursing Home Closures

The turbulence associated with such changes is illustrated by widespread closures and bankruptcies of hospitals and nursing homes. Since 1983, 70 hospitals and over 63 nursing homes have closed in New York State, including 34 hospitals and 44 nursing homes since 1994. Additionally, numerous facilities have declared bankruptcy. Despite these closures, excess capacity remains and resistance to mergers and other consolidations persists. Understandably, facility boards, workers, and communities are committed to preserving institutions in which they have perceived investments.

[2] Ibid

[3] For a discussion of BBA's impact on NYC hospitals, see, e.g., Salit, S., Fass, S., & Nowak, M. (2002). Out of the frying pan: New York City hospitals in an age of deregulation. *Health Affairs*. *21*, 127-139.

Table 1. New York State Hospital Closures since 1983

Hospital Name	County	Year Closed
Brunswick Hospital Center*	Suffolk	2005
New York United Hospital	Westchester	2005
St. Vincent's Catholic Medical Center – St. Mary's	Kings	2005
The Hospital	Delaware	2005
St. Vincent's Catholic Medical Center – Bayley Seton	Richmond	2005
Our Lady of Mercy Medical Center – Florence D'Urso Pav	Bronx	2004
St. Vincent's Catholic Medical Center – St. Joseph's	Queens	2004
Beth Israel Medical Center – Singer Division	New York	2004
Staten Island University Hospital – Concord Div	Richmond	2003
Myers Community Hospital	Wayne	2003
Brooklyn Hospital Center – Caledonian Campus	Kings	2003
Interfaith Medical Center – Jewish Hospital of Brooklyn	Kings	2003
Mary McClellan Hospital	Washington	2003
Island Medical Center	Nassau	2003
St. Agnes Hospital	Westchester	2003
Amsterdam Memorial*	Montgomery	2002
Olean General Hospital*	Cattaraugus	2001
Genesee Hospital	Monroe	2001
Massapequa General Hospital	Nassau	2000
St. John's Episcopal Hospital, Community Div	Suffolk	1999
New York Flushing Hospital Medical Center – North Div	Queens	1999
St. Mary's Hospital	Monroe	1999
Lady of Victory – Lackawanna	Erie	1999
Union Hospital of the Bronx	Bronx	1998
Salamanca	Cattaraugus	1998
Columbus Community Healthcare	Erie	1998
Leonard Hospital	Rensselaer	1997
Samaritan Medical Center – Stone Street Div	Jefferson	1997
Mohawk Valley General	Herkimer	1996
Julia Butterfield Memorial	Putnam	1996
Wyckoff Heights Hospital – Jackson Heights Div	Queens	1996
Flushing Hospital – Little Neck Div	Queens	1996
Westchester Medical Center – Mental Retardation Institute	Westchester	1995
Medical Arts Center Hospital	New York	1994

Table 1 (continued). New York State Hospital Closures since 1983

Hospital Name	County	Year Closed
Mercy Hospital	Jefferson	1993
Greene Division – Columbia-Greene Medical Center	Greene	1993
St. Francis	Erie	1992
Waterloo Memorial – Taylor Brown	Seneca	1991
Adirondack Regional	Saratoga	1991
Salamanca	Cattaraugus	1991
Tioga General	Tioga	1990
Community	Delaware	1989
Holy Family Medical Center	Kings	1989
Arnold Gregory	Orleans	1989
Emma Laing Stevens	Washington	1989
Childrens	Oneida	1988
Jamestown General	Chautauqua	1988
Doctors Sunnyside	Orange	1988
Parsons	Queens	1988
Johnstown	Fulton	1988
Baptist Medical Center	Kings	1987
Long Island Jewish – Manhasset Division	Nassau	1987
Sheridan Park	Erie	1987
Deaconess Division – Buffalo General	Erie	1987
Seneca Falls	Seneca	1986
Flatbush General	Kings	1986
Lafayette General	Erie	1986
Bethesda	Steuben	1986
Cohoes Memorial	Albany	1986
Tuxedo Memorial	Orange	1985
Lydia E. Hall	Nassau	1985
Boulevard	Queens	1985
Prospect	Bronx	1985
Ideal-United Health Services	Broome	1984
Herkimer Memorial	Herkimer	1984
Terrace Heights	Queens	1984
Cumberland	Kings	1983
Jewish Memorial	New York	1983
Rose	Oneida	1983

* Brunswick Hospital – closed all medical-surgical beds, but maintain rehabilitation services, Amsterdam Memorial – closed emergency department, ICU and ceased using medical-surgical beds in 2002, in 2005 received approval to reopen inpatient beds. The beds are used for sub-acute care in connection with their nursing home, Olean General – services consolidated at main Olean General site and still in operation.
Source: New York State Department of Health

Table 2. New York State Nursing Home Closures since 1983

Nursing Home Name	County	Year Closed
Childs Nursing Home Company	Albany	2006
Cedar Hedge Nursing Home	Clinton	2006
Episcopal Residential Health Care Facility	Erie	2006
The Hospital Skilled Nursing Facility	Delaware	2005
Sunrest Health Facilities	Suffolk	2005
New York United Hospital Medical Center Skilled Nursing Pavilion	Westchester	2005
Hebrew Home For The Aged At Riverdale Baptist Div	Bronx	2005
Rehab Institute Of New York At Florence Nightingale Health Center	New York	2005
Menorah Home & Hospital For Aged And Infirm	Kings	2005
Kresge Residence	Erie	2004
Hutton Nursing Home	Ulster	2004
Manor Oak Skilled Nursing Facilities	Chautauqua	2004
St Lukes Manor Of Batavia	Genesee	2004
Manor Oak Skilled Nursing Facilities	Erie	2004
Loeb Center Montefiore Medical Center	Bronx	2004
Norloch Manor	Monroe	2004
Bethel Methodist Home	Westchester	2003
Wesley-On-East	Monroe	2003
Mary McClellan Skilled Nursing Facility	Washington	2003
Mt St Mary's Long Term Care Facility	Niagara	2003
Eden Park Health Care Center	Columbia	2003
Potsdam Nursing Home	St Lawrence	2003
St Mary's Manor	Niagara	2003
Manor Oak Skilled Nursing Facilities Inc	Wyoming	2003
The Gardens At Manhattan Health And Rehabilitation Center	Erie	2003
Eden Park Health Care Center	Albany	2003
St Clare Manor	Niagara	2003
Williamsville View Manor	Erie	2003
Lyden Care Center	Queens	2002
Genesee Hospital ECF	Monroe	2002
Our Lady of Victory/Head Trauma Unit	Erie	2002
Chandler Care Center	Westchester	2002
The Waters of Syracuse	Onondaga	2002
Beechwood Sanitarium	Monroe	2000
Dover Nursing Home	Kings	2000
Niagara Lutheran Delaware Home	Erie	1999

Table 2 (continued). New York State Nursing Home Closures since 1983

Nursing Home Name	County	Year Closed
Oswego Hospital ECF	Oswego	1999
Dutchess County HCF	Dutchess	1999
Leisure Arms	Rensselaer	1997
Eden Park Nursing	Rensselaer	1997
Broadacres	Oneida	1996
Madonna Residences, Inc	Kings	1995
Franklin Plaza Nursing Home	Nassau	1994
Catherine McAuley Manor	Erie	1993
Swiss Home Health Related Facility	Westchester	1993
St. Mary's Hospital Brain Injury Unit	Monroe	1992
Maryknoll Nursing Home	Westchester	1991
Gerrit Smith Memorial Infirmary	Madison	1991
Taylor-Brown Memorial Hospital Nursing Home	Seneca	1990
Good Samaritan Nursing Home	Albany	1990
Elcor's Marriott Manor Health Related Facility	Chemung	1990
Arnold Gregory Memorial Hospital Skilled Nursing Facility	Orleans	1989
Strong Memorial Hospital Skilled Nursing Facility	Monroe	1988
Chenango Bridge Nursing Home	Broome	1988
Placid Memorial Hospital	Essex	1988
Surfside Nursing Home	Queens	1988
City Hospital at Elmhurst Public Home	Queens	1988
St. George Nursing Home	Erie	1988
Margaret-Anthony Nursing Home	Chautauqua	1988
House of the Holy Comforter	Bronx	1986
Flower City Nursing Home	Monroe	1985
Jewish Home & Infirmary of Rochester	Monroe	1985

Source: New York State Department of Health

Health care facilities close for a variety of reasons, and rarely close due to one isolated cause. Common factors that lead to closures include:

- **Poor financial health**: First and foremost, facilities close due to lack of funds. As the adage indicates, "no margin, no mission." Not surprisingly, hospitals and nursing homes that close tend to have been in severe financial distress for an extended period of time before closing.

- **Aging physical plant**: Nationally, the average age of a hospital physical plant in 2004 was 9.8 years.[4] In New York, the Dormitory Authority for the State of New York (DASNY) estimates that the average age of a New York hospital in 2004 was approximately 12.5 years. Nationally, the biggest increases in capital expenditures have occurred in regular fixed equipment, meaning that hospitals have concentrated on repairs and renovations rather than design and construction of new facilities.[5]

- **Aging physical plant for nursing homes**: According to officials at the Department of Health, the majority of nursing homes in New York State were built before 1960. From the information available, the median year at which facilities began operating as nursing homes is 1971, but many facilities operate in buildings much older, built for purposes other than nursing homes and later converted.
- **Low occupancy rates:** An empty bed does not generate revenue. Even when a bed is unoccupied, there are significant fixed costs associated with maintaining that bed, including staffing and capital costs. Unoccupied beds are significant money drains on hospitals and nursing homes. Low occupancy rates can also indicate that facilities are unnecessary or undesirable; empty beds can reflect choices by patients and physician to seek and provide care elsewhere.

- **Poor community reputation:** All hospitals and nursing homes are community institutions, serving and served by people in the community. Those facilities with reputations as providers of high-quality care and as "good citizens" attract the area's physicians and patients. A good reputation therefore generally sustains a higher occupancy rate and a poor one helps sink an institution.

- **Weak management/leadership:** A critical factor to any successful hospital and nursing home is strong and efficient management and leadership. Management is responsible for

[4] American Hospital Association, (2006). Chartbook: Trends Affecting Hospitals and Health Systems, April 2006. Retrieved July 24, 2006, from the American Hospital Association Web site: http://www.aha.org/aha/research-and-trends/health-and-hospital-trends/2006.html

[5] Runy, L. (2003).Penny wise? Financial pressures force a short-term mind-set in capital spending. *Health Facilities Management*. *16(2)*, 20-21.

establishing and implementing a strategic plan that is in keeping with an organization's mission. Health care leaders should create a sense of organizational commitment, and provide a supportive work environment to help to prevent/protect against burnout, which will ultimately reduce employee turnover and save money.[6]

According to the Healthcare Financial Management Association, rating agencies such as Moody's and Standard and Poor's cite the following governance and management issues as critical to their rating decisions:

- *Governance*: Is the board involved in a meaningful way in strategic decision-making for the hospital? Does the board have the necessary skills to make informed decisions? Do skills of board members complement those of the management team?
- *Management*: Has management proven its ability to weather regulatory change and market threats? Do senior managers inform and educate their board? Do they have demonstrated relevant experience? Do they use effective methods to monitor and improve performance? Do they use systematic strategic and financial planning? Do they assess and serve community needs?[7]

- **Weak markets/access to capital**: Many facilities have deferred capital improvements and require significant upgrades to their physical plants. Yet, access to capital financing is weak for many New York State providers that struggle with high debt burdens and limited liquidity. Without adequate access to capital, hospitals and nursing homes cannot invest in the physical plant or equipment that will ensure high-quality health care.

- **Difficulty attracting and retaining staff:** Hospitals and nursing homes in New York State, as with the rest of the nation, are finding it increasingly difficult to attract and

[6] See: Organzo, A.J., et al, (2006). Are attributes or organizational performance in large health care organizations relevant in primary care practices? *Health Care Management Review*. *31 (1)*, 2-10.
Castle, N.G. (2006). Organizational commitment and turnover of nursing home administrators. *Health Care Management Review*. *31 (2)*, 156-165.

[7] HFMA, & Pricewaterhouse Coopers (2003). Financing the future report 1: How are hospitals financing the future? Access to capacity in health care today. Retrieved July 21, 2006, from Healthcare Financial Management Association Web site: http://www.hfma.org/NR/rdonlyres/2E95F3D0-B095-4F04-8AA1-AAE264109806/0/FNF1_No1.pdf

retain quality health care workers. Experienced nurses are in especially short supply. In addition, the migration of young workers from upstate New York to New York City and other parts of the country has exacerbated the shortage of health care workers upstate.[8]

- **Competition from other providers**: Hospitals and nursing homes face increasing competition both within their industries and from alternative providers.
    - **Within the Industry:** Hospitals and nursing homes compete vigorously among themselves in multiple ways. First, hospitals must selectively contract with health plans to be placed on their preferred provider networks. This may induce hospitals to offer significant price reductions to the plan to receive this network designation and/or to provide services attractive to health plans.[9] Second, hospitals are engaged in a "medical arms race" for high-margin services where they make redundant investments in costly clinical technologies to provide services attractive to individual plan beneficiaries and physicians.[10] In the face of declining occupancy rates, nursing homes also compete vigorously with one another to fill beds. Nursing homes are devoting increasing money and effort to marketing activities, targeting discharge planners with their information.
    - **Alternative sites of care:** Hospitals face increasing competition from other providers of care, such as ambulatory surgery centers, that have lower overhead costs than hospitals. The services provided by these niche providers are often well-reimbursed and deprive hospitals of revenues that were historically used to cross subsidize less profitable services. Similarly, nursing homes face increasing competition as more long term services are provided in non-institutional settings. Patient preferences and technology advances are driving a shift to home and community-based settings. This is especially so for nursing homes which provide a great deal of custodial care and who thus compete for the same resident pool with home care agencies and assisted living residences.

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[8] See: Roberts, S. Flight of young adults is causing alarm upstate. (2006, June 13). *New York Times*, p. A1. Available online: http://www.nytimes.com/2006/06/13/nyregion/13census.html

[9] Devers, K.J., Brewster, L.R., & Casalino, L.P. (2003). Changes in hospital competitive strategy: A new medical arms race?. *Health Services Research. 38 (1 Pt 2)*, 447-469. Available online: http://www.pubmedcentral.gov/articlerender.fcgi?tool=pubmed&pubmedid=12650375

[10] Ibid

- **Size of nursing home**: Following national trends, those New York State nursing homes that have closed tend to be smaller institutions. Nationwide, the proportion of homes with fewer than 100 beds declined from 65.7% of total facilities to just over 50%[11] It is important to note that studies have shown that poor quality is less of a contributing factor to closure than size[12].

- **"Cashing out"**: Unlike New York hospitals, a large proportion (48%) of New York nursing homes are proprietary (for-profit), so that the real estate on which a nursing home sits can be sold with few restrictions and the licensed beds are transferable to other nursing homes. Establishing a new nursing home has become increasingly difficult; therefore, each licensed nursing home bed has a high market value. Consequently, some providers prefer to "cash out" rather than to continue operations, often by selling their real estate assets.

Table 3. Nursing Home Sponsorship

Region	Ownership Class		
	Proprietary	Public	Voluntary
Central	36%	8%	56%
Hudson Valley	46%	10%	45%
Long Island	76%	4%	21%
New York City	53%	4%	43%
Northern	32%	19%	49%
Western	45%	12%	43%
Statewide	48%	8%	44%

Source: New York State Department of Health

[11] Centers for Disease Control and Prevention, (1995, 1997, 1999). National Nursing Home Survey. Retrieved July 24, 2006, from National Center for Health Statistics Web site: http://www.cdc.gov/nchs/nnhs.htm#Public-Use%20Data%20Files

[12] Castle, N.G. (2005).Nursing home closures and quality of care. *Medical Care Research and Review*. *62 (1)*, 111-132. Available online: http://mcr.sagepub.com/cgi/reprint/62/1/111.pdf

II. Instability of the System

The Commission finds New York States' health care providers to be in critically unstable condition. Providers cannot sustain chronic financial losses and continue to provide the world class health care and important public goods that New Yorkers expect and deserve. "[N]o ordinary enterprise can continue to operate indefinitely with losses. Hospitals with losses for several years should either close, merge, or make changes to become more profitable."[13] As hospitals and nursing homes struggle to remain solvent, they face possible closure due to market forces alone. Because such market driven closures can occur irrespective of or even contrary to public policy goals, access to and quality of care are at risk. The most important institutions to preserve may also be the most fragile.

Hospital System Fiscal Instability

The dire financial situation of New York's hospitals can be seen across all categories of hospitals, from rural to inner-city, from large academic medical centers to small critical access hospitals. According to the Healthcare Association of New York State (HANYS), hospitals in New York State have lost an aggregate $2.4 billion over the past eight years.[14] In 2005 alone, the statewide operating margin[15], which is the traditional measure of hospitals' financial health, was -0.2% (-$95.4 million).[16] While some hospitals are on relatively solid financial ground, the majority are losing money, just breaking even, or operating with a 0-1% financial margin.[17] [18]

Margins in New York have never been generous. Year after year, New York hospitals' operating margins fall far below national norms. Before 1997, those margins were artificially

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[13] Duffy, S.O., & Friedman, B. (1993). Hospitals with chronic financial losses: What came next?. *Health Affairs. 12 (2)*, 151-163. Available online: http://content.healthaffairs.org/cgi/reprint/12/2/151

[14] Healthcare Association of New York State. (2006, November 16). New York's hospitals lose money for the 8th straight year: Negative operating margin ranks New York 49th in the nation. Retrieved November 16, 2006, from Healthcare Association of New York State Web site: http://www.hanys.org/communications/pr/2006/upload/11_15_06_EightYearsFinancial.pdf

[15] Gain or loss from operating sources (operating income/total operating revenue).

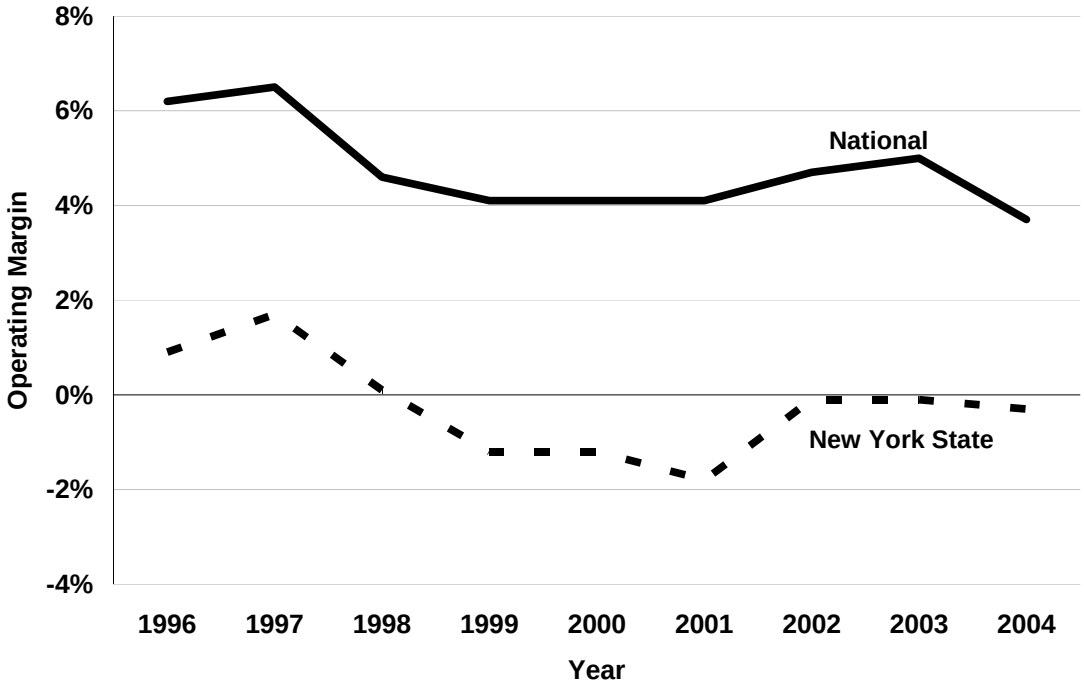
[16] Healthcare Association of New York State. (2006, November 16). New York's hospitals lose money for the 8th straight year: Negative operating margin ranks New York 49th in the nation. Retrieved November 16, 2006, from Healthcare Association of New York State Web site: http://www.hanys.org/communications/pr/2006/upload/11_15_06_EightYearsFinancial.pdf

[17] Ibid

[18] The New York Health Plan Association (NYHPA) paints a different picture by using net income, finding that two-thirds in fact generated profits in 2004, and of the one-third of hospitals that had losses, 15 facilities comprised approximately 75% of total losses for New York State. See: http://www.empirenewswire.com/release/downloads/nyshpa.pdf

maintained in the zero to 1% range, and after a nominal improvement in 1997, they declined precipitously. In 2005, the national average operating margin for hospitals was 3.7%, four percentage points higher than New York State's.[19] Comparing 1996-2003 operating margins in the 50 states and the District of Columbia, New York State has the dubious distinction of ranking among the very worst in terms of operating margins.[20]

Figure 1: Hospital Operating Margins, New York State and United States, 1996-2004



Source: Greater New York Health Association analysis of Medicare cost reports

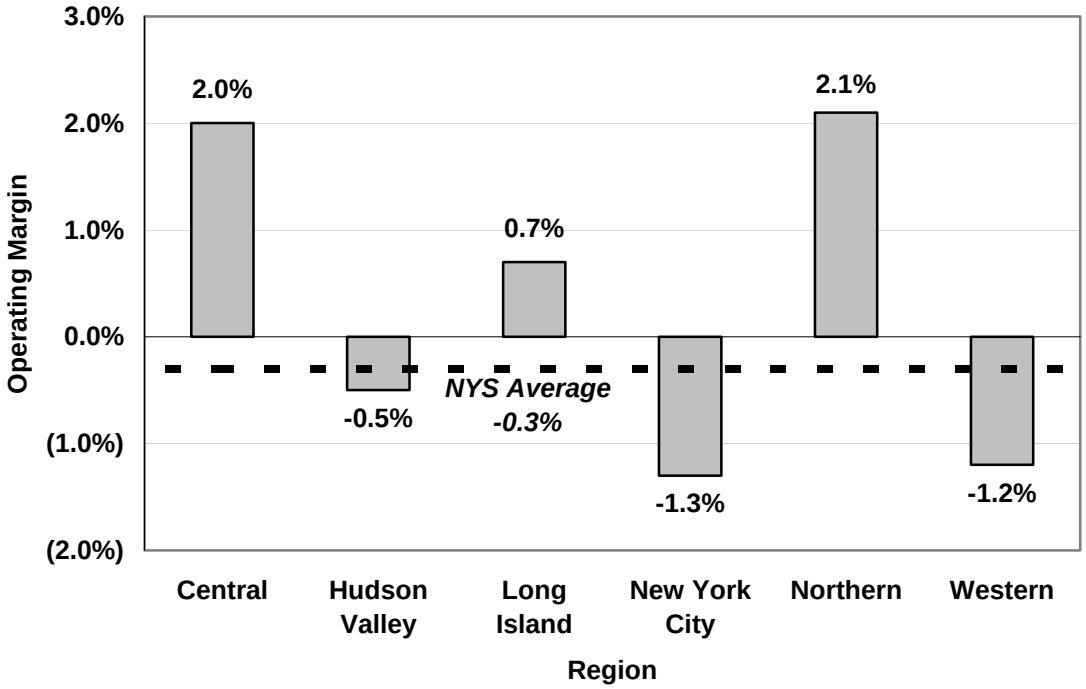
Certain regions in the State fare worse than others. Hospitals in the New York City region are the most financially vulnerable in the State. A July 2003 United Hospital Fund

[19] Healthcare Association of New York State. (2006, November 16). New York's hospitals lose money for the 8th straight year: Negative operating margin ranks New York 49th in the nation. Retrieved November 16, 2006, from Healthcare Association of New York State Web site: http://www.hanys.org/communications/pr/2006/upload/11_15_06_EightYearsFinancial.pdf

[20] Raske, K.E. (2006, February 7). Testimony Of Kenneth E. Raske, President of Greater New York Hospital Association on the Executive Budget Proposal for 2006–07 Before the New York State Senate Finance and Assembly Ways and Means Committees. Retrieved July 21, 2006, from Greater New York Hospital Association Web site: http://www.gnyha.org/testimony/2006/pt20060207.pdf

found that one-third of New York City hospitals' viability was "in doubt," and faced financial problems "severe enough to jeopardize their continuing viability." [21]

Figure 2: Hospital Operating Margins by Region, 2004



Source: HANYS 2004 Audited Financial Statements[22]

Weak operating margins are not the sole indicators of hospitals' annual financial stress. New York State hospitals are also the most heavily indebted in the nation. The equity financing ratio (the percent of assets financed through cash savings as opposed to debt) in New York is the worst of the 50 states and the District of Columbia. While most hospitals in the nation finance capital investments by an approximately 50%-50% combination of savings and borrowings, New York State had an 18% equity financing contribution rate by 2003.[23] In other

[21] Brooks, P. (2003, July). Losses continue at NYC hospitals; Viability of one-third in doubt. *Hospital Watch*, *14 (3)*, 1-6. Available online: http://www.uhfnyc.org/usr_doc/hwv14n3.pdf

[22] Healthcare Association of New York State. (2005, November 16). Hospitals in New York lose money for seventh year in a row. Retrieved September 21, 2006, from Healthcare Association of New York State Web site: http://www.hanys.org/communications/pr/111505_pr.cfm

[23] Raske, K.E. (2006, February 7). Testimony Of Kenneth E. Raske, President of Greater New York Hospital Association on the Executive Budget Proposal for 2006–07 Before the New York State Senate Finance and Assembly Ways and Means Committees. Retrieved July 21, 2006, from Greater New York Hospital Association Web site: http://www.gnyha.org/testimony/2006/pt20060207.pdf

words, New York State relies more on debt to cover necessary expenses than does any other state's health care delivery system. This heavy dependence on debt will further destabilize New York's health care delivery system, and may cripple the State's health care structure in the long term.

The fiscal problems of NY's hospitals are reflected in and exacerbated by their difficulties raising capital. US hospitals generally have a wide range of capital sources to tap, both external and internal.[24] External sources of capital include proceeds generated from bond issuances, bank loans, sale of real estate, real estate investment trusts, public grants, and philanthropy. Internal sources include operating and non-operating cash flow and divested assets.

The Healthcare Financial Management Association identified two types of hospitals to discern which hospitals have the best access to capital. The first type, those with "broad access" to capital, has stellar financial profiles: high profitability, high liquidity, and limited debt burden. Those with "limited access" to capital are neither profitable nor have adequate liquid assets, and are significantly burdened with debt. According to this report, New York's access to capital is bleak. Compared to the fifty states and DC, "New York ranks first in both proportion and number of hospitals designated as having limited access to capital."[25]
The State's limited access to capital is also reflected in the bond ratings of the various New York hospitals. Due to many factors, including average age of plant, days cash on hand, as well as operating margin and debt to capitalization ratios, the hospitals' bond ratings are dismal. In its February 2006 report, the Moody's rating agency referred to New York State as "one of the most difficult, if not the most difficult, states to operate a hospital."[26]

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[24] Healthcare Financial Management Association, & Pricewaterhouse Coopers. (2003). Financing the future project reports I and II. Retrieved July 21, 2006, from Healthcare Financial Management Association Web site: http://www.hfma.org/library/accounting/capitalfinance/FinancingtheFuture.htm

[25] Ibid

[26] Moody's Investor's Service Global Credit Research. (2006). Not-for-profit hospitals: 2006 State of the States. Moody's Investor's Service 2006 Outlook.

Table 4. Statewide Ranking of Hospitals with Limited Access to Capital

Rank	Wide	Constrained
1	Indiana	**New York**
2	Wisconsin	Hawaii
3	Nebraska	Washington, DC
4	New Hampshire	Pennsylvania
5	Vermont	West Virginia
6	Minnesota	New Jersey
7	Ohio	North Dakota
8	Virginia	Massachusetts
9	Arizona	California
10	Tennessee	Connecticut

Source: Solucient[27]

The low credit rating of the hospitals has two primary effects. First, the higher the debt service costs due to poor credit ratings, the less an institution can spend on other expenditures such as capital improvement, technology upgrades, and pension coverage. Second, because the bond ratings are bleak, the vast majority of not-for-profit hospitals and nursing homes in the DASNY portfolio require some sort of credit enhancement. Credit enhancement sources include letters of credit, bond insurance, local taxes, and the Federal Housing Administration's (FHA) section 242 Hospital Mortgage Insurance Program.[28] Notably, in 2000, the FHA program insured over 70% of hospital credits issued through DASNY, and over 60% of FHA-insured debt nationwide is in New York State.[29]

[27] Healthcare Financial Management Association, & Pricewaterhouse Coopers. (2003). Financing the future II Report 6: The outlook for capital access and spending. Retrieved July 21, 2006, from Healthcare Financial Management Association Web site: http://www.hfma.org/NR/rdonlyres/ED7D0E8B-E896-4B1C-8466-B33CA4B72095/0/FF2_No6_Outlook_w1.pdf

[28] See: United States Government Accountability Office. (2006). *Hospital mortgage insurance program: Program and risk management could be enhanced* (1-66), showing that the geographic concentration of FHA-insured hospitals located in New York "makes the [FHA] program vulnerable to state policies and regional economic conditions." Availabe online: http://www.gao.gov/new.items/d06316.pdf

[29] Health Care Reform Working Group. (2004). *Health Care Reform Working Group – Final Report, November 17, 2004*, 1-32. Available online: http://www.health.state.ny.us/health_care/medicaid/related/health_care_reform/pdf/final_report.pdf

Table 5. New York State Hospital Medians Compared to Rating Agency Medians

	Hospital Medians								
		S&P, All Health Care, 2004**				Fitch Nonprofit Hospital and Health Care System, 2004***			
Ratios	**New York State, 2003***	**AA+ to AA-**	**A+ to A-**	**BBB+ to BBB-**	**Spec**	**AA**	**A**	**BBB**	**Below BBB**
Average Age of Plant	12.5	8.9	9.1	9.8	12.6	9.4	9.9	9.3	13.1
Days Operating Cash Available	30.1	211	159	110	50	232.2	177.2	117.5	49.3
Operating Margin	0.0%	3.1%	3.5%	1.2%	(1.3%)	3.5%	2.5%	1.0%	(1.8%)
Debt to Capitalization	50.9%	32.8%	37.3%	44.3%	65.3%	34.8%	39.0%	47.3%	75.1%

Source: * DASNY, 2003 audited financial statements
** Standard and Poor's, "U.S. Not-For-Profit Health Care 2004 Median Ratios," June 10, 2004
*** FitchRatings, Health Care Special Report, "2005 Median Ratios for Nonprofit Hospitals and Health Care Systems," August 9, 2005

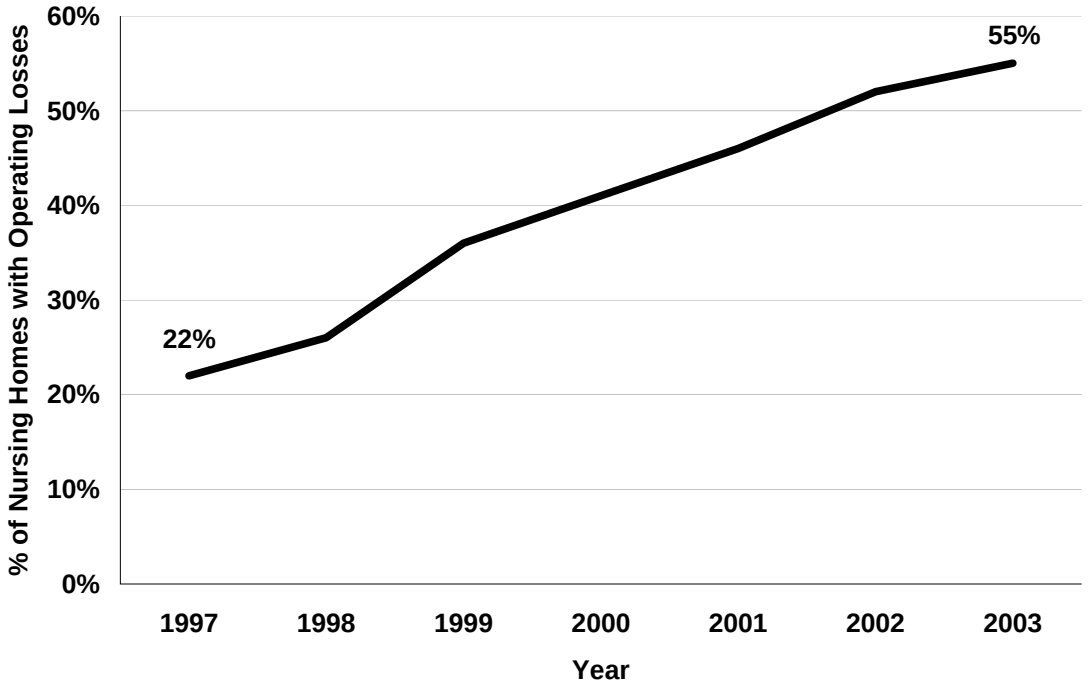
To help ameliorate the hospitals' limited capital access, DASNY, the State agency that provides financing and construction services to not-for-profit healthcare facilities and the State's largest issuer of health-related debt, issued secured hospital revenue bonds. These bonds "were issued to allow financially distressed New York not-for-profit- hospitals access to the capital markets. The establishment of the Secured Hospital Program became necessary because the physical plants of certain hospitals were deteriorating, but such hospitals' financial conditions were too weak to enable them to borrow the monies necessary to modernize their facilities."[30] Authorization to issue bonds under this program, however, expired on March 1, 1998. Approximately $837 million is outstanding, spread over ten institutions. Currently, DASNY offers multiple programs to provide financing for capital construction and rehabilitation projects for non-profit health care facilities in New York State which are secured by various credit structures.

[30] Dormitory Authority State of New York. Financial services: Health care. Retrieved July 24, 2006, from Dormitory Authority State of New York Web site: http://dasny.org/finance/finserv/index.php#anchor820988

Nursing Home System Fiscal Instability

New York State's nursing homes are in a similarly precarious situation. In 1997, less than a quarter of the State's nursing homes were operating in the red. The majority - at least 55% - now operate at a loss.

Figure 3: Nursing Homes with Operating Losses, 1997-2003



Source: Residential Health Care Facility-4 (RHCF-4) Cost Reports, 1997-2003

The financial strain on NY nursing homes may be increasing. According to a survey conducted by the Joint Association Task Force on Nursing Home Reimbursement, New York's median nursing home margin fell from +0.6% in 2001 to -0.1% in 2002, and again to -0.6% in 2003. Rural nursing homes are in much worse financial health, with median margins declining from -5.2% to -7.4% in the same time period.[31] As a result of these poor margins, nursing

[31] Joint Association Task Force on Nursing Home Reimbursement. (2006). *Joint Association Task Force on Nursing Home Reimbursement: A briefing for member facilities.* 6-7.
The Task Force was comprised of the New York Association of Homes and Services for the Aging, the Healthcare Association of New York State, and the New York State Health Facilities Association.

homes financial position is also deteriorating: the median number of days cash-on-hand in 2003 was only 21.[32]

Pressures on the System

Numerous pressures on the system contribute to the weak bottom lines of NY's health care providers. Moody's Investor Services attributes the bleak financial condition of New York hospitals to: the state's "challenging" demographics, including a high Medicaid-dependent and large immigrant population; payer concentration (tightening of the insurance market); a high degree of competition between providers; high cost of operation; merger difficulties; large number of high-cost academic medical centers; and the legacy of a highly regulated system.[33] Additional major factors include:

- **Uninsured residents.** The problem of the uninsured and underinsured is one of the most vexing problems facing health care delivery in both New York State and the United States as a whole. Over 45 million Americans below 65 years-old, 18% of the non-elderly US population, lacked health care coverage in 2004.[34] An estimated 17% of New York State residents under age 65, almost 3 million New Yorkers, are uninsured.[35] A large portion of the State's uninsured population lives in New York City; 25% of City residents are uninsured, whereas 13% of State residents living outside of the City are uninsured.[36] Most of the uninsured in New York are low-income, working adults. Members of racial/ethnic minorities are disproportionately uninsured.

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[32] Department of Health. (2003). *Residential Health Care Facility Cost Reports (RHCF-4)*.

[33] Moody's Investor's Service Global Credit Research. (2006). Not-for-profit hospitals: 2006 State of the States. Moody's Investor's Service 2006 Outlook.

[34] Kaiser Commission on Medicaid and the Uninsured, (2006, January). The uninsured: a primer - Key facts about Americans without health insurance. Retrieved July 24, 2006, from Kaiser Family Foundation Web site http://kff.org/uninsured/upload/7451.pdf

[35] Kaiser Family Foundation, New York: Health insurance coverage of nonelderly 0-64, states (2003-2004), U.S. (2004). Retrieved July 24, 2006, from statehealthfacts.org Web site: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=New+York&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status&topic=Nonelderly+%280%2d64%29

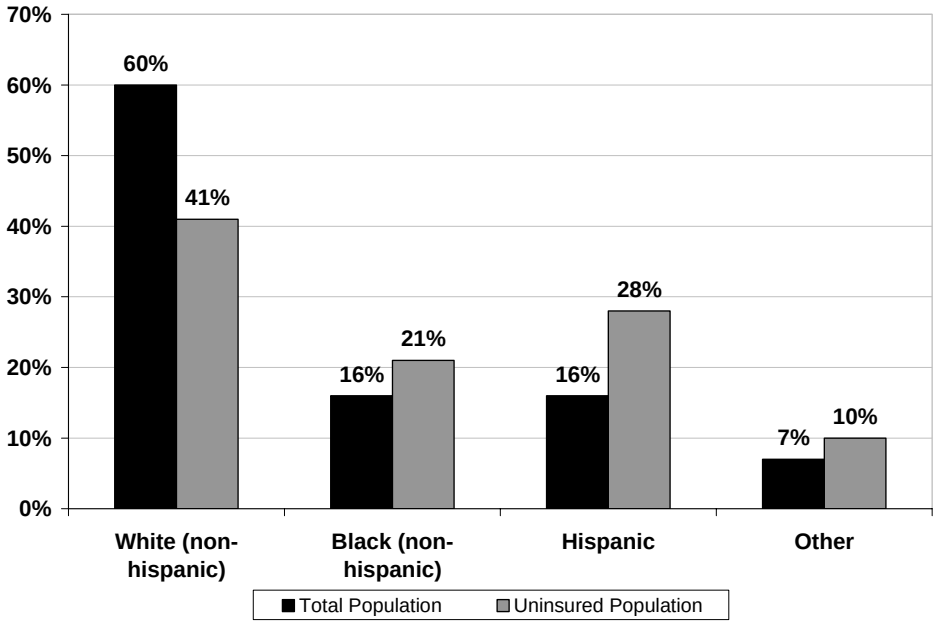
[36] Holahan, D., Ely, A., Haslanger, K., Birnbaum, M., & Hubert, E. (2004). Health insurance coverage in New York, 2002. Retrieved July 24, 2006 from United Health Fund Web site: http://www.uhfnyc.org/usr_doc/chartbook2004.pdf

Table 6. Uninsured in New York City and New York State, Nonelderly, 2002-2003

	Uninsured Nonelderly (Children and Adults under age 65)	
	New York City	New York State
At or below 200% of the Federal Poverty Level	65%	62%
Workers and their dependents	75%	78%
Adults ages 18-64	83%	83%

Source: March 2003 and March 2004 Current Population Survey, Annual Social and Economic Supplement

Figure 4. Distribution of Uninsured by Race/Ethnicity for New York State, Nonelderly, 2002-2003



Source: March 2003 and March 2004 Current Population Survey, Annual Social and Economic Supplement

Lack of health coverage is a serious burden for the uninsured themselves and for the institutions that care for them. Those without health coverage are less likely to seek and receive preventive care, more likely to be hospitalized for avoidable health problems, and more likely to be diagnosed in the later (and more expensive) stages of disease.[37] Even in New York

[37] Kaiser Commission on Medicaid and the Uninsured, (2006, January). The uninsured: a primer - Key facts about Americans without health insurance. Retrieved July 24, 2006, from Kaiser Family Foundation Web site http://kff.org/uninsured/upload/7451.pdf

City with its vast public hospital system, uninsured residents face larger obstacles to care than those with insurance.[38]

NY's hospitals provide substantial amounts of uncompensated care to the uninsured and also receive some support for their care of the uninsured. New York is one of a few states that has a public funding pool to reimburse hospitals for free care they provide as well as for bad debt from patient care.[39] In FY 2005-06, New York State provided $847 million per year in HCRA funding to subsidize care for the uninsured; $765 million from the general hospital indigent care pool, and $82 million from the high need indigent care pool. Pool funds are distributed through a complex formula based in part on the level of unreimbursed care each hospital provides in comparison to other hospitals and the proportion of unreimbursed care to each hospital's total costs.[40] The distribution formula relies on 1996 cost data and has not been updated.. The pool does not completely compensate hospitals for the cost of providing care to uninsured New Yorkers. According to GNYHA, HCRA covers a statewide average of 50% of the cost of providing care to the uninsured, ranging from 20% to 80% coverage for particular hospitals.[41] In addition to HCRA, hospitals rely on other public monies to support their margins.

- **Outmigration of services.** The delivery of many acute care services has shifted from an inpatient to an outpatient setting. This shift has been driven by changing reimbursement incentives, clinical technology and pharmaceutical innovation, and consumer preferences. Cardiac catheterization, colonoscopy, and cancer treatment (radiation therapy and chemotherapy) services are now largely provided on an ambulatory basis.

This shift in care has precipitated the growth in ambulatory surgery centers (ASCs), outpatient cancer centers, and outpatient diagnostic centers. These centers increase competition in health care, and may improve quality by specialization of services.[42] However, many outpatient centers practice "cream skimming," choosing to provide the most profitable

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[38] Louis Harris and Associates, Inc. (1998, February). 1997 survey of health care in New York City. Retrieved July 24, 2006, from The Commonwealth Fund Web site: http://www.cmwf.org/surveys/surveys_show.htm?doc_id=228066

[39] More information is available online: http://www.health.state.ny.us/nysdoh/hcra/hcrahome.htm

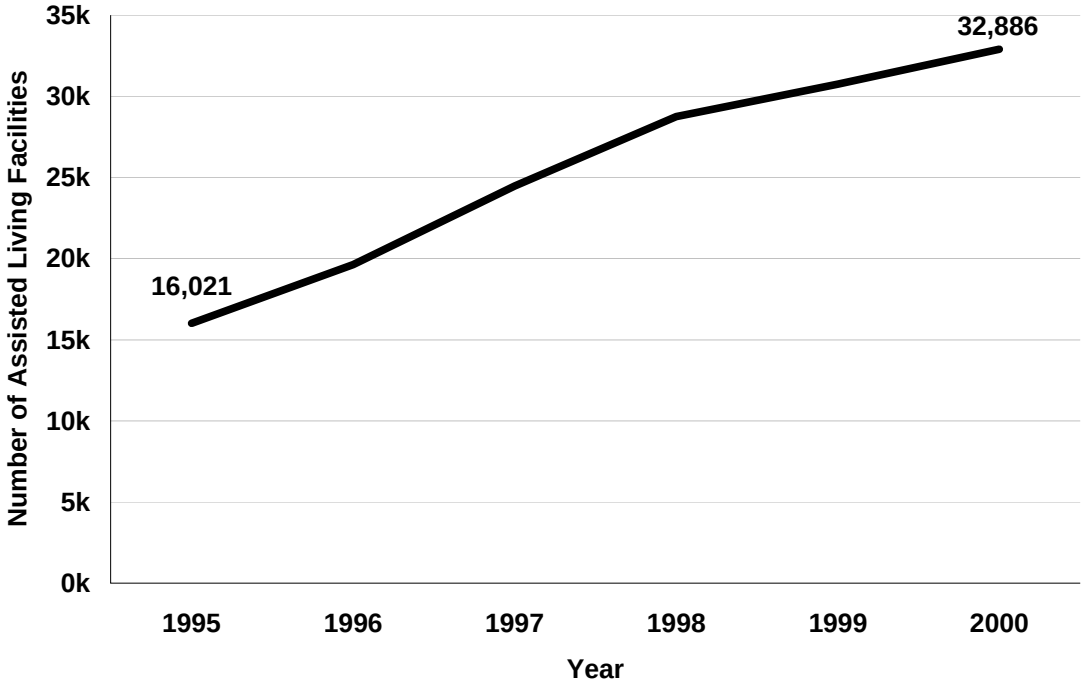
[40] Greater New York Hospital Association. Questions and answers on the New York health care reform act. Retrieved July 24, 2006, from the Greater New York Hospital Association Web site: http://www.gnyha.org/pubinfo/HCRA_QA.pdf

[41] Greater New York Hospital Association. Questions and answers on the New York health care reform act. Retrieved July 24, 2006, from the Greater New York Hospital Association Web site: http://www.gnyha.org/pubinfo/HCRA_QA.pdf

[42] Shactman, D. (2005). Specialty hospitals, ambulatory surgery centers, and general hospitals: Charting a wise public policy course. *Health Affairs*. *24 (3*), 868-873. Available online: http://content.healthaffairs.org/cgi/content/full/24/3/868?

medical services without bearing the burden of providing other less attractively reimbursed ones. They also do not bear the full overhead costs incurred by institutions in which the services were previously provided. Because these centers capture some of the lucrative services from hospitals by selecting certain profitable diagnostic related groups (DRGs), general hospitals may lose those profitable patients to the centers and will continue to disrupt the general hospitals' cross-subsidization of unprofitable services that only Article 28 hospitals are required to provide. Second, the outpatient centers may avoid patients who are uninsured or underinsured, leaving the burden of uncompensated care solely on general hospitals.[43] Finally, the shift of the locus of care could further reduce New York hospitals' low occupancy rates and exacerbate the problem of excess capacity.[44]

Figure 5: Estimated Number of Assisted Living Facilities in the United States, 1995-2000



Source: National Center for Assisted Living

[43] See, e.g., Guterman, S. (2006). Specialty hospitals: A problem or a symptom? *Health Affairs*. *25 (1)*, 95-105. Available online: http://content.healthaffairs.org/cgi/content/full/25/1/95

[44] Shactman, D. (2005). Specialty hospitals, ambulatory surgery centers, and general hospitals: Charting a wise public policy course. *Health Affairs*. *24 (3*), 868-873. Available online: http://content.healthaffairs.org/cgi/content/full/24/3/868?

Within the long term care sector, nursing facilities in New York State are also facing some competition from home and community-based providers. The growth of attractive, supportive housing alternatives for seniors with the means to afford them helped drive these changes in nursing home occupancy rates and patient populations. These newer alternatives include a variety of residential senior housing and assisted living arrangements. In 2002, it was estimated that assisted living facilities in the United States housed 910,000 people.[45]

Assisted living has grown rapidly as a supportive housing arrangement. However, because costs are high and public reimbursement scarce, older persons with modest means have had limited access to this option. This may be changing. While efforts are in their nascent stages, the AARP reports that there have been successful experiments in extending assisted living services to low income, frail elderly residents of subsidized housing.[46] Many states have advanced the growth of residential care through assisted living by providing for such facility care in their Medicaid Waiver programs. As a result, some states have seen an increase in ALP residents and a concomitant decrease in nursing home clients.

Table 7. Number of Medicaid Waiver Clients in Residential Settings

	Year		
State	**2000**	**2002**	**2004**
Arizona	1,240	2,300	3,067
Colorado	2,654	3,773	3,804
Florida	1,458	2,681	4,167
Georgia	2,262	2,759	2,851
Minnesota	397	2,895	4,144
New Jersey	699	1,500	2,195
Oregon	2,573	3,600	3,731
Washington	2,919	3,762	7,404

Source: AARP, Wilden, R. & Redfoot, D.L., "In Brief: Adding Assisted Living Services to Subsidized Housing: Serving Frail Older Persons With Low Incomes," Research Report of the AARP Public Policy Institute, January 2002.

[45] Mollica, R. (2002). State assisted living policy: 2002. Retrieved July 24, 2006, from National Academy for State Health Policy Web site: http://www.nashp.org/_docdisp_page.cfm?LID=24F0A0A1-2066-4E84-B113F4B919FC006C

[46] Wilden, R., & Redfoot, D.L. (2002, January). Adding assisted living services to subsidized housing: Serving frail older persons with low incomes. Retrieved July 24, 2006, from AARP Web site: http://assets.aarp.org/rgcenter/il/2002_01_living.pdf

In addition to assisted living, growth has also occurred in home and community-based alternatives to institutional care. There are now more than 3,500 adult day centers operating in the US providing care for 150,000 seniors each day.[47]

The Program of All-Inclusive Care for the Elderly (PACE) model successfully shifts the focus of long-term care to non-institutional settings. PACE combines Medicare and Medicaid payments into one capitated payment (set fee per patient) to long-term care providers, who carefully plan and manage service delivery to keep nursing-home-eligible seniors out of hospitals and nursing homes. Program evaluations have shown a decrease in hospital and nursing home utilization among PACE participants, which is more powerful due to the fact that all participants have chronic conditions and disabilities. PACE expansion in New York has been slow, but there are some successful growing programs and the legislature recently approved the addition of four more "pre-PACE-like" (Medicaid capitation only) programs.

- **Declining Hospital Average Length of Stay (ALOS).** Declines in ALOS exacerbate problems associated with excess inpatient capacity. While still higher than the national average, New York State's inpatient hospital ALOS has fallen considerably. The ALOS for New York State in 2004 was 6.1 days, down from 8.4 days in 1994. Prior to 1994, ALOS was consistently in the range of 8.5 to 9.3 days).[48] The national average LOS for hospital inpatient stays was 4.8 days in 2003, down from 5.7 days in 1994.[49] The recent drop in LOS is primarily attributable to clinical and pharmaceutical innovations and an increase in ambulatory or same-day surgery. Treatment advances, including new drug therapies and less invasive surgical techniques, have made possible fewer and shorter hospital stays, as have cost-management controls and alternative forms of health care organization and payment.[50]

Though lower than in the past, the high ALOS in NY hospitals is not justified by patient severity and should be further reduced. A shorter length of stay can often benefit

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[47] (2006, July 14). Aging services in America: The facts. Retrieved July 24, 2006, from American Association of Homes and Services for the Aging Web site: http://www.aahsa.org./aging_services/default.asp

[48] Department of Health. (2004). *Statewide Planning and Research Cooperative System*, 243. Available online: http://www.nyhealthcarecommission.org/docs/sparcs_complete_november2005.pdf. Earlier information is available in the Statewide Planning and Research Cooperative System Annual Reports.

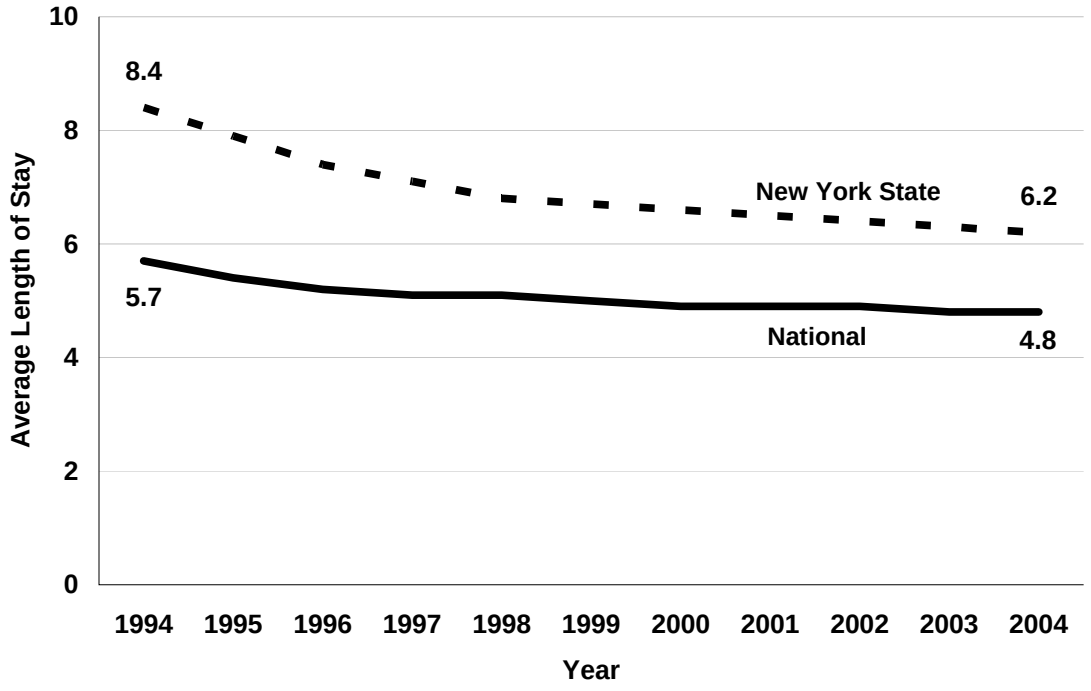
[49] Kozak, L.J., Owings, M.F., & Hall, M.J. (2004). National hospital discharge survey: 2001 annual summary with detailed diagnosis and procedure data. *Vital Health Statistics. 13 (156).* Available online: http://www.cdc.gov/nchs/data/series/sr_13/sr13_156.pdf

[50] (2002, October 10). Length of hospital stays continues to decline. Retrieved July 24, 2006, from HealthLink: Medical College of Wisconsin Web site: http://healthlink.mcw.edu/article/1013703780.html

patients, allowing them to return to their daily lives soon after hospitalization. Patients can be exposed to infections often present in hospitals and to the possibility of medical errors. The benefits of getting people up and moving around are best realized by moving them to residential environments such as their homes or nursing homes.[51] If ALOS were reduced to more appropriate levels, the excess capacity in New York State would be substantially greater than it is today.

In addition, shorter ALOS can have significant cost benefits for hospitals. Most payers have abandoned per diem payment structures to correct the perverse incentive to extend a hospital's ALOS as long as possible. The shift to a prospective payment system (PPS) means that hospitals receive a fixed payment per admission and a longer length of stay does not generate extra revenue. Instead, the costs associated with a longer LOS increase costs and cut into a hospital's margins.

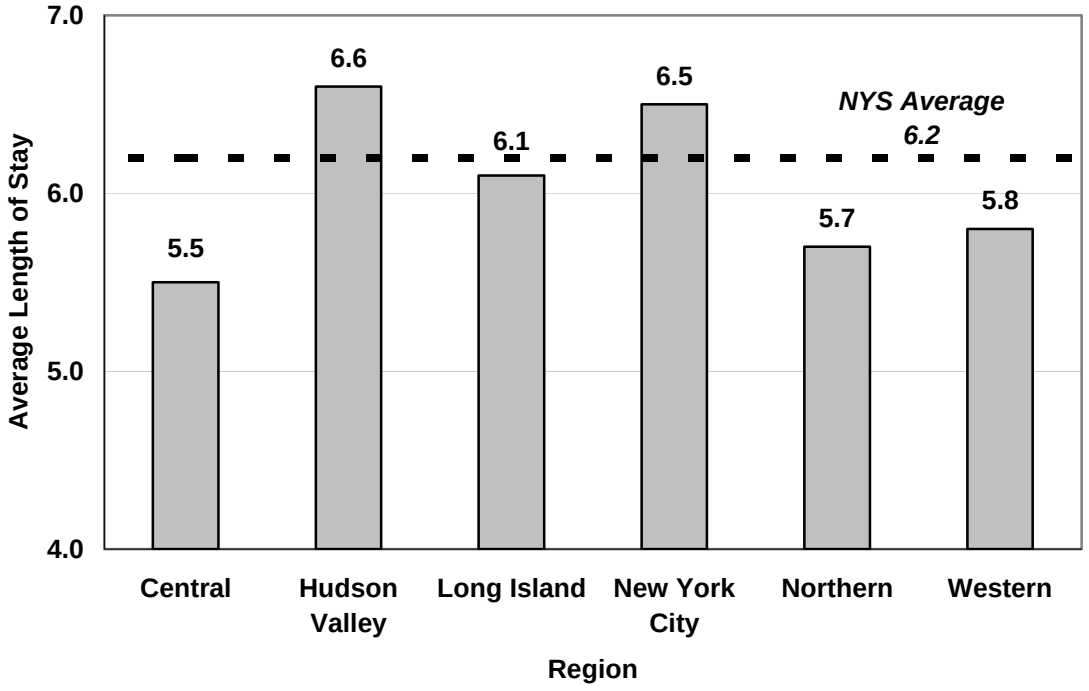
Figure 6: New York State and National Hospital Length of Stay, 1994-2004



Source: National Hospital Discharge Survey: National Center for Health Statistics and Statewide Planning and Research Cooperative System (SPARCS) data

[51] Excellus Blue Cross/Blue Shield. (2002). Average length of stay in upstate New York hospitals: Opportunities for savings. *Excellus Health Policy Reports*. *4*, 1-16. Available online: https://www.excellusbcbs.com/download/files/excellus_health_policy_report_4.pdf

Figure 7: New York State Hospital Length of Stay by Region, 2004



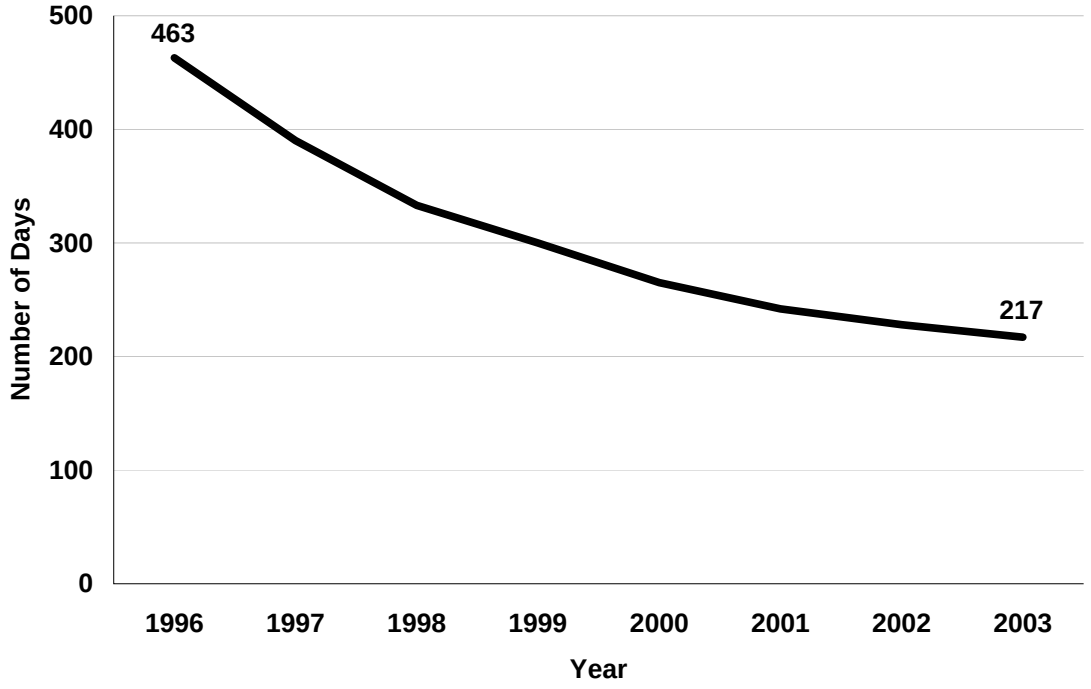
Source: 2004 Statewide Planning and Research Cooperative System (SPARCS) data

As with hospitals, ALOS in New York's nursing homes has declined dramatically over the last decade. Much of the decrease is attributable to changes in the service mix of nursing homes; many facilities have reduced their focus on traditional long-term services to expand their post-acute short-term rehabilitation services, which generally have a length-of-stay of less than 30 days. Between the growing short-stay services and the changing admission patterns for longer stay residents, the average length of stay in New York's nursing homes has been cut in half in just under seven years. The statewide average was 217 days in 2003, down from 463 days in 1996.

This increased churning of nursing home residents has had an impact on facility operations and finances. Facilities must provide increased nursing ratios, increased housekeeping services, increased documentation and supervision, and specialized clinical and therapeutic services. While Medicare pays additionally for each resident requiring more nursing and therapy, Medicaid reimbursement had been capped according to the facility's 1983 cost structure and other ceilings. Therefore, while the industry's costs have risen dramatically,

it is not clear that revenues have kept pace. Recent legislation to update the nursing home base year may address this imbalance.

Figure 8: New York State Nursing Homes Average Length of Stay, 1996-2003



Source: Residential Health Care Facility-4 (RHCF-4) Cost Reports, 1996-2003

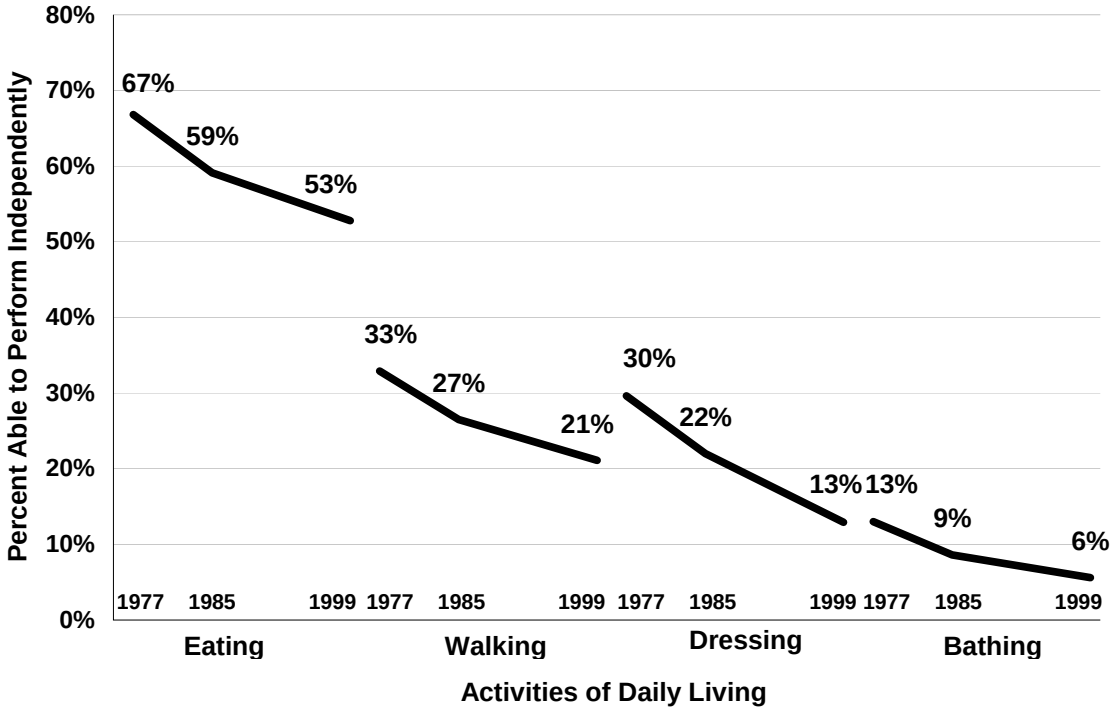
- **Drop in Severity of Illness (Hospitals).** Contrary to the national trend, the severity of illness of New York City residents who require hospitalization as measured by the case mix index (CMI) has declined sharply in a majority of City hospitals.[52] Due largely to fortunate developments related to major epidemics (e.g., AIDS, substance abuse, tuberculosis), high-acuity admissions have fallen. This drop in CMI directly affects the financial viability of the State's and City's hospital system. "Under DRG payment systems, the CMI determines how much inpatient revenue a hospital will receive. In theory, since DRG payments are based on costs, the CMI should not affect hospital profitability. However, in practice, the CMI is often related to profits."[53]

[52] United Hospital Fund, (2005).Drop in severity of illness further strains hospital finances. *Hospital Watch. 16 (1)*, 1-6. Available online: http://www.uhfnyc.org/usr_doc/hw16_1.pdf

[53] United Hospital Fund, (2005).Drop in severity of illness further strains hospital finances. *Hospital Watch. 16 (1)*, 1-6. Available online: http://www.uhfnyc.org/usr_doc/hw16_1.pdf

o **Increase in Severity of Illness and Disability (Nursing Homes):** While the hospitals may be experiencing severity declines, nursing homes are dealing with more needy patients and residents—getting them "sicker and quicker." Nationwide, nursing home residents are older and more frail, and this is certainly true in New York as well.

Figure 9: Percentage of Nursing Home Residents able to Independently Perform Activities of Daily Living



Source: National Nursing Home Survey

o **Workforce Issues.** New York is more expensive than most states to employ workers, including nurses and other health care workers. According to the Bureau of Labor Statistics, New York ranks sixth among all the States in salaries for registered nurses.[54] Retention of experienced health care personnel, especially nurses, is also a challenge. A 2004 GNYHA study found an 8.5% turnover rate for registered nurses at GNYHA-member hospitals. More than one- third of the hospitals reported turnover rates of 10% or higher.[55] To address these

[54] Bureau of Labor Statistics, (2005). Occupational employment and wages, May 2005: Registered Nurses. Retrieved July 24, 2006, from U.S. Department of Labor Web site: http://www.bls.gov/oes/current/oes291111.htm

[55] Greater New York Hospital Association, (2004, April 23). New York-area hospitals continue to face shortage of nurses. Retrieved July 24, 2006, from Greater New York Hospital Association Web site: http://www.gnyha.org/press/2004/pr20040423.html

issues, more than $1.3 billion has been invested in workforce recruitment, retraining, and retention though various programs.

Table 8. Employment and Wages of Registered Nurses by State, May 2005

State	Estimated Total Employment	Mean Wage	
		Hourly	Annual
California	226,350	$33.86	$70,430
Maryland	49,010	$32.37	$67,330
Massachusetts	76,870	$31.85	$66,250
Hawaii	9,240	$31.49	$65,490
New Jersey	80,940	$30.32	$63,070
New York	164,370	$30.29	$63,010

Source: Bureau of Labor Statistics, May 2005 Occupation and Wage Estimates

For nursing homes, turnover for registered nurses, licensed practical nurses, and certified nursing aides categories is significant. While better than the national average, turnover rates for these categories are between 40 and 50%. These translate to vacancy rates of 16-17% for RNs and LPNs.

Table 9. Nursing Home Staff Turnover, 2002

Licensure	New York State	National
C.N.A	41.7%	71.1%
L.P.N	33.3%	48.9%
Staff R.N	44.4%	48.9%

Source: American Health Care, 2002 Survey of Nursing Staff Vacancy & Turnover Rates in Nursing Homes

Often, these vacancies are “filled” with overtime and agency staffing, both of which contribute to a facility’s instability. Over-time and agency payments are a significant financial burden for many nursing homes, whose Medicaid rates do not recognize these increase costs. Moreover, both overtime use and agency staff use are correlated with lower quality measures, so that a facility’s reputation—and often its occupancy—are hurt by staff turnover and vacancies.

- **Shifting Demographics and Consumer Preferences.** Changes in demographics have a significant impact on the demand for hospital and nursing home beds.[56] Trends in total population suggest that statewide need for inpatient capacity will remain flat for the foreseeable future, with some differences at the regional level. Aging of the population will occur slowly, affecting demand only gradually. Growth in the 75+ cohort, which generates the largest demand for nursing home care, will be relatively flat over the next 20 years. The average baby boomer will be 55 in 2010, so the full impact of this generation will not be felt until the 2020s, when the baby boom generation first reaches their mid-70s. Older people today are healthier than older people of decades ago. People live longer, retire later, have fewer disabilities, have less functional loss, and report themselves to be in better health. The National Academy of Sciences reports a statistically significant 3.6% decline in chronic disability prevalence rates in the elderly United States population, from 24.9% in 1982, to 21.3% in 1994. These trends, together with continuing advances in medical care may have contributed to the nursing home utilization decline for the 65+ population between 1998 and 2003.

Beyond demographics, consumer attitudes towards and preferences for health care services are changing. Patients are now more engaged in medical decision-making, participate as active partners in their care, value living independently, and shun institutional care arrangements. Technology advances increasingly allow patients to realize their preferences. The impact of these shifting preferences is likely to be felt most strongly in the long term care continuum of services. While the bulk of today's frail elderly, who were shaped by the Depression and WWII, are fairly trusting and accepting of institutions, the generations behind them—including the "silent generation" and the "baby boomers" show strong preferences for non-institutional alternatives.

[56] Commission on Health Care Facilities in the 21st Century. (2006). *Planning for the future: Capacity needs in a changing health care system*, 1-41. New York: Commission on Health Care Facilities in the 21st Century.

III. Excess Capacity

Excess capacity in our state's health care system locks us into a vicious cycle. The costs associated with maintaining unneeded beds and institutions are steep. Perpetuating inefficiencies at weak, unneeded facilities drives the costs of health care ever higher. As a result, access to care is diminished, quality of care suffers, safety net functions are threatened, and modern health care becomes increasingly unaffordable for individuals, businesses, and government.

New York State Has Too Many Hospital Beds

A fundamental driver of the crisis in New York's health care delivery system is excess capacity. Simply stated, New York State is over-bedded and many beds lie empty. There are approximately 3.3 hospital beds per 1,000 New Yorkers, compared to the national figure of 2.8 beds per 1,000 people.[57] Were ALOS in NY hospitals closer to national norms, the excess capacity in the state would be substantially greater. Even a statewide reduction in ALOS to the levels in the Central and Northern regions of the state would result in significantly more excess capacity.

Table 10. Beds Per 1,000 Population – Selected States

Rank	State	Beds/1,000 Population (2004)	Rank	State	Beds/1,000 Population (2004)
1	District of Columbia	6.2	11	Iowa	3.7
2	South Dakota	6.0	11	Kentucky	3.7
3	North Dakota	5.6	13	Arkansas	3.5
4	Montana	4.7	13	Tennessee	3.5
5	Mississippi	4.5	15	Alabama	3.4
6	Nebraska	4.2	16	Missouri	3.3
7	West Virginia	4.1	**16**	**New York**	**3.3**
8	Wyoming	4.0	18	Minnesota	3.2
9	Kansas	3.8	18	Pennsylvania	3.2
9	Louisiana	3.8	20	Oklahoma	3.1

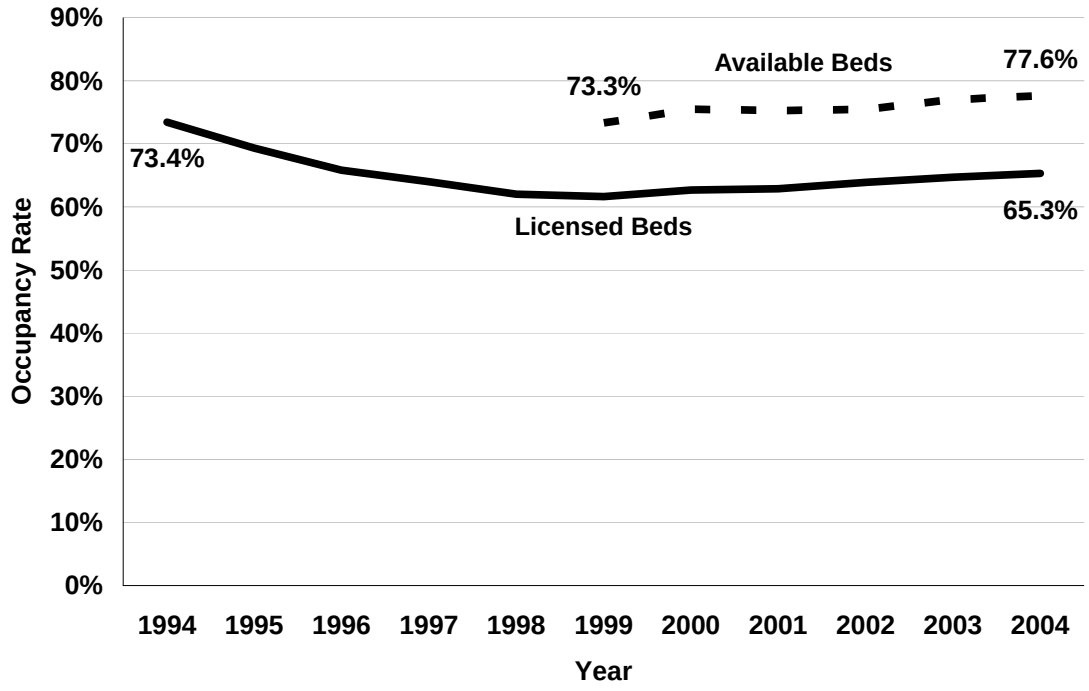
Source: Kaiser Family Foundation

[57] Kaiser Family Foundation, New York: Beds per 1,000 Population, 1999-2004. Retrieved August 21, 2006, from statehealthfacts.org Web site: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=New+York&category=Providers+%26+Service+Use&subcategory=Hospital+Trends&topic=Beds%2c+1999%2d2004

Excess capacity is both a cause and an effect of low and steadily declining hospital occupancy rates. The statewide hospital occupancy rate has fallen from 82.8% in 1983 to 65.3% in 2004, a decrease of 17.5%, including a decline from 73.4% of certified beds in 1994, a decrease of 8.1%. On a given day, as many as one-third or more of the state's hospital beds lie empty. This is far lower than what historically has been considered an ideal rate of 85%, which ensures efficient operations and allows some surge capacity for periods when the daily patient census increases. On a staffed bed basis, approximately 77% of beds statewide are occupied.[58]

While statewide occupancy rates are low, there is some variation of occupancy both between and within regions. The average occupancy rate for many individual hospitals show them to be more than half empty, and some regions of the State, including the Western and Central regions, have especially low occupancy rates based on both certified and staffed bed count.

Figure 10. Hospital Licensed and Available Bed Occupancy Rates, 1994 to 2004



Source: 2004 Statewide Planning and Research Cooperative System (SPARCS) data

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[58] New York State Department of Health. (2004). *Institutional Cost Reports*, 1-52. Available online: http://www.nyhealthcarecommission.org/docs/2004_icr_commission_data.pdf

Figure 11. Hospital Licensed Bed Occupancy Rates by Region, 2004

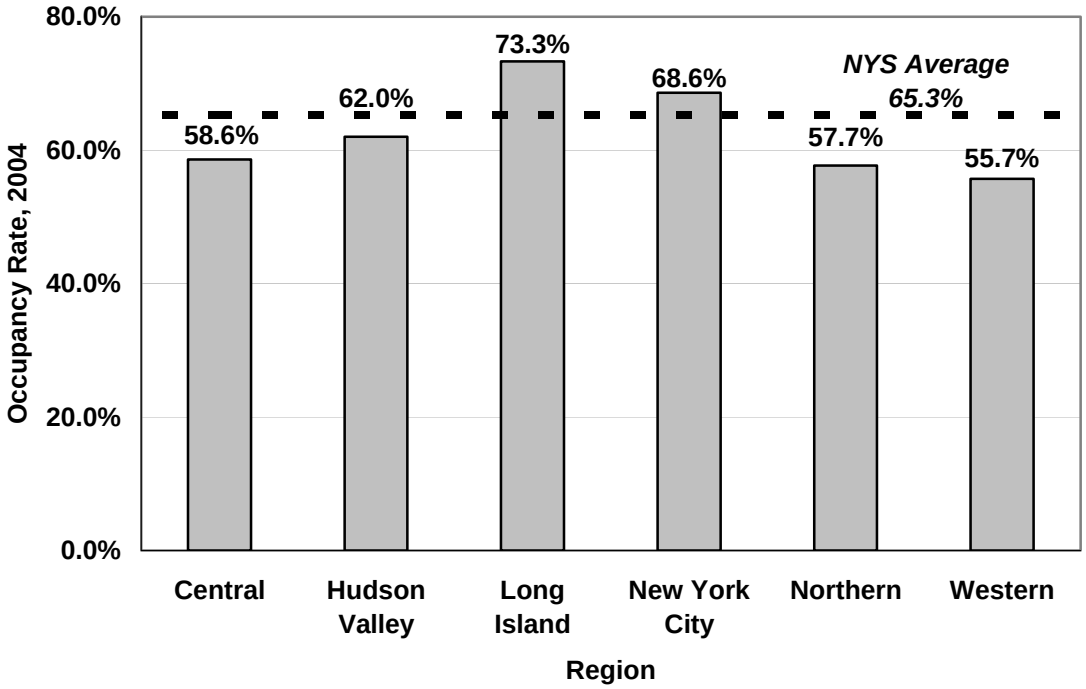
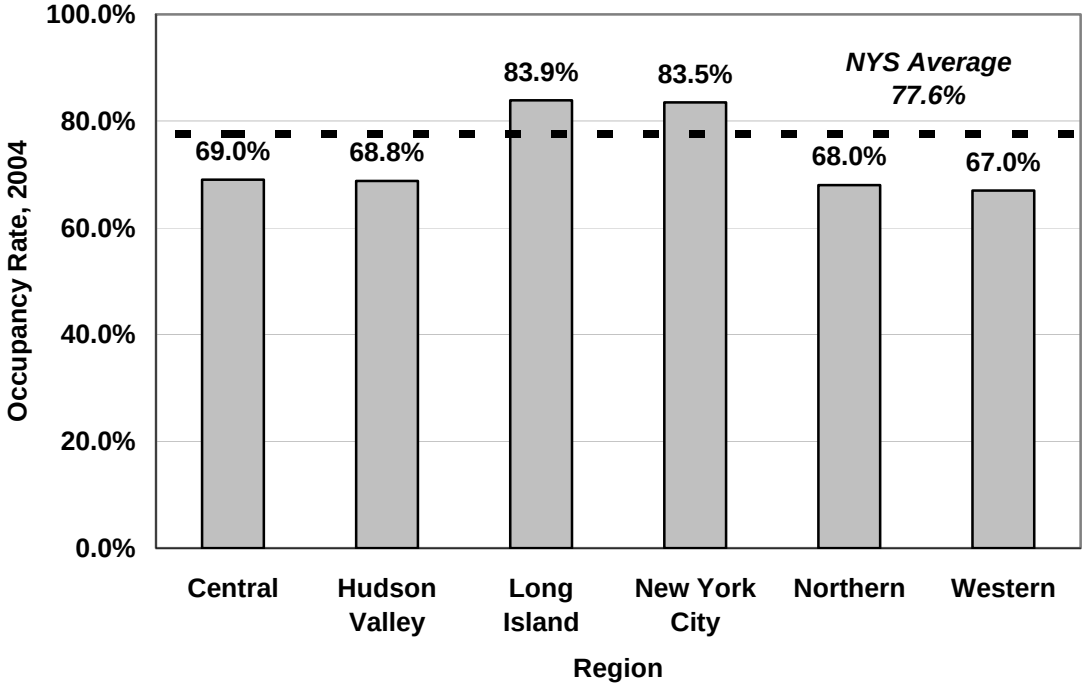


Figure 12. Hospital Available Bed Occupancy Rates by Region, 2004



Regions of New York State Have Too Many Nursing Home Beds

Nursing home occupancy in New York State has been steadily declining, from 97% in 1997 to 93% in 2004. There are various definitions of the ideal nursing home occupancy rate. A 97% occupancy rate historically has been the goal for nursing homes in terms of viability and efficiency. The New York State Department of Health also uses 97% as a measure of whether new beds can be made available in region. From a financial perspective, maintaining at least a 95% occupancy rate is crucially important to nursing homes because that is the rate required to qualify for "bed-hold payments," which allows the State to compensate nursing homes in order for the nursing home to reserve an empty bed while waiting for its resident to return from a hospitalization.

Figure 13. Nursing Home Licensed Bed Occupancy Rates, 1994 to 2004

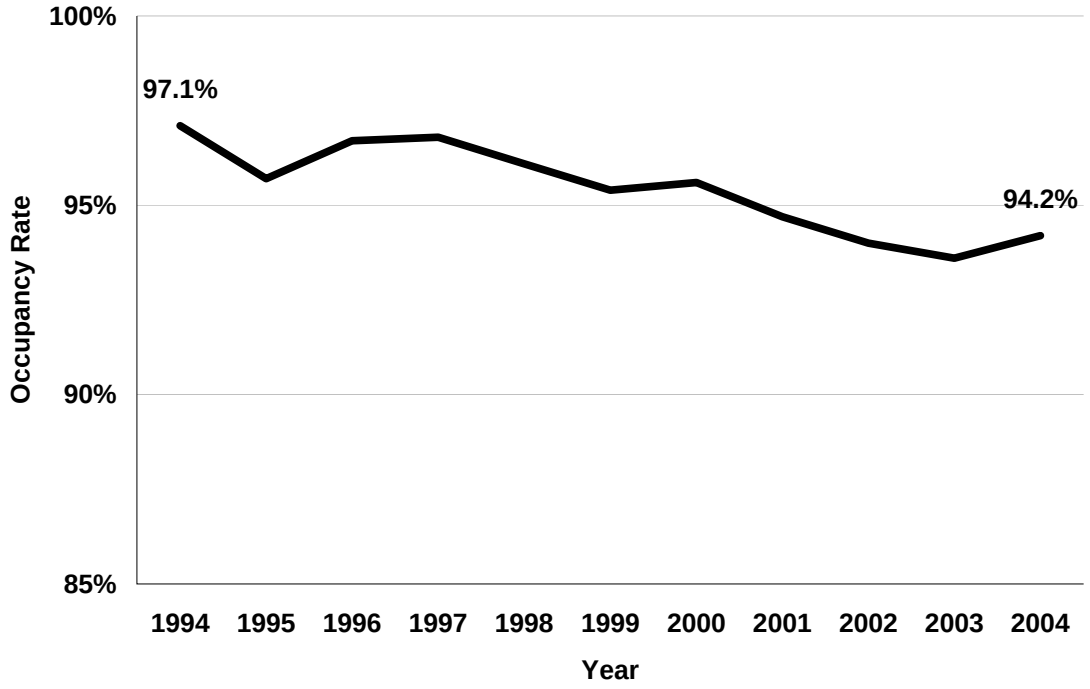
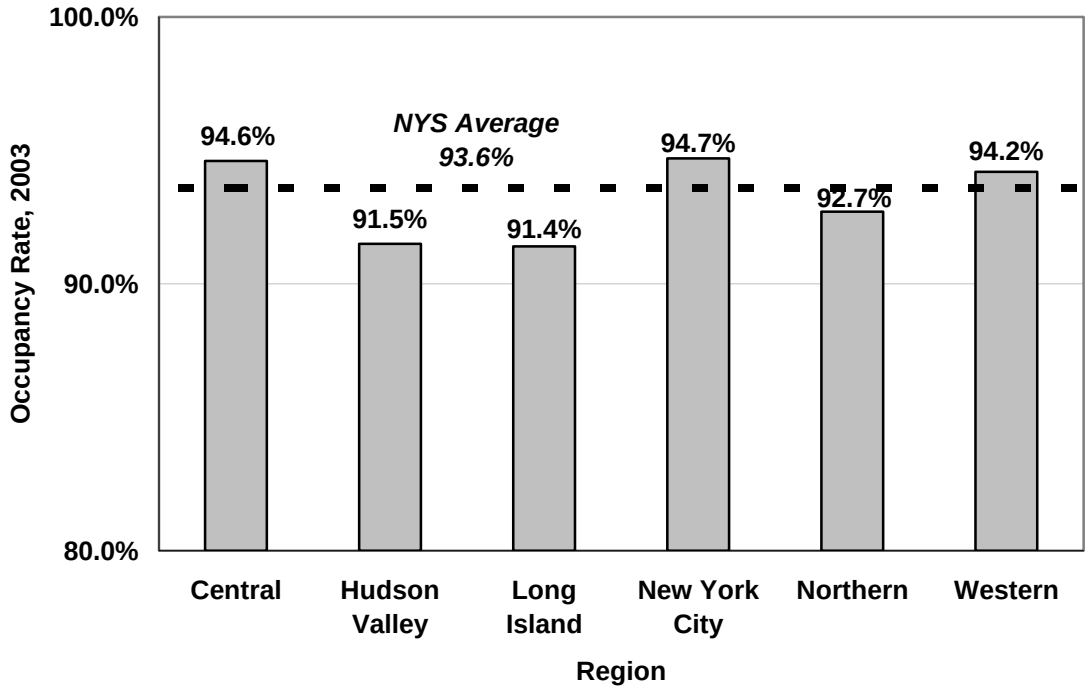


Figure 14. Nursing Home Licensed Bed Occupancy Rates by Region, 2003 (Adjusted for partial years)



Although occupancy rates have been declining, New York's nursing homes have increased the numbers of people they serve. Shorter-term stays for sub-acute care have become so prevalent that the number of total nursing home admissions has more than doubled since 1997. The rapid growth of sub-acute services, together with rapid resident turnover rates (less than 30 days length-of-stay), reduces the occupancy of an efficient provider. The State's nursing home average length of stay decreased from approximately one year in 1997 to 217 days in 2003. Patient turnover leads to vacant beds due to admission/discharge timing issues, the need to match roommate gender and other factors.

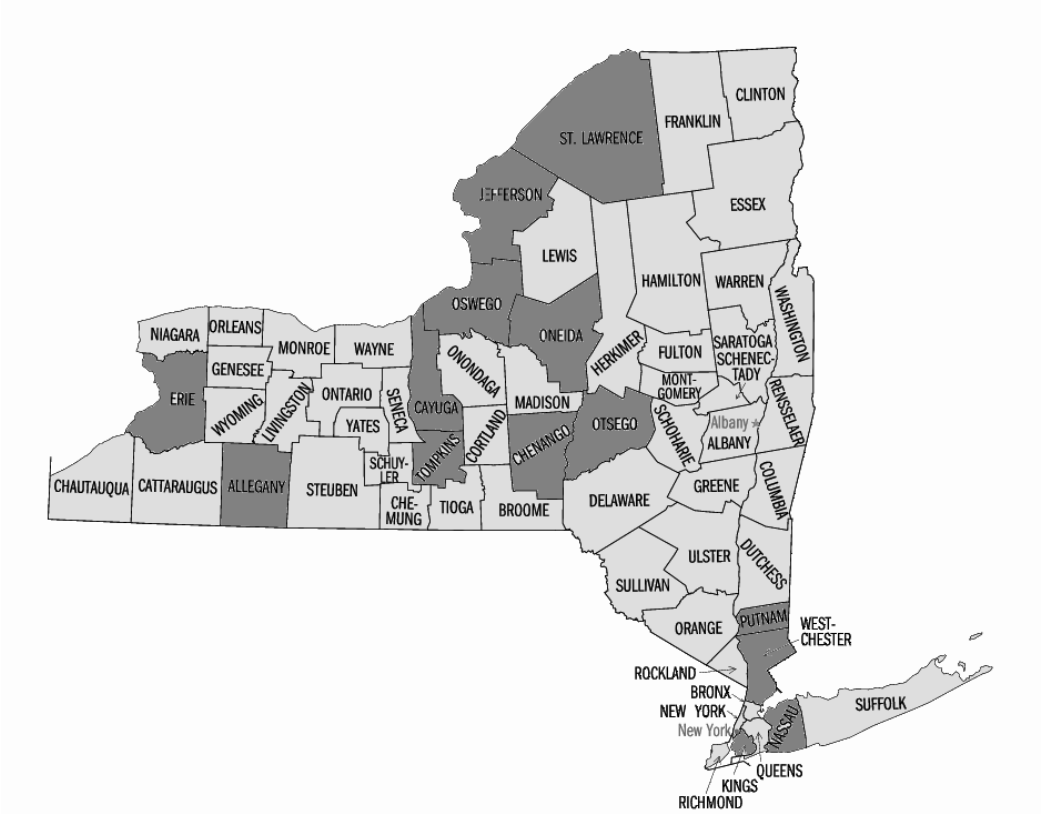
According to the 2007 New York State residential health care facility bed need methodology, the State has roughly the right number of beds. In the aggregate, the supply is roughly equivalent to need, with about 2,000 beds still needed statewide. However, this analysis is based on current utilization patterns. Many trends could only further strengthen the need to shift future resources. For example, progress in medical treatment and technology has enabled many older New Yorkers to live longer in less restricted settings. Though the population is

gradually aging, the shift to home and community-based care could keep pace with this trend, particularly as baby boomers turn away from institutional care settings.

The bed need methodology also reveals that nursing home beds are unevenly distributed across the state. The methodology indicates that the Bronx, New York (Manhattan), Westchester, Schenectady, St. Lawrence, Oneida, Monroe, Chatauqua, and Albany counties have too many beds. Notably, the bed need methodology does not tell the whole picture; even in counties with a calculated deficit of beds, the county occupancy remains quite low, indicating over-bedding. These counties include Cayuga, Jefferson, Westchester, Putnam, and Columbia.

The Commission also considered the relative availability of non-institutional long-term care alternatives, such as adult day health care, long-term home care, and supportive housing, in determining whether there was excess capacity in the nursing home sector. If a county has a high occupancy but few home- and community-based options, it is likely that the nursing home beds are utilized by individuals who may otherwise be cared for in an alternate setting, if it existed. After examining the State's bed need methodology and figures, county nursing home occupancy, and availability of non-institutional care alternatives, several counties emerge as high-priorities for resource shifts:

Figure 15. New York State Counties with LTC Resource Shift Opportunities



New York State Has Too Few Home- and Community-Based Alternatives to Nursing Homes

Regardless of nursing home bed availability, the state has an insufficient supply of non-institutional alternatives. Many additional "slots" of adult day health care, long-term home health care, and supportive housing are needed. In the majority of counties, the existing supply of such alternative services meets less than half of the total calculated need. As a result, some residents who do not require institutional care are institutionalized because there are no available alternatives for them. The shortage of non-institutional slots is more severe in upstate and rural areas of the state.

A combination of surplus nursing home beds together with a need for non-institutional services creates an opportunity to shift resources from facilities to alternatives. For example, New York State's own rightsizing demonstration permitted nursing home beds to be permanently de-certified and exchanged for other certified capacity, including adult day health care, long-term home health care, and Medicaid-supported Assisted Living Program (ALP) beds. As many as 2,500 nursing home beds were eligible for conversion under this demonstration.

Shifting resources to non-institutional care requires certain factors to be in place. Limiting factors may be insufficient supplies of affordable and accessible senior housing, and limited workforce availability such as qualified home care attendants. Thus, it is consistent that many States with rightsizing initiatives have focused on creating more assisted living, supportive housing, and other congregate care options that can be more staff-efficient. Additionally, investment and support of technology and informal caregivers can make shifting resources out of nursing homes more viable.

What's Wrong With Excess Capacity?

A surplus of beds threatens quality of care, promotes inefficiencies, increases costs, threatens the provision of public goods, and contributes to the fragile finances of health care providers. In many other industries, the cost of excess capacity is borne by the institution or corporation itself. In health care delivery, however, a large portion of excess capacity falls on the tax-paying public, due to the presence of Medicare, Medicaid, and other public health

payors.[59] The heavy public cost of unneeded beds has prompted state and federal lawmakers to concentrate on elimination of excess capacity. For example, former Congressional Representative Pete Stark, stated "Low occupancy is a symptom of the indulgent spending spree the Country's hospitals have been on," and Gail Wilensky, former Administrator of the Health Care Financing Administration (now Centers for Medicare and Medicaid Services) suggested that four out of every ten empty staffed hospital beds should be reduced.[60] "[P]ressure to fill empty beds puts hospitals at a disadvantage in negotiating rates with payers and the widespread availability of beds means that physicians have few incentives to shorten the length of stay of their patients. Most importantly, the oversupply means that the industry is not generating enough revenue to adequately cover its fixed costs."[61]

Excess Capacity Jeopardizes Quality of Care

In health care, there is a direct positive relationship between volume and outcomes. The more cases or procedures performed by a hospital or physician, the better the quality of care. A review of 135 studies found that 71% of studies of hospital volume and 69% of studies of physician volume reported statistically significant associations between higher volume and better outcomes.[62] It is a public health imperative to concentrate higher volumes at fewer institutions to improve patient care. For this reason, New York and many other states establish minimum volume thresholds below which hospitals may not perform certain advanced procedures. Excess capacity in the hospital system disperses volume and expertise while potentially diminishing quality care.

Excess capacity also subsidizes inferior care by blocking necessary investments. Facilities have less chance of attracting the best doctors, buying and maintaining the latest equipment, and maintaining adequate nurse staffing when they must devote inordinate resources to preserving old, underused physical plants. With fewer resources to spend on equipment, salaries, and new technologies, the quality of care suffers.

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[59] Gaynor, M., & Anderson, G.F. (1995). Uncertain demand, the structure of hospital costs, and cost of empty hospital beds. *Journal of Health Economics*. *14 (3)*, 292.

[60] Ibid, p. 293.

[61] Advisory Commission on Hospitals (1999). Report of the Advisory Commission on Hospitals. Retrieved September 22, 2006, from New Jersey Department of Health and Senior Services Web site: http://www.state.nj.us/health/hcsa/acoh/trends.htm

[62] Halm, E.A., Lee, C., & Chassin, M.R. (2002). Is volume related to outcome in health care? A systemic review and methodologic critique of the literature. *Annals of Internal Medicine*. *137*, 511-520.

Excess Capacity Promotes Unnecessary Utilization of Services

It is well documented that hospitalizations expand in relation to number of beds available. Capacity generates utilization so that a bed built is a bed filled, a phenomenon often called Roemer's law. Similarly, greater numbers of expensive tests and procedures are performed when resources like imaging machines, diagnostic labs, and surgical suites are available and need to be paid for. Areas with excess capacity repeatedly demonstrate higher rates of hospital admission, greater numbers of patient days, and surgeries; differences that cannot be explained by differences in rates of illness or age according to the Dartmouth Atlas of Health Care.[63] "In situations where there is excess capacity, the body of evidence suggests that physicians tend to utilize more [medically unnecessary] procedures...Studies have found similar relationships in physician supply-to-utilization patterns (such as between supplies of cardiologists and invasive heart procedures) and high-tech equipment-to-utilization patterns. It appears that much of the unwanted variation in hospitalization rates, use of procedures, and intensity of care is directly attributable to the differences across geographic areas in physicians, technology and beds per capita."[64]

Similar patterns occur among nursing homes that are struggling to fill excess beds and qualify for bed-hold payments. To maintain occupancy levels, nursing homes may admit less-intensive residents who do not require such round the clock skilled care. But doing so can not only negatively impact the facility's Medicaid rate by lowering its case mix index; it can also institutionalize individuals that could have their needs met in a less-restrictive alternative.

Excess Capacity Duplicates Services and Hinders Collaboration

When capacity exceeds community need, health care providers must compete vigorously to maintain a viable market share. For instance, prior to the reduction of services at St. Mary's Hospital in 1999 and the closure of the Genesee Hospital in 2001, Rochester area hospitals were operating at less than 70% occupancy, and perceived the need to engage in competitive but non-productive activities such as advertising. Hospitals felt compelled to purchase physician

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[63] Center for the Evaluative Clinical Sciences. (2005). Supply-Sensitive Care. Retrieved September 22, 2006, from Dartmouth Atlas Project Brief Web site: http://www.dartmouthatlas.org/topics/supply_sensitive.pdf

[64] Finger Lakes Health Systems Agency. (2005). *Capacity Matters*. 1-16. Rochester: Finger Lakes Health Systems Agency.

practices, a financially draining strategy, in an effort to lock in or capture market share. Instead of joint services, hospitals instead concluded they must have enough capacity to satisfy their individual sought-after market share. For instance, hoping to gain market share, in the last half of the 1990s each hospital system in Monroe County developed new obstetric units for more births than they historically experienced; the result was an excess of obstetric capacity which lasted until the closure of the Genesee Hospital.[65]

Today, New York's providers continue to compete with another in a "medical arms race." To attract both physicians and patients, they feel compelled to seek the most sophisticated technologies and specialties that generate higher reimbursement rates and financial margins. The result is unnecessary duplication of services, especially of costly high-end services like magnetic resonance imaging, cardiac catheterization, and transplant centers, and too little integration of regional service delivery. Elimination of systemic redundancies could save money without compromising access to care.

Excess Capacity Threatens Safety Net Services

Low occupancy rates and the associated financial pressures on hospitals can lessen hospitals' commitments to provide care for vulnerable populations. Hospitals in financial trouble may be forced to retrench, resulting in potential loss of access to care. As fiscal pressures increase, facilities may be inclined to close or shrink their less financially viable services in inner city neighborhoods or in rural communities.

Excess Capacity Increases Costs

Excess capacity is expensive to maintain. Despite the dramatic shift to outpatient care, the costs of maintaining a "bricks and mortar" based health system hang like an albatross around the neck of New York's providers and taxpayers. Even beds, wards, or buildings that are unused and unstaffed represent fixed costs that must still be paid and thus spread over a dwindling number of patients and other over all other services at that particular facility. Additionally, dollars spent in retiring capital debt of a given facility are not available for other productive uses. Finally, dollars spent on duplicative service capacity caused by excess capacity cannot be then captured and reinvested to fill community needs.

[65] Ibid

IV. Adapting to and Managing Change

New York's health care system has multiple strengths on which to build. The state has some of the finest hospitals in the world, nursing homes that provide superb and concerned care to our most frail and elderly residents, a strong foundation of non-institutional care providers, a committed health care workforce, and a vast commitment of public dollars to health care. From crisis arises opportunity; the dire condition of the State's health care system creates an opportunity to reshape the health care system of tomorrow.

It is not too late to reconfigure NY's health care delivery system. The time to act, however, is now. We can no longer deny reality or bury our heads in the sand. We cannot continue to bail out troubled and unneeded facilities simply because they exist or to satisfy powerful constituencies. We cannot rely solely on market-based incentives to eliminate excess capacity or promote public goods. We need a health care delivery system that is more flexible and provides better value than the one we have today. We need to look beyond the "bricks and mortar" of the hospital and nursing home and instead to the health care delivery system as a whole.

Absent intervention, the Commission believes that the future of our state's health care system is bleak. It is painfully obvious that health care providers cannot sustain chronic annual losses and continue to fulfill their missions; it is impossible to provide care for which we cannot pay. Closures and bankruptcies of health care institutions have become increasingly common. Given the financial predicament of New York's hospitals and nursing homes, more are almost certain to close. Moreover, without state involvement, those facilities that are forced to close based on market forces alone may be those facilities that are most valued by various communities throughout the State. We are left with a stark choice; we can fail to act thereby allowing the system to drift in an unplanned direction, costs to keep rising, and access to care to remain in doubt. Alternatively, we can direct system systemic change, ensuring that New Yorkers continue to receive high-quality, accessible health care. We choose the latter path.

Transformation of our health care system, above all else, must benefit patients and taxpayers. Stabilization and modernization of our system will also benefit New York State's economy and competitiveness. Health care is a major engine of the State's economy. Hospitals and health systems in the state generate approximately $91.5 billion each year for local and state

economies and support more than 644,900 jobs. These figures represent nearly ten percent of the gross state product and over 7 percent of all non-farm jobs.[66] To stabilize the employment marketplace, the State must work to stabilize the health care industry, including the restructuring and closing of hospitals.

Framework for Solutions – Producing Maximum Efficiencies

The Commission is charged with "rightsizing" institutions to stabilize the State's health care system. Rightsizing includes the possible consolidation, closure, conversion, and restructuring of institutions, and reallocation of local and statewide resources.
The strategy adopted to remove excess capacity from the hospital and nursing home systems will dictate the opportunities and scale of benefits realized. Strategies such as outright closure of a facility, a merger of multiple facilities or an across the board reduction in beds all meet the goal of reducing overall capacity. However, the closure of hospitals and nursing homes generally presents the greatest opportunity for savings by concentrating the benefits of lowered capacity.

Benefits of Closure and Consolidation

According to Manatt, Phelps, and Phillips, a leading health care law firm, "When a hospital is drowning in red ink with no hope of resurfacing, the logical step for trustees-consistent with their fiduciary obligation to preserve and protect the charitable asset under their control-is to close the hospital."[67] The closure of a facility has many advantages including the removal of fixed operating costs, forgone capital expenses, elimination of duplicative services within the market, increased efficiency at remaining institutions and opportunities for lease, sale or conversion of the facility's property. Operating costs such as utilities, cleaning, security and maintenance do not transfer to other facilities along with the patient base of a closed facility. Additional savings are realized by forgoing renovations on aged physical plants. Depending on the age of the physical plant, significant capital investments are required on an ongoing basis to keep a facility current with modern care and regulatory requirements. These capital expenditures include activities such as correcting fire safety deficiencies, improving air conditioning,

[66] Health Care Association of New York State. (2006, June). What's at stake: The impact of New York's hospitals on the economy and our communities.
[67] Schwartz, J.R. (2001, January). Closing...Closing...Closed. Retrieved September 25, 2006, from Manatt, Phelps, and Phillips Web site: http://www.manatt.com/newsevents.aspx?id=225&folder=24

converting from semi-private to private rooms, renovating outpatient spaces, and improving parking facilities and elevators. Furthermore, the benefits of these eliminated costs accrue indefinitely.

To a lesser extent, some of these benefits may also be realized in the case of facility consolidations or mergers. In these instances, operating costs may be reduced, duplicative services may be removed from the market, facilities may operate more efficiently and opportunities for conversion may arise. However, a successful merger presents different challenges than outright closure of a facility. Consolidation of administrative services is an early and obvious benefit of merger agreements, but greater efficiencies are realized by integrating and rationalizing clinical services and removing excess capacity from the combined entity. Integrating clinical services requires addressing complex compromises among medical staffs and employee unions. Medical staff may be resistant to integration and make efforts to protect their territory within the remaining institution. These and other challenges have plagued merger attempts throughout the country and led to unsuccessful attempts to rightsize capacity.[68] In New Jersey, a special commission formed to study its state's hospital system concluded that "Reducing staffed beds, consolidating clinical services, and eliminating duplicative administrative functions appear to be necessary but insufficient to accomplish system-wide savings that the anticipated reductions in utilization will require."[69]

Impact of Closures: What Does The Evidence Say?

Health Care Providers Emerge Stronger: Peer-reviewed evidence from past hospital closures confirm that the closure of institutions may contribute to the vitality of remaining institutions. In urban markets, hospital closure may result in an "evolutionary increase" in efficiency among remaining institutions in the market. Evaluation research indicates that when an urban hospital closes, other hospitals within their markets experience increased inpatient and emergency room visits and became more efficient on a cost per adjusted admission basis. Frequently the hospital

[68] Meyer, J.A., Wicks, E.K., & Carlyn, M. (1998). A tale of two cities: Hospital mergers in St. Louis and Philadelphia not reducing excess capacity. Economic and Social Research Institute: Washington, DC.

[69] Advisory Commission on Hospitals (1999). Report of the Advisory Commission on Hospitals. Retrieved September 22, 2006, from New Jersey Department of Health and Senior Services Web site: http://www.state.nj.us/health/hcsa/acoh/trends.htm

that closed was the least efficient in the market prior to closure.[70] The remaining institutions become more efficient by absorbing the additional patient volume and filling previously established, but unused capacity.

Access to Care and Health Status Are Preserved: Peer-reviewed studies indicate that the repercussions of hospital closures on public health are nonexistent or minimal. There is little evidence of changes in access to care, health status, or mortality rates following hospital closures. For example, Buchmueller, Jacobson and Wold found that hospital closures have a modest effect on access to care in urban areas. Moreover, they found that "…hospital closures may shift care to doctor's offices, generally considered an appropriate and cost-effective source of regular care."[71] Additionally, studies of the impact of rural hospital closures in Saskatchewan, Canada found that despite fears to the contrary, residents in affected communities reported that hospital closures did not affect their own health.[72] A study by the Office of Inspector General of the U.S. Department of Health and Human Services (OIG) found that of the hospitals closed nationwide in 2000, 50 percent of rural facilities and 52 percent of urban facilities were within three miles of another inpatient facility. An additional 18 percent of closed rural facilities were between four and 10 miles of another hospital, as were an additional 38 percent of the urban facilities that closed. In most cases when a hospital closed, health care was still available nearby.[73]

Closures have far less impact than feared because facilities that close have been in trouble for extended periods of time. Almost always, they have experienced a cycle of declining patient census and revenues and gradually withered away until reaching the point of closure. In testimony before the New York City Council, GNYHA stated that "we note that most hospitals that close experience a significant drop in demand <u>before</u> 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

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[70] Lindrooth R.C., LoSasso A., & Bazzoli G. (2003). The effect of hospital closure on markets. *Journal of Health Economics. 22 (5).* 691-712

[71] Buchmueller T.C., Jacobson M., & Wold C. (2003). How far to the hospital? The effect of hospital closures on access to care. *Journal of Health Economics. 25 (4).* 740-761.

[72] Liu L., Hader J., Broassart B., White R., & Lewis S. (2001). Impact of rural hospital closures in Saskatchewan, Canada. *Social Science & Medicine. 52 (12).* 1793-1804.

[73] U.S. Department of Health and Human Services, Office of the Inspector General. (2002). *Hospital Closure 2000* (OEI-04-02-00010). Available online: http://oig.hhs.gov/oei/reports/oei-04-02-00010.pdf

that are facing financial problems often transfer and consolidate services to other sites in order to enhance the efficiency 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 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…In summary, the negative impact on access related to the closure of a hospital is typically a gradual process that tracks the pace of financial deterioration of the hospital rather than occurring suddenly as the institution physically closes its doors."[74]

- **Community Needs Are Met:** Another benefit of facility closure is the opportunity to convert the facility to alternative uses which better align resources with community needs. Closed facilities may be used for non-acute medical services or developed for residential or commercial purposes. Numerous examples exist of such successful conversions, including:
    - Morrisania Hospital, an 11-story Bronx hospital which closed, reopened under the auspices of the Women's Housing and Economic Development Corporation to provide apartments for low-income and formerly homeless families. In addition, the facility hosts a family health center and the Urban Horizons Center which offers an array of social services such as job training, a Head Start program, child care and counseling. The conversion was financed by a $23 million investment of state, federal and private funds.
    - St. Marys' Hospital, in Rochester, closed its inpatient services in 1999. The facility now operates as a comprehensive community health center and urgent care center.
    - Amsterdam Memorial Hospital, in 2002, closed its inpatient acute care beds. It retains an inpatient rehabilitation unit, and provides urgent care services and ambulatory surgery.
    - In 1997, Germantown Hospital in Philadelphia, PA joined the Albert Einstein Healthcare Network. The inpatient beds were transferred to the nearby Albert Einstein Medical Center and the Germantown facility was converted to Germantown Community Health Services. The facility includes a 170-bed nursing home, a 24

[74] Greater New York Hospital Association. (2005, June 15). Testimony of Greater New York Hospital Association before the New York City Council Committee on Health at a Hearing on Hospital Closures, delivered by Susan C. Waltman.

hour emergency department, outpatient diagnostic and treatment services and physician offices.[75]

On the long term care side, a combination of surplus nursing home beds together with a need for non-institutional services creates an opportunity to shift resources from nursing home facilities to alternatives. For example, New York State's own "Rightsizing Demonstration" permitted nursing home beds to be permanently de-certified and exchanged for other certified capacity, including adult day health care, long-term home health care, and Medicaid-supported Assisted Living Program (aka "ALP") beds. As many as 2,500 nursing home beds could be converted under this demonstration.

Other States have similar voluntary rightsizing initiatives that convert nursing home resources into non-institutional alternatives, including Wisconsin, Nebraska, Kentucky, Iowa, Washington, and Minnesota. Through Minnesota's initiative, nursing home beds declined by nearly 4,000 or 8% in two years, falling in line with declining nursing home utilization rates. At the same time, they expanded their Elderly Waiver and Alternative Care programs, so that Minnesota spends nearly equally between nursing facilities and home care, serving more individuals than previously, according to the Minnesota Dept of Human Services.

[75] Baittinger, E., & Zuckerman, A. (2005). Hospital closures: Moving from failure to revitalized community resources. *Strategies & Solutions, March 2005*. Retrieved September 27, 2006, from http://www.hss-inc.com/enewsletters/march2005.htm.

V. Commission Process and Methodology

The Commission on Health Care Facilities in the 21st Century was a broad-based, non-partisan panel created by Governor Pataki and the New York State Legislature to undertake a rational, independent review of health care capacity and resources in New York State. It was created to ensure that the regional and local supply of hospital and nursing home facilities is best configured to appropriately respond to community needs for high-quality, affordable and accessible care, with meaningful efficiencies in delivery and financing that promote infrastructure stability.

The Commission was statutorily charged with evaluating all nursing homes and general acute care hospitals using factors listed below:

1. The need for capacity in the hospital and nursing home systems in each region;
2. The capacity currently existing in such systems in each region;
3. The economic impact of right-sizing actions on the state, regional and local economies, including the capacity of the health care system to provide employment or training to health care workers affected by such actions;
4. The amount of capital debt being carried by general hospitals and nursing homes, and the nature of the bonding and credit enhancement, if any, supporting such debt, and the financial status of general hospitals and nursing homes, including revenues from Medicare, Medicaid, other government funds, and private third-party payors;
5. The availability of alternative sources of funding with regard to the capital debt of affected facilities and a plan for paying or retiring any outstanding bonds in accordance with the contract with bondholders;
6. The existence of other health care services in the affected region, including the availability of services for the uninsured and underinsured, and including services provided other than by general hospitals and nursing homes;
7. The potential conversion of facilities or current facility capacity for uses other than as inpatient or residential health care facilities;
8. The extent to which a facility serves the health care needs of the region, including serving Medicaid recipients, the uninsured, and underserved communities; and
9. The potential for improved quality of care and the redirection of resources from supporting excess capacity toward reinvestment into productive health care purposes, and the extent to which the actions recommended by the Commission would result in greater stability and efficiency in the delivery of needed health care services for a community.

Commission Approach

The Commission's task required an approach that balanced "science" and "art." Its deliberations were significantly informed and driven by extensive review of objective data and quantitative analysis. However, analysis of community needs and resources cannot be reduced to a mere "numbers game" and the Commission's recommendations are not solely the product of mathematical algorithms. Significant public input, understandings of local market conditions, professional judgment, and factual information were combined to form the basis of the Commission's deliberations.

Commission Structure

The Commission operated independently of any existing agency or entity. While the Commission relied on the data and expertise from various state agencies, including the Department of Health (DOH), the Dormitory Authority for the State of New York, and the Division of the Budget, the Commission was neither a part nor an initiative of these agencies. The Commission was staffed by seven full-time dedicated employees, including an executive director, a deputy director/lead counsel, policy analysts, and assistants. Its chairman was Stephen Berger. From July 2005 to December 2006, the Commission met 14 times.

The Commission had eighteen statewide members, 12 of whom were appointed by the Governor, 2 by the Assembly Speaker, 1 by the Assembly's Minority Leader, 2 by the President Pro Tem of the Senate, and 1 by the Senate's Minority Leader. Statewide members voted on every issue pertaining to the Commission, including its final recommendations.

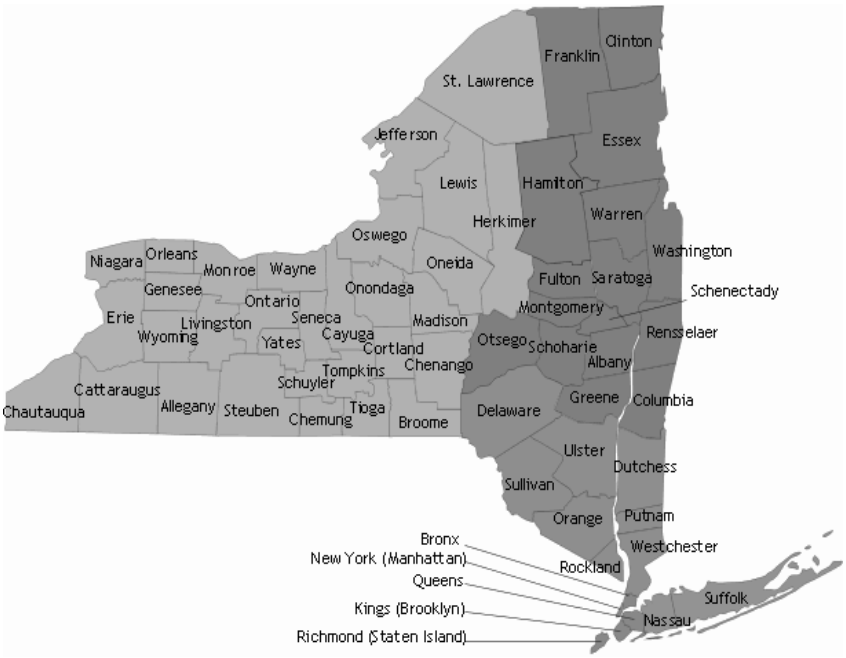
Regional Definitions and Representation

Given the size and diversity of the State of New York, the structure of the Commission was designed to have a strong focus on regional concerns and issues. For the Commission's purposes, the State was divided into six regions:

- **Central:** Broome, Cayuga, Chemung, Chenango, Cortland, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Oneida, Onondaga, Ontario, Oswego, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, and Yates counties
- **Hudson Valley:** Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester counties

- **Long Island:** Nassau and Suffolk counties
- **New York City:** Bronx, Kings (Brooklyn), New York (Manhattan), Queens and Richmond (Staten Island) counties
- **Northern:** Albany, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties
- **Western:** Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, and Wyoming counties

Figure 16. Commission Regions



In addition to the eighteen statewide voting members, there were up to six regional members for each of the six regions listed above, appointed in equal part by the Governor, Senate, and Assembly. These regional members voted and were counted for quorum purposes only when the Commission acted on recommendations relating solely to the regional member's respective region.

Regional Advisory Committees

In addition to the Commission body, the legislation established regional advisory committees (RACs). Each of the six regions listed above had an associated RAC. Each RAC was established with twelve potential members, appointed in equal parts by the Governor, Senate, and Assembly.

The RACs played an important role in the Commission's process. They provided essential community knowledge and insights into local market conditions. They played vital information gathering roles by fostering discussions with and among local stakeholders. Each of the six RACs held extensive meetings with key stakeholders, including hospital CEOs, nursing home administrators, and representatives from trade groups, unions, patient advocates, insurers, and public health officials.

Each RAC was charged with developing non-binding recommendations "for reconfiguring its region's general hospital and nursing home bed supply to align bed supply with regional and local needs." In addition identifying specific facilities to be reconfigured or closed, the legislation required each RAC to address the following points in its submitted report:

(i)	Recommended dates by which such actions should occur;
(ii)	Necessary investments, if any, that should be made in each case to carry out the regional advisory committee's recommendations, including any necessary workforce, training, or other investments to ensure that remaining facilities are able to adequately provide services within the context of a restructured institutional provider health care system in such region; and
(iii)	The regional advisory committee's justification for its recommendations, including its use of the factors.

Following the qualitative data-gathering phase of the public hearings and private meetings, each RAC developed its set of initial, non-binding recommendations. To facilitate an active engagement by the RACs with the entire Commission, each RAC met with full Commission before officially transmitting their reports to the Commission on November 15, 2006. This ensured that the Commission would properly consider the local expertise of the RAC, and the interests and concerns of local and regional stakeholders.

Local Input and Community Outreach

The legislature charged the Commission and the RACs with holding formal public hearings with public notice to solicit local input from a wide array of interested parties including

patients and consumers, providers, payers, labor, elected officials, and the business community. In total, nineteen hearings were held throughout the regions. The Commission and RACs heard from hundreds of witnesses and reviewed thousands of pages of testimony submitted during the hearings. Additionally, numerous parties submitted written testimony to the RACs throughout the tenure of the Commission.

Table 11. Public Hearings by Region

Region	Date	Location
Central	February 21, 2006	Binghamton
	February 24, 2006	Syracuse
	March 27, 2006	Rochester
	April 4, 2006	Watertown
Hudson Valley	February 15, 2006	Valhalla
	February 22, 2006	New Paltz
	March 1, 2006	Middletown
Long Island	March 22, 2006	Riverhead
	April 11, 2006	Hempstead
New York City	February 17, 2006	Staten Island
	February 24, 2006	Brooklyn
	March 7, 2006	Queens
	March 28, 2006	Bronx
	March 30, 2006	Manhattan
Northern	February 8, 2006	Albany
	March 1, 2006	Plattsburgh
Western	February 27, 2006	Sanborn
	March 3, 2006	Buffalo
	March 14, 2006	Jamestown

Analytic Framework

The Commission and staff performed detailed analysis of each hospital and nursing home throughout the State. In order to focus its efforts at rightsizing the health care delivery system, the Commission unanimously adopted an analytic framework to focus the Commission's hard-look analysis on several hospitals and nursing homes. This framework was a starting point for focused and continual deliberations and discussions, and was not final determinations of which institutions to rightsize.

Derived from the nine legislated factors listed above, the Commission and staff designed a rational, independent, and equitable approach that categorically differentiated each hospital and nursing home using six key criteria. Once established, these criteria served as a basis by which all institutions were evaluated:

1. Service to Vulnerable Populations
2. Availability of Services
3. Quality of Care
4. Utilization
5. Viability
6. Economic Impact

Within each criteria, the Commission examined numerous metrics, as shown below:

Table 12. Commission Framework Criteria Metrics

Vulnerable Populations	Availability of Services	Quality of Care	Utilization	Viability	Economic Impact
• **% Uninsured Discharges** • **% Medicaid Discharges** • **% Medicare Discharges** • **ER payor mix** • **% Medicaid Admissions (nursing homes)** • **% High acuity** • **DSH Hospital** • **MUA** • **% Non-white Discharges**	• **Provision of Comprehensive Services** • **Provision of Essential Services/Sole Community Provider** • **Distance/ Commute Time to Other Providers** • **Rural Hospital Designation**	• **JCAHO accreditation** • **Special Designations** • **CMS Hospital Compare Data** • **CMS Nursing Home Compare Data**	• **Inpatient Occupancy Rates** • **Volume of Outpatient Visits** • **Volume of ED Visits**	• **Profitability** • **Days of Cash on Hand** • **Capital Debt** • **Bonding and Credit Enhancements** • **Linkages and Affiliations**	• **FTEs/County Population** • **Local Unemployment Rate**

Because regions provide the best set of comparisons and respect differences across the state, each institution's rating was assigned relative to institutions within the same region. Each institution received a rating of -1, 0, or +1 on each criterion, and each criterion carried equal weight. Therefore, each institution received a final rating of -6 to +6, and from this final score,

institutions were divided into three categories: high, medium, and low priority for rightsizing. Those institutions that were rated as high priority received a harder-look analysis than those with a low priority. However, these categories were not determinative. High priority institutions were not necessarily subject to Commission recommendations nor were low priority institutions necessarily immune.

This analytic framework had some distinct advantages. It sufficiently accounted for real world complexities, while remaining understandable, explainable, and actionable; and while it was evidence-based, data-driven, and objective, it allowed for professional and practical judgment that accounted for nuances and subtleties that an overly-rigid algorithm could not.

This analytic framework was the start of a multi-leveled analysis performed by the Commission and staff. To complement the framework, the Commission sought regional input by stakeholders, experts, and members of the community through multiple public hearings held throughout the State.

Absorption and Access Analysis (AAA)

The Commission developed a model for determining whether adequate alternative inpatient capacity exists within reasonable proximity to a hospital considered for closure. The model revealed whether inpatients at a particular hospital could be absorbed by neighboring hospitals and the travel time that would be required if patients were to disperse among those hospitals. The model drew on work by The Health Economics and Outcomes Research Institute (THEORI) at GNYHA. Neither THEORI nor GNYHA had any involvement or influence on the Commission's analysis or deliberations regarding any individual facilities.

The model simulated the closure of individual hospital campuses (focal hospitals) throughout New York State based on 2004 SPARCS and ICR data. In preparation, each patient in the SPARCS database was assigned to a cohort. A cohort was a group of patients residing in the same ZIP code and admitted to the hospital for the same condition or procedure. Elective admissions were grouped into 35 clinically meaningful service lines (such as cardiac surgery, neurology, orthopedics, and psychiatry), while emergency admissions were grouped together as if they were a distinct service line. To simulate a closure, the focal hospital's patients were randomly reassigned to other hospitals (coverage partners) based upon the real-world distribution of cases in the patient's cohort. (For example, if patients in a particular cohort were admitted to

hospitals other than the focal hospital in the proportion of 30% to Hospital A and 70% to Hospital B, then the focal hospital's patients were randomly reassigned to those hospitals in the same proportion.) The coverage partners were sorted based on their share of the focal hospital's reassigned patients, and *principal* coverage partners were identified, usually as the hospitals to which the first two-thirds of the focal hospital's patients were reassigned.

To determine whether the focal hospital's coverage partners had sufficient capacity to absorb its patients, each reassigned patient's inpatient days were added to the coverage partner's daily census on approximately the same dates and times that the patient was in the focal hospital. Then a revised average daily census and peak daily census were computed for the coverage partner. The peak daily census was defined as the thirty days of the year in which the daily census—measured at the peak hours of day—was highest. Finally, the revised average and peak daily census counts were compared with the coverage partner's available beds.

To determine whether it was feasible for the focal hospital's patients to travel to their reassigned hospitals, the weighted average driving time to the reassigned hospitals was computed for the focal hospital's patients. The weighting of the average driving times to each reassigned hospital was based on each coverage partner's share of the focal hospital's reassigned patients. The average driving times were computed from the centroid of each patient's Census tract to the reassigned hospital.

The model is fundamentally conservative and does not rely on assumptions that we might realistically make regarding an altered health care delivery landscape. For example, it assumes no reduction in average length of stay (ALOS) although even a very modest ALOS reduction can dramatically increase capacity. Furthermore, it assumes no reduction in overall service utilization although the reduction of excess capacity can be assumed to reduce inappropriate utilization of services.

Voluntary Rightsizing Efforts

The Commission promulgated policies to encourage and protect facilities that wished to engage in voluntary rightsizing efforts. Philosophically, the Commission believed that "bottom-up" solutions derived by health care providers can be superior to "top-down" imposed edicts. Practically, the Commission also believed that locally developed solutions with stakeholder buy-in are easier to implement.

Because talks between facilities were for the purpose of developing potential Commission recommendations, the Commission was able to extend its umbrella of state action immunity to shield such facilities from potential antitrust violations. The Commission's procedures were developed collaboratively with the State Department of Health and the Office of the State Attorney General. In addition, representatives of the Commission briefed the Federal Department of Justice and the Federal Trade Commission on these procedures, neither of which expressed objections. The formal procedures used to conduct such voluntary discussion between providers were described and disseminated to all health facilities in the State.[76]

[76] Commission on Health Care Facilities in the 21st Century. (2006). *Voluntary Rightsizing Procedure*, 1-2. Available online: http://www.nyhealthcarecommission.org/docs/voluntary_rightsizing_procedure.pdf.

VI. Policy Recommendations

The Commission's direct mandate and authority to rightsize and reconfigure the states' hospital and nursing home industries was a vast and complicated endeavor. Despite the breadth of its charge, the work of the Commission is only one element in a comprehensive reform agenda. In some respects, the Commission's recommendations for specific facilities address the "symptoms" of a sick system. It is equally or more critical to also address the "root causes" so that comprehensive rightsizing and reconfiguration can occur.

The Commission's enabling statute provides for recommendations related to a streamlined regulatory process, reimbursement, and other topics. As part of its deliberations, the Commission frequently considered the ways in which the structure and financing of the health care delivery system affect its mandate to create a system that better meets community needs. Thus, the Commission makes the following recommendations for areas needing broader policy reform. It is hoped that these recommendations will provide a blueprint for further work toward improving our health care system.

A. Reimbursement and Medicaid

Financial incentives powerfully affect the supply, demand, and location of healthcare services. At times, they distort patterns of service delivery. Driven by the imperative of financial survival, providers may pursue high-margin services rather than services that best align with community needs. Fiscal pressures can also drive facilities to provide otherwise redundant or unneeded services solely to cross-subsidize other elements in their service mix that are crucial but unprofitable.

Direct state action to change the amount and distribution of funding for Medicaid and public goods would be an important step in reforming the reimbursement system in New York. Furthermore, Medicaid policy has the potential to influence the actions of private and federal payors. The Commission recommends that the State of New York undertake a comprehensive review of reimbursement policy and develop new payment systems that support a realignment of health services delivery. Such review should recognize these principles:

- The current growth rate of Medicaid expenditures is an unsustainable burden on taxpayers.
- Diversion of health care resources is unacceptable. Dollars that are freed up must be reinvested in the health care system.
- Reimbursement reform should strengthen the long-term viability of institutions that disproportionately serve vulnerable populations including the uninsured and low income patients.
- Reimbursement reform should encourage the provision of preventive, primary and other baseline services and discourage the medical arms race for duplicative provision of high-end services.
- The relationship between private payers and the financial viability of the health care delivery system needs to be carefully examined. Reducing unnecessary hospital capacity and maintaining critical health services are as important to the insurance sector as they are to the public sector. As such, it is reasonable to expect these companies to participate in initiatives to promote financial alignment between payers and providers, and to participate in reinvestment strategies by reimbursing adequately while maintaining adequate reserves to meet current and future health care needs.
- Future capital investments should reflect shifts in the venue of care from institutional to home and community based settings.

Within the specific arena of long term care, New York State should:

- Expand the availability of home and community-based alternatives to nursing home placement and educate physicians, paraprofessionals, and consumers about these alternatives.
- Implement recently enacted reforms to the current method of facility-based reimbursement.
- Explore alternate payment methods such as resident-based pricing and/or the expansion of managed care models on a demonstration basis.
- Implement its single point-of-entry system.

- Develop programs and reimbursement mechanisms for high-quality, cost- effective chronic care management.
- Address the disproportionate burden on particular institutions of uncompensated long term care patients.

Comprehensive discussions of issues and options in acute and long term care reimbursement reform can be found in the appendices to this report.

B. The Uninsured

The uninsured remains one of the most serious and persistent health care problems both in the nation and New York. The United States is the only wealthy industrialized nation that does not provide universal health insurance coverage. Nearly one in five non-elderly individuals in the US and NY State lack health care coverage.

The uninsured face problems accessing needed health care services. Many either do not receive or postpone seeking care due to financial barriers. When they do receive care, it is often episodic and fragmented. Preventable or treatable chronic conditions develop into more complicated and expensive conditions to treat. Compared to insured patients, uninsured patients have less favorable health outcomes and higher rates of complications and deaths. The Institute of Medicine estimates that lack of health insurance causes roughly 18,000 unnecessary deaths every year.[77]

Uninsured Americans often present to hospital emergency rooms where their care can be uncoordinated and more expensive to deliver. In addition, health care providers bear a substantial burden in providing care for this to the uninsured and indigent. According to the Urban Institute, New York State's medical providers spent about $2.8 billion in 2005 on providing care for uninsured New Yorkers.[78] Hospitals provided $1.8 billion of that care, and physicians accounted for $412 million. The balance came from health centers, Veterans facilities, and the federal Indian Health Service.

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[77] Institute of Medicine. (2002). *Care without coverage: Too little, too late* (LCCN 2002105905, 1-212). Washington, DC: National Academies Press.

[78] Bovbjerg, R.R., Dorn, S., Hadley, J., Holahan, J., & Miller, D.M. (2006). Caring for the Uninsured in New York. *Urban Institute*, Retrieved October 20, 2006, from http://www.urban.org/publications/311372.html.

A comprehensive solution to the uninsured will require federal efforts. However, New York State has made major strides in expanding access to health insurance for its residents. Between 2000 and 2004, the percentage of the uninsured in NYS declined while the percentage nationally has increased. Although the numbers of uninsured clearly remain unacceptably and chronically high, the trend in New York State is moving in the right direction.

The encouraging developments in NY are due in large part to expansion of our public coverage programs combined with relative stability in our base of employer-sponsored coverage. NY State has large and generous public insurance programs. New York Medicaid's program now covers more than 4.5 million NYS residents. Of those, roughly 2 million are children and another 2 million are adults. It also covers half a million elderly persons as well as 600,000 blind and disabled persons. New York's Medicaid program has one of the broadest coverage eligibilities in the nation and offers a very comprehensive benefit package. In addition, New York's Child Health Plus is one of the nation's oldest and largest state children's health insurance programs. It covers children up to age 19, at higher income eligibility levels than Medicaid, and has approximately 400,000 enrollees. One of the newer programs in the state is Family Health Plus, a public health insurance program for adults between the ages of 19 and 64 who do not have health insurance - either on their own or through their employers - but have income or resources too high to qualify for Medicaid. It is available to single adults, couples without children, and parents with limited incomes. Family Health Plus has more than half a million enrollees.

Healthy New York was established to make insurance more affordable and more accessible to workers in small businesses with 50 or fewer employees. It is also available to eligible working uninsured individuals including sole proprietors. The program, which now has more than 100,000 enrollees, creates standardized health insurance benefit packages that are offered by health maintenance organizations (HMOs) in New York State.

The Commission recommends that New York State reaffirm its historic commitment to health care for the poor and other vulnerable populations. Consistent with the Institute of Medicine's guiding principles,[79] New York State should ensure that health coverage is universal, continuous, affordable to individuals and families, and affordable and sustainable for society at large. While guarding against fraud, New York should lower administrative barriers to

[79] Institute of Medicine. (2004). *Insuring America's health: Principles and recommendations* (LCCN 2003114736, 1-224). Washington, DC: National Academies Press.

enrollment to help ensure that all uninsured but eligible persons are placed in the appropriate program and make it easier for eligible persons to retain coverage. New York should build upon its impressive network of public programs to weave them into a seamless system of coverage that is more coordinated and easier to navigate. Furthermore, New York should study coverage expansion efforts in other states and adopt additional strategies to sustain its recent progress in reducing the number of uninsured New Yorkers.

C. Developing Primary Care Infrastructure

Primary care is an essential component of the health care delivery system. Patients and society as a whole derive substantial benefits when patients have regular and continuous access to care in the least intensive, least expensive venue appropriate to a patient's condition.

Effective reform and investment in primary care is essential to reversing long term trends affecting health care costs, access and quality, especially for underserved populations. Evidence shows that having a primary care physician promotes overall community health. In New York City, for example, minority populations without a primary care giver were 3.5 times more likely to be hypertensive,[80] and patients receiving blood pressure checks in the emergency department were eight times more likely to be non-compliant with their treatment.[81] Rural residents also face barriers to high quality primary and preventive care including longer distances to get to health care delivery sites, physician shortages, lack of transportation, and a scarcity of mental health professionals and programs.[82] Compared with their urban counterparts, residents of rural areas are more likely to report fair or poor health status, to have chronic conditions, and to die from heart disease. They have fewer visits to health care providers and are less likely to receive recommended preventive services. Rural minorities appear to be particularly disadvantaged.[83]

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[80] Shea, S., Misra D., Ehrlich, M.H., Field, L., & Francis, C.K. (1992). Predisposing factors for severe, uncontrolled hypertension in an inner-city minority population. *New England Journal of Medicine. 327.* 776-781.

[81] Shea, S., Misra D., Ehrlich, M.H., Field, L., & Francis, C.K. (1992). Correlates of nonadherence to hypertension treatment in an inner-city minority population. *American Journal of Public Health. 82 (11).* 1607-1612.

[82] United States Department of Health & Human Services Agency for Health Care Policy and Research. (1996). *Improving Health for Rural Populations Research in Action Fact Sheet* (AHCPR Publication No. 96-P040). Rockville, MD: Agency for Health Care Policy and Research. Available online: http://www.ahrq.gov/research/rural.htm

[83] United States Department of Health & Human Services Agency for Healthcare Research and Quality. (2005). *Health care disparities in rural areas: Selected findings from the 2004 National Healthcare Disparities report* (AHRQ Publication No. 05-P022). Rockville, MD: Agency for Healthcare Research and Quality. Available online: http://www.ahrq.gov/research/ruraldisp/ruraldispar.pdf

Some patients, especially those in low income communities, face difficulties accessing primary care other than in a hospital setting. Private physician's offices may refuse or limit the care they provide to Medicaid patients. Further, there are not enough primary care providers in indigent neighborhoods. Of nine low-income minority communities in New York City, for example, only 28 primary care physicians had hospital privileges and were fully accessible to 1.7 million residents.[84] Government funded clinics may have unacceptably long waiting lists, or be inconveniently located.

Given the scarcity of private physicians for low income patients, hospitals often fill a crucial need by providing primary care outpatient services. However, hospitals are not optimally suited to provide primary care. Emergency departments, in particular, are not the best venue for patients to receive primary care. Because contact with patients is episodic and because different physicians may be seen each time, emergency departments lack the ability to provide long-term continuity and the integration of care across multiple disciplines. Care provided in emergency departments is also very expensive. In contrast to the fragmented emergency department model of primary care, high quality primary care can help people lead healthy lives, improve health outcomes, provide coordination of care across a continuum of services, prevent unnecessary hospitalizations, and reduce costs. [85]

The Commission recommends pursuit of a primary care reform agenda including the following elements:

- ensuring that all New York residents have a primary care "home"
- stemming the erosion of primary care capacity
- investing in primary care infrastructure, including investment in facilities, equipment and information technology
- ensuring adequate financial support to the primary health care safety net
- gaining participation by all payors to support such investments, and
- investing in the development of a primary care workforce.

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[84] Brelloche, C., Carter, A.B. (1990). Building primary health care in NYC's low-income communities. *Community Service Society of New York* working paper. *iv:5.*

[85] Rosenbaum, S., Shin, P., Whittington R.P.T. (2006). Laying the foundation: Health system reform in New York State and the primary care imperative: Executive summary. Retrieved September 22, 2006, from the Community Health Care Association of New York State Web site:

D. Developing Hybrid Delivery Models

During its analysis and deliberations, the Commission repeatedly identified communities whose needs could be well served with less than a "full service" hospital but which require more than an ambulatory care center. In these areas, there tends to be a single hospital with low utilization, weak finances, and inferior quality. While such institutions may appear to be candidates for closure, they cannot be closed unless an alternative set of services remains available to community residents. To close a hospital without preserving certain services would irresponsibly leave parts of the state bereft of needed health care access.

Most often, the services that required preservation include a combination of emergency or urgent care, ambulatory care, and to a lesser extent, ambulatory surgery, and imaging. However, today's reimbursement system makes this an unprofitable and unviable set of services. Hospitals are thus required to maintain unnecessary services for the sole purpose of cross-subsidizing the necessary but money-losing services. The lack of alternatives has led to a situation in which whole hospitals must be maintained in order to deliver the smaller subset of needed services that could be provided by more focused facilities. These hospitals face structural financial challenges, and in response, may pursue unnecessary capital investments in order to expand their revenue base.

At the moment, there is no financially viable model for this kind of hybrid institution, other than a Critical Access Hospital (CAH). CAHs receive higher Medicare reimbursement rates based on the costs of services rendered. The criteria for this federal designation are designed for rural settings and would not apply broadly enough to be useful in all instances

To better align community needs and resources, the Commission recommends that the State and industry collaborate to test and develop new "hybrid" delivery models. Such hybrids would maintain features of a traditional hospital determined to be necessary while eliminating redundant and unneeded features. Creative and financially viable alternatives, such as free standing emergency rooms or community health centers with urgicare capabilities, could advance the achievement of a rightsized and restructured health care delivery system. The benefits could include enhanced access to services, less duplication, and amelioration of the economic impact of full hospital closures.

E. State University of New York (SUNY) Hospitals

The State University of New York operates teaching hospitals at its Health Science Centers in Brooklyn, Syracuse and Stony Brook. The SUNY hospitals are important resources and recipients of public funds and subsidies. Their academic mission to train physicians and their mission to serve patients regardless of ability to pay must be preserved. Similarly, the SUNY hospitals must be able to compete within the marketplace, operate cost effectively, and establish stronger relationships with community hospitals.

As state-controlled institutions, the SUNY teaching hospitals faced unique challenges adapting to new market conditions that arose in the 1990s. To address these constraints, New York State enacted "hospital flex legislation" in 1998 that granted the SUNY hospitals greater operational flexibility to participate in managed care networks and similar cooperative arrangements. This flexibility was not completely unfettered, however, and the SUNY hospitals continue to suffer competitive disadvantages. Additional legislation has since been proposed that would further expand operational flexibility, even going so far as to restructure the SUNY hospitals as private, not-for-profit corporations. Other states, including Massachusetts, Michigan, and Wisconsin, have take this approach and spun off their teaching hospitals to allow them to function more effectively in the market.

Supporters of privatizing the SUNY hospitals cite numerous advantages to spinning-off the hospitals from the State University system. They contend that doing so will enable the hospitals to work cooperatively with other health care providers to develop high-quality, cost-effective systems of care within their respective regions. Increased management autonomy will promote more effective long-term planning, expedite short-term decision-making and help ensure future competitiveness and financial stability. Non-public facilities will have more competitive salary and benefit obligations to employees. Privatization would also decrease or eliminate the need for ongoing State subsidies, which currently amount to over $147 million in annual operating costs and $350 million in capital costs. Proponents also point out that many leading academic medical centers operate their medical schools and principal teaching hospitals under separate ownership without deleterious effects on their research enterprise. Prominent examples include Harvard, Yale, Cornell, Columbia and Washington Universities, all of which

own no hospitals yet remain leaders in research funding according to the National Institutes of Health (NIH) rankings. [86]

There is also considerable opposition to potential privatization of the SUNY hospitals. Organized labor, especially the New York State Public Employees Federation (PEF) and New York State United Teachers (NYSUT), opposes privatization based on fears of lay-offs and benefit cuts. Opponents also argue that privatization would not improve efficiency or quality, would erode the educational mission, and potentially result in elimination of important but unprofitable services.

The Commission recommends that the Commissioner of Health, in consultation with other relevant parties, conduct a comprehensive analysis of the feasibility of privatizing the teaching hospitals at Stony Brook, Syracuse and Brooklyn. This analysis should consider the clinical and economic impact of potential changes on the hospitals, their communities, their medical school affiliations, their research capabilities, their employees, and taxpayers. Based on the results of this analysis, the Commissioner should develop a concrete timetable for action.

F. Healthcare Workforce Development

Maintaining and developing the healthcare workforce should be a key public policy concern. The healthcare workforce is a large component of New York's economy, accounting for 1 in 9 jobs in the state. The success of the health care system across the entire continuum of care is dependent upon an adequate supply of qualified personnel at all levels. Shortages have led to recruitment and retention problems throughout the industry. Further, the ongoing implementation of health information technology has created gaps between the skill levels of the current healthcare workforce and the skills required to deliver care in a high-tech environment.

Over the past several years, approximately $1.3 billion has been invested in workforce recruitment, retraining and retention through five programs: the Health Care Worker Retraining Initiative, Community Health Care Conversion Demonstration Project, TANF Health Worker Retraining Initiative, Supplemental General Hospital, Recruitment and Retention Rate Adjustment Program, and the Nursing Home Quality Improvement Demonstration Program. Today, additional strategies should be implemented to:

[86] National Institues of Health, (2006). Award Trends Ranking Information. Retrieved October 20, 2006, from National Institutes of Health Offices of Extramural Research Web site: http://grants.nih.gov/grants/award/awardtr.htm

- redress persistent shortages in a variety of occupations including registered nurses, pharmacists, radiology technicians, home care attendants and other paraprofessionals, and to
- educate and retrain workers to prepare them for the increasing uses of advanced health technologies in their jobs
- facilitate the timely transfer of personnel displaced by Commission recommendations to other employment within the health care sector.

G. Information Technology

The need for improved use of information technology throughout the health care system has been well publicized in recent years. Effective use of IT in hospitals, nursing homes, ambulatory care centers and physician's offices can improve quality of care, reduce errors and control costs. Reconfiguration of the healthcare system places higher demands on information sharing as patients are moved into different settings based on their changing clinical needs. In addition, the ability of the State to monitor potential epidemics, bio-terrorism and general health trends can be significantly improved by the electronic availability of timely, standardized information. Similarly, those involved in regional health planning efforts across the state would benefit from access to electronic databases.

The effectiveness of information technology is constrained if health care providers cannot share information with each other, within the context of HIPAA and privacy concerns. As the HIT infrastructure is developed in NY, the state must ensure that systems are able to communicate, using open architecture and embracing the principle of interoperability. It is not in the public interest for individual health information to become a commodity or for information systems to become balkanized.

HIT systems are costly and require significant investment in hardware, software and training. Further, HIT is a high-risk endeavor. When implemented properly, it can yield incredible results. Failed implementation can be catastrophically expensive and time consuming.

Given these barriers, the healthcare industry lags behind other industries in its investment and use of IT. Industries such as financial services have invested 10% or more of their revenues in information systems, while the health care industry is estimated to have invested less than 4% of its revenues. Part of the reason may be that currently, providers bear almost all of the costs of

IT investment, while the financial benefits accrue to those who pay for care. Accelerating forward momentum towards universal adoption of IT may require shared investment strategies between government, providers, payers and purchasers. The availability of Heal NY Grants for IT investment is a promising opportunity to further advances in this area.

H. County Nursing Homes

Approximately 10% of the nursing home beds in NYS are in county owned and operated facilities. These homes are departments of county government and are ultimately governed by elected representatives. Many of these 44 county-owned facilities lose money each year and pressure from taxpayers to hold the line on property taxes is stronger than ever. Further, the face of long term care is changing with the growth of home and community based services. This shift calls into question the appropriateness of the county homes' traditional institutional model. Increasingly, counties are asking whether they should remain in the nursing home business.

A report issued by the Center for Governmental Research, "What Should be Done With County Nursing Facilities in New York State?" outlines the challenges faced by county nursing homes and describes the range of options that counties have pursued or considered.[87] County homes differ from proprietary and voluntary homes in a number of ways. County homes have a mission to care for poor and indigent elderly county residents regardless of ability to pay. They have difficulty competing with the voluntary and proprietary sectors for high-intensity, better reimbursed patients. County homes receive certain revenue and incur unique expenses because of their status as government entities. While they benefit from intergovernmental transfers and county subsidies, they also carry a burden of cost allocations that may bear little relationship to actual expense, and their employees often receive more generous wages, salaries and benefits than their counterparts in private homes. While each home has an administrator, policy and management decisions rest with the county legislature or board of supervisors who are subject to numerous pressures.

According to the Center for Governmental Research, counties will have an increasingly difficult time operating their nursing homes as if they were just another department of county government. Among the options that counties have pursued or considered are the following:

[87] Center for Governmental Research, Inc. (1997). *What Should Be Done With County Nursing Facilities in New York State?* Rochester, NY: CGR, Inc. Executive summary available online: http://government.cce.cornell.edu/doc/reports/options/summary.asp

- Contract for management services to operate the county home
- Sell licensed beds
- Convert the home to a public benefit corporation
- Transfer the home to a not-for-profit corporation or sell to a proprietary corporation.

Given the complexity of this issue, New York State should undertake a comprehensive review of the future role of county-owned and operated nursing homes. These facilities are essential providers of care for residents who are otherwise difficult to serve. However, many of these homes are in severe financial distress, lack operational flexibility, are burdened with excessive labor costs and struggle to maintain quality of care. A clear policy should be developed to guide decision making about county nursing homes in a changing environment and to protect poor and indigent residents who may have difficulty receiving care in other settings.

I. Niche Providers

A significant amount of health care services has migrated out of the hospital to other settings. Ambulatory, "niche" providers are unburdened by the large overhead costs borne by hospitals and so can be less costly for payors and users. Patients benefit from a wider choice of venues in which to receive care.

The movement of services out of large institutions is likely to continue. This would not be problematic except for the fact that hospitals treat a disproportionate share of complex and difficult high-risk cases, while other providers effectively "cherry pick," profiting more from specializing in lower-risk cases utilizing high value services. In today's health care environment, hospitals rely on high value services to subsidize less profitable services that are critical to the community. Examples of these less profitable "public goods" are emergency departments, trauma centers, burn care services, and non-income generating services like disaster preparedness. In addition, payer surcharges on high value services are used to fund other public good functions such as indigent care. As a result, the out-migration of high value services from hospitals to niche providers has the potential for weakening these public good funding sources. Alternate funding mechanisms for these essential services are needed and niche providers must share in the burden of paying for public goods and charity care. In addition, there may be a need to enhance quality-of-care monitoring and reporting in non-regulated and private settings.

J. Roadmap for the Future: Continuation of the Commission's Work

The work of the Commission illustrates the many and diverse opportunities that exist to improve the delivery of health care services in New York State. The Commission's work should be considered a beginning, rather than an end, of a broader reform effort. We need to build on this effort to address an ongoing need for structured decision-making regarding health care resource allocations. The speed of change in health care, driven by changing technology, populations and finance, makes it essential that the work of reforming the system and the regulatory framework be continuous. New York State should implement an ongoing process to sustain the efforts initiated by this Commission.

VII. Recommendations for Facility Rightsizing and Reconfiguration

PREFACE TO RECOMMENDATIONS

The following provisions apply to all the recommendations in this section:

1. Unless otherwise specified, the term "add" means that the Commissioner of Health shall approve one or more applications for approval to provide the enumerated service(s) and/or establish or construct the approximate number of enumerated beds or slots to be operated by or in affiliation with the enumerated facility(ies).

2. "ADHCP" means an adult day health care program described in Part 425 of Title 10 of the New York Codes, Rules and Regulations.

3. Unless otherwise specified, the term "affiliate" means that the Commissioner of Health shall approve an application providing for greater clinical or financial integration between the subject facilities, which may include the possible allocation of services between such facilities and/or the joining of such facilities under a single unified governance structure. Where a subject facility fails to execute a binding agreement to effect such affiliation by the date specified in the recommendation, the Commissioner of Health may revoke or annul the operating certificate of that facility. Where no date is specified, such date shall be deemed to be December 31, 2007.

4. "ALP" means an assisted living program described in section 461-l of the Social Services Law.

5. Unless otherwise specified, "beds" means inpatient acute care beds.

6. Unless otherwise specified, the term "close" means that the Commissioner of Health shall revoke the operating certificate of the subject facility as expeditiously as

necessary and possible to preserve quality of care, and that the subject facility shall be converted to another use and/or sold or otherwise transferred. Unless otherwise specified, any beds associated with such operating certificate shall cease to exist, and shall not be transferred to another facility or otherwise allocated.

7. Unless otherwise specified, the term "convert", as applied to a facility, means that the Commissioner of Health shall revoke the operating certificate of the subject facility and approve an application for the establishment of the new facility identified in the recommendation. Unless otherwise specified, the term "convert", as applied to beds means that the Commissioner of Health shall approve an application to change the designation of the approximate number of enumerated beds on the operating certificate of the subject facility from their current designation to the designation specified in the recommendation.

8. Unless otherwise specified, the term "discontinue" means that the Commissioner of Health shall limit and/or modify the operating certificate of the subject facility and/or take any other action necessary to eliminate that facility's authorization to provide the enumerated service(s), and shall eliminate any associated beds from the operating certificate of the subject facility. Such beds shall cease to exist, and shall not be transferred to another facility or otherwise allocated.

9. Unless otherwise specified, the term "downsize" means that the Commissioner of Health shall eliminate the approximate number of enumerated beds from the operating certificate of the subject facility. Such beds shall cease to exist, and shall not be transferred to another facility or otherwise allocated.

10. "DTC" means a diagnostic and treatment center described in Article 28 of the Public Health Law.

11. Unless otherwise specified, the term "explore" shall mean that the Commissioner of Health shall supervise discussions including the subject facilities intended to evaluate

the enumerated goal(s), and, should the Commissioner determine such goal(s) to be consistent with the mandate and other recommendations of the Commission, implement such goals as described in this report.

12. Unless otherwise specified, the term "facility" means a provider, building or campus.

13. Unless otherwise specified, the term "joined under a single unified governance structure" means that the Commissioner of Health shall approve an application joining the subject facilities under a single unified governance structure that has full authority to engage in strategic planning, restructure clinical services, bed capacity, and facilities, and negotiate and contract on behalf of subject facilities, and the incentive to structure services to achieve maximum efficiency. The governing board of the new entity must have powers sufficient to compel actions by any of the individual institutions. Where a subject facility fails to execute a binding agreement to effect such joining by the date specified in the recommendation, the Commissioner of Health may revoke or annul the operating certificate of that facility. Where no date is specified, such date shall be deemed to be December 31, 2007.

14. "LTHHCP" means a long term home health care program described in article 36 of the Public Health Law.

15. "PACE" means a program of all-inclusive care for the elderly described in subdivision 11 of section 4403-f of the Public Health Law.

16. Unless otherwise specified, the term "rebuild" means that the Commissioner of Health shall approve an application to construct a facility to replace the subject facility or facilities that is reasonably consistent with the terms of the recommendation, and that the subject facility shall be converted to another use and/or sold or otherwise transferred.

17. “RHCF” means a residential health care facility described in Article 28 of the Public Health Law.

18. “TCU” means a transitional care unit described in Article 28 of the Public Health Law.

19. Unless otherwise specified, the term “transfer” means that the Commissioner of Health shall approve an application to move the location of the enumerated beds that is reasonably consistent with the terms of the recommendation, but that such beds shall continue to be operated by the same subject facility.

20. Where a recommendation requires action on the part of a subject facility in order to be implemented, the Commissioner of Health shall have the authority to take any action necessary to compel such action by the subject facility, including but not limited to refusal to act on any application from the subject facility, refusal to provide any other consent requested by the subject facility, or the suspension, limitation or modification of that facility’s operating certificate.

21. Where a recommendation or the results thereof may have an adverse effect on competition, the Commissioner of Health shall take any steps necessary to actively supervise the implementation of such recommendation and/or the results of such recommendation, to ensure that such implementation or results remain consistent with the clearly articulated policy of the State in regard to such implementation or results.

22. The Commissioner shall implement all recommendations pursuant to, and in a manner consistent with, (i) the police power of the State, (ii) the Commissioner’s specific authority and duty to take cognizance of the interests of health and life of the people of the State, and of all matters pertaining thereto, and (iii) the Commissioner’s duty to take all actions necessary to implement the recommendations in a reasonable, cost-efficient manner.

23. Unless otherwise specified, the Commissioner of Health shall implement each recommendation as expeditiously as possible, but in no event later than June 30, 2008.

CENTRAL REGION

ACUTE CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

Crouse Hospital (Onondaga County)
University Hospital, SUNY Upstate Health Science Center (Onondaga County)

Recommended Action

It is recommended that Crouse Hospital and SUNY Upstate Medical Center be joined under a single unified governance structure under the control of an entity other than the State University of New York, and that the joined facility be licensed for approximately 500 to 600 inpatient beds. It is further recommended that the Commissioner refrain from either approving any applications that have been or will be filed by either facility or providing any other consent requested by either facility, prior to the execution by the facilities of a binding agreement to join under a single unified governance structure, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff.

Facility Description(s)

University Hospital is a 366-bed, tertiary referral center for the greater Syracuse region. It has the city's only level 1 trauma center, and provides more than 80 hospital-based clinics and numerous specialty centers, including the area's only pediatric emergency center and intensive care unit, burn center, regional oncology center, and renal and pancreatic transplant program.

University Hospital is the teaching hospital of Central New York's only academic medical center, the State University of New York (SUNY) Upstate Medical Center at Syracuse. It is part of the SUNY Upstate Medical University, which also houses the colleges of medicine, nursing, graduate studies, and health professions. The SUNY Upstate Medical University is Onondaga County's leading employer, with approximately 3,300 full time equivalent employees.

Crouse Hospital, a 576-bed facility, is the larger of the two institutions. It offers emergency, medical/surgical and intensive care, psychiatry, numerous outpatient services, and more than half of the area's obstetrical and neonatal care. The hospital is a major teaching site for SUNY medical students and residents. Crouse has approximately 1,800 full-time equivalent employees.

The campuses of Crouse Hospital and SUNY Upstate Medical University are adjacent, and at some locations they are physically interconnected.

Assessment

University Hospital and Crouse have a combined total of 942 certified beds on two interconnected campuses, both of which require major modernization. Their combined average daily census was only 563 in 2004. Neither institution can be eliminated completely; portions of both are required to meet the community's health care needs and to sustain SUNY Upstate's medical education role.

Summary Statistics 2004	**SUNY**	**Crouse**
Discharges	16,770	21,603
Inpatient % Medicaid/Uninsured	24%	26%
Uncompensated Care	$65 million	$23 million
ED Visits	48,704	24,716
Certified Beds	366	576
Staffed Beds	366	463
Average Daily Census	294	269

Collectively, SUNY and Crouse have excess inpatient capacity. SUNY operated all of its 366 beds at an average occupancy rate of 80% from 2002 to 2004. Crouse had an average occupancy of certified beds of just 47% between 2002 and 2004. Crouse, however, reports operating only 463 of its 576 beds for a staffed occupancy rate of 60% in 2004. A combined organization of approximately 500-600 beds will be sized sufficiently to meet patient needs, the education requirements of SUNY, and maintain the competitive hospital market within the Syracuse area.

Excess capacity weakens the financial status of Crouse Hospital. Crouse filed for bankruptcy protection in 2001, with debts of $91 million. The hospital emerged from bankruptcy in 2003 by deferring payment of $62 million in principal for five years. Repayment of the $62 million begins in 2008.

Each hospital plans to undertake independently very costly and duplicative modernization projects. The two hospitals' plans cost approximately $190 million in total. University Hospital soon will construct a six-story addition to its east wing, which will house a children's hospital as well as expanded cardiovascular, neuroscience and oncology programs. The $99 million expansion project will increase the amount of space dedicated to pediatric medicine from 18,000 square feet to 87,000 square feet, and it is anticipated to open in the spring of 2009. Crouse Hospital also needs substantial capital investment in order to remain competitive. Many parts of Crouse are at least 30 years old. The hospital is in the early stages of an $88 million dollar capital campaign to upgrade its facilities.

The strategy of continuing to invest in these two separate yet adjacent entities with duplicative services can no longer be justified. An integrated organization will reduce the duplication of services across the two facilities (e.g., emergency departments, medical/surgical beds, operating rooms), consolidate the patient base for medical education, reduce administrative inefficiencies, and minimize capital investment. Medical education will be enhanced, and the combined entity should help the physician shortage across upstate New York.

Recommendation 2

Facility (ies)

Auburn Hospital (Cayuga County)

Recommended Action

It is recommended that Auburn Hospital downsize by approximately 91 beds to approximately 100 certified beds. It is further recommended that Auburn Hospital discontinue its obstetrical services and that these services be provided by other area hospitals.

Facility Description(s)

Auburn Memorial Hospital is a suburban community hospital in Cayuga County with 191 licensed beds. It offers emergency, medical/surgical and intensive care, psychiatry and obstetrics services. It has no outpatient services at the hospital site. It had approximately 6,508 discharges and 23,054 emergency visits in 2004. Approximately 40% of its admissions originated in the emergency department. The facility occupies a city block in a single building with wings dating from between 1920 and 1970. The hospital has an adjacent 80-bed nursing home, the Finger Lakes Center for Living, which is fully occupied. Its payor mix is comprised of 55% Medicare, 20% commercial insurance, and 16% Medicaid. The hospital had approximately 794 FTEs in 2003.

Assessment

Auburn Hospital is underutilized. Only 40-45% of its certified beds have been occupied in recent years; in 2004, it had just 41% occupancy of its certified beds. One-hundred beds are currently staffed, and its average daily census is 68. The hospital suffered loss of key staff and significant revenues were lost when inpatient care transitioned to outpatient settings.

Auburn is struggling financially. The hospital had a near break-even operating margin prior to 2003. In 2004, Auburn reported a loss of $3.1 million. In 2005, their operating loss increased to $5 million. The projected operating loss for 2006 is between $2 and $3 million. Its debt is approximately $50 million, including $19.5 million secured by Cayuga County, $5 million financing for the nursing home, $3.9 million line of credit from First Niagara Bank, a pension plan under-funded by approximately $20 million, and a $260,000 mortgage for an urgent care center. Auburn has no DASNY debt.

Auburn is implementing a fiscal stabilization plan to ameliorate its financial difficulties. It has retained a consulting firm for turnaround assistance, and is aggressively cutting costs.

Auburn should alter its current service mix. It has only 15 obstetrics beds and, according to the provider, performs approximately 300 births per year. These services are readily available at other area hospitals. The Commission recommends the elimination of obstetrics at Auburn because these services contribute to Auburn's financial problems, and the elimination of obstetrics will not create community access problems. Additionally, Auburn has a small complement of 14 psychiatric beds, of which, according to the hospital, only half are filled. Given the full occupancy of psychiatric beds in neighboring Syracuse, it is worth exploring whether these services can be more effectively organized on a regional basis.

Despite its small size and low utilization, Auburn should not be closed. The hospital is located 23 miles from the nearest hospital, which is in Syracuse, and is bordered on the west by Seneca County, which does not have a single hospital. Closure of the hospital would result in an increase in estimated average travel time for patients from 9 to 52 minutes. Auburn Memorial Hospital is necessary to preserve access to care.

Optimally, Auburn could close part of its physical plant to reduce fixed costs and reflect its actual staffing level. However, its physical configuration in a single, low-lying building makes this difficult to do. Auburn can enhance its physical plant by establishing more single bedded rooms that would be more attractive to patients, thereby helping increase its overall patient volume.

Recommendation 3

Facility (ies)

St. Joseph's Hospital (Chemung County)
Arnot Ogden Medical Center (Chemung County)

Recommended Action

It is recommended that Arnot Ogden Medical Center and St. Joseph's Hospital participate in discussions supervised by the Commissioner of Health to explore the affiliation of such facilities to end the medical arms race in Elmira that is expending scarce resources on duplicative services and progressively weakening both institutions. St. Joseph's pursuit of a relationship with the Guthrie Health System will not serve the best interests of the Elmira community. It is further recommended that the Commissioner refrain from either approving any applications that have been or will be filed by either facility or providing any other consent requested by either facility, prior to the conclusion of such discussions between Arnot Ogden Medical Center and St. Joseph's Hospital, as determined by the Commissioner of Health, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff. If either Arnot Ogden Medical Center or St. Joseph's Hospital fail to participate in such discussions in good faith, as determined by the Commissioner of Health, it is recommended that the Commissioner of Health close that facility and expand the other to accommodate the patient volume of the closed facility.

Facility Description(s)

Arnot Ogden Medical Center is a non-sectarian 216-bed, tertiary referral center in Elmira, which includes a heart institute, cancer center, diabetes center, health center for women, maternal and child health center, and an HIV primary care clinic. Arnot Ogden also provides level III neonatal care and level II trauma care. The next closest location for these services is approximately 70

miles away. The hospital has updated its facility, including an expanded emergency department that was completed in 2005. It has approximately 1,300 full-time equivalent employees.

St. Joseph's is a 224-bed Catholic acute care facility in Elmira that provides medical/surgical and physical medicine and rehabilitation services. The facility also provides inpatient and outpatient mental health, drug and alcohol services. The emergency department is approved to receive involuntary psychiatric admissions. St. Joseph's is an aging facility and requires investments in facility upgrades, including an upgraded emergency department. St. Joseph’s has approximately 800 full-time equivalent employees.

Both hospitals are located in the city of Elmira, approximately two miles apart.

Assessment

There is excess inpatient capacity in Elmira. The two hospitals each ran at an average daily census of approximately 137 patients in 2004. Respectively, they had occupancy rates of 63% at Arnot Ogden and 61% at St Joseph’s based on certified beds in that year. St Joseph’s operated 183 of their 224 certified beds, while Arnot Ogden operated all 216 of their certified beds. St. Joseph’s occupancy based on available beds was 75% in 2004.

St. Joseph’s is barely breaking even financially. From 2001 to 2003, St. Joseph’s reported negative profit margins with an average loss of -2%. It has invested between $1.5 and $1.8 million annually on technology and facility upgrades. Profit margins at Arnot Ogden are somewhat stronger than at St. Joseph’s, with an average loss of 0.5% for the period 2001 through 2003. Neither facility carries DASNY debt.

Competition for medical services has been particularly fierce between these two hospitals. Arnot Ogden has traditionally provided a full scope of cardiac services, including cardiac catheterizations. St. Joseph's submitted a certificate of need application for cardiac catheterization services, which was denied. Arnot Ogden also provides outpatient dialysis services, which is approximately 70% occupied. St. Joseph's submitted a certificate of need

application for similar dialysis services, which was approved. The local planning agency, the Finger Lakes Health Systems Agency, however, did not support the establishment of dialysis services at St. Joseph's.

Arnot Ogden and St. Joseph's attempted to merge approximately fifteen years ago. They resolved potential religious issues during the merger proceedings; however, the merger was ultimately unsuccessful due to their inability to resolve existing debt structure under a new entity.

St. Joseph's contacted Pennsylvania-based Guthrie Health three years ago about forming a partnership. Guthrie has secured a presence in New York's southern tier. Guthrie operates Corning Hospital, which is west of Elmira in Corning, New York, and a base of Guthrie Clinic physicians in practice sites throughout the Southern Tier. This outreach has impacted physician referral patterns in Elmira. Historically, physicians in the community have tried to maintain a balance between the two hospitals. Recently, Guthrie Clinic based physicians are admitting to St. Joseph's and referring specialty care to Robert Packer Hospital, a Guthrie-affiliated facility in Sayre, Pennsylvania that provides tertiary care. Admissions at Arnot Ogden have declined approximately 800 per year.

St. Joseph's announced in June 2006 its intention to form a collaborative partnership with Guthrie. Further collaboration between Guthrie and St. Joseph's will not fulfill the need for a single hospital in Elmira with common governance and management. The Commission believes that the Elmira community would be best served by an integrated provider with the capacity to rationalize services and ensure that health care needs are met within the community. Integration of Arnot Ogden and St. Joseph's would reduce the duplication of services across the two facilities (e.g., emergency departments, medical/surgical beds, operating rooms), reduce administrative inefficiencies, limit the medical arms race between the facilities, and ensure the continuation of health care availability in the area.

Recommendation 4

Facility (ies)

Albert Lindley Lee Hospital (Oswego County)

Recommended Action

It is recommended that Albert Lindley Lee Hospital close all of its 67 beds. It is further recommended that the hospital convert to an outpatient/urgent care center with Article 28 diagnostic and treatment center licensure.

Facility Description(s)

Albert Lindley Lee Memorial Hospital is a 67-bed acute care facility in the town of Fulton in Oswego County. The hospital offers medical/surgical and emergency care. A.L. Lee has approximately 321 full-time equivalent employees. Despite its small size, the facility is underutilized; roughly half its beds were empty in 2003. Certified and staffed occupancy at A.L. Lee was 56% in 2004. The hospital's operating margin was -2% from 2000 through 2003. A.L. Lee has (non-DASNY) long-term debt of approximately $4 million. The recent renovation of its emergency room and outpatient facilities cost approximately $3.4 million. More substantial renovations are required in order for the facility to remain up-to-date and competitive.

Assessment

A.L. Lee Hospital is in close proximity, approximately twelve miles, to Oswego Hospital. Oswego is larger and more modern and sophisticated than A.L. Lee. Oswego has 132 certified beds and provides a broad array of services, including inpatient obstetrics and a more comprehensive outpatient program. Oswego Hospital recently completed $35 million worth of capital renovations, including a new ambulatory surgery entrance, operating rooms, intensive care unit, maternity department and other upgrades. Oswego is also in reasonably strong

financial shape; it posted a positive 4.3% margin in 2003. A.L. Lee Hospital and Oswego Hospital had extensive merger talks, but these ended when A.L. Lee Hospital withdrew from the discussions.

There is excess inpatient capacity in Oswego County and no demonstrated need for two hospitals in the Oswego County area. The two hospitals had a combined total average daily census of 106 patients in 2004. The two hospitals have 199 certified beds, which, if were all located at one facility would be 72% occupied. A single facility will operate more efficiently and will have a larger patient volume which will allow it to offer more comprehensive services and improve quality of care. Oswego Hospital is the more appropriate location for this combined facility because it is larger and recently renovated, and because the population of Fulton, where A.L. Lee is located, continues to shrink.

Other hospitals in A.L. Lee's service area also could accommodate the patients when A.L. Lee closes. A.L. Lee's closure will not have a major impact on local physicians' ability to practice medicine because many have privileges at both A.L. Lee and Oswego Hospital

A health care facility in Fulton must remain to meet the outpatient and urgent care needs of the community. A.L. Lee provided approximately 47,000 outpatient visits in 2004. Patients using the facility will continue to need access to community-based primary care. Oswego Hospital's outpatient facility provided approximately 190,000 outpatient visits in 2004, and it is unclear if the existing facilities could accommodate the additional volume from A.L. Lee.

CENTRAL REGION

LONG-TERM CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

Van Duyn Home and Hospital (Onondaga County)
Community General Hospital's Skilled Nursing Facility (Onondaga County)

Recommended Action

It is recommended that Van Duyn Home and Hospital and Community General Hospital's Skilled Nursing Facility be joined under a single unified governance structure under the control of Community General Hospital, and downsize their combined number of RHCF beds by approximately 75.

Facility Description(s)

Van Duyn is a 526-bed residential health care facility located in Syracuse, owned and operated by Onondaga County. Van Duyn provides baseline services* and shorter-term care. It serves a key role in moving patients out of the hospital, including potential residents who are unlikely to be admitted to private facilities due to their Medicaid-pending status, which puts months of payment at risk for a provider.

* Baseline services are designated by operating certificate. A facility that provides baseline services offers all services required by federal and state regulations: nursing and medical care, which includes podiatry and opthamology, physical and occupational therapy, social services, recreational activities, dietician services, nutritional support, and personal care.

While Van Duyn has fairly high occupancy rate, ranging from 95% to 97% over the 2002 to 2004 period, the facility operates at a considerable operating loss. The projected deficit for Van Duyn in 2006-07 is $8 million, which is a significant burden on Onondaga tax-payers.

Van Duyn has a very low case mix index (1.02 in 2003, compared to an adjusted statewide average of 1.19), and 22% of its residents in 2001-2003 were designated as "PA" or "PB," which are the two lowest need levels by the resource utilization group (RUG) score. PA and PB residents have the greatest potential for placement in alternative community settings. Van Duyn may be filling some its beds with individuals who may be better-served in less-restrictive settings.

Van Duyn is on the same campus as Community General Hospital (CGH), which, in addition to providing acute care services, also houses a 50-bed skilled nursing facility (SNF). The Community General SNF also has a fairly high occupancy rate, which ranged from 94% to 96% over the 2002 to 2004 period. CGH receives a hospital-based SNF Medicaid rate. The CGH SNF's case mix index in 2003 was 1.02, which is relatively low, and between 2001 and 2003, 19% of its residents fell in the PA/PB category. At the same time, CGH needs space for its acute care plans, including private rooms.

Assessment

Both Van Duyn and the CGH SNF face constraints due to their physical plants. Van Duyn's building includes a long, double-loaded corridor, which impairs the staff's line-of-sight, and restricts social interactions and on-floor therapeutic activities. Some existing nursing home beds are unnecessary given Onondaga's Program of All Inclusive Care for the Elderly (PACE) and the growth of home- and community-based services in the county that could delay or avoid nursing home placement.

An integrated organization will reduce the duplication of services across the two facilities, reduce operating costs at Van Duyn, enable Van Duyn to receive a hospital-based reimbursement rate, and create an integrated continuum of care on the campus. Under Community General's

control, Van Duyn must continue its role as a leading provider of care serving hard-to-place populations including those patients with Medicaid-pending status. The reconfiguration and change of ownership is being developed with a consultant, and will require capital support.

Recommendation 2

Facility (ies)

Mercy of Northern New York (Jefferson County)

Recommended Action

It is recommended that Mercy of Northern New York downsize by 76 RHCF beds to 224 RHCF beds. It is further recommended that the facility add a 60-bed ALP, a 16-slot ADHCP and possibly other non-institutional services in the vacated Madonna building.

Facility Description(s)

Mercy of Northern New York (MNNY) is a voluntary, 300-bed residential health care facility in Jefferson County. The facility provides baseline services and a broader spectrum of services, including certified home care, renal dialysis, and ambulatory physical and behavioral health services. The facility emerged from bankruptcy in January 2006, and is developing plans to put itself on solid financial footing. MNNY suffers from relatively low occupancy, which ranged from 92% to 94% over 2002 to 2004, and a 90% Medicaid payor mix, which has reduced bed-hold revenue by several hundred thousand dollars each year.

MNNY has a low case mix index (1.09), and approximately 25% of its residents in 2001-03 were low-acuity. MNNY has questionable quality of care. It has been at the top of the *Consumer Reports* nursing home watch list for the past four years. The combination of low occupancy and

low revenue resulted in the facility providing nursing hours per resident per day significantly that was below statewide average, which in turn could hurt its quality of care and reputation.

Assessment

Jefferson County presents a compelling opportunity to shift long-term care resources from institutional to alternative settings. There is a small surplus of nursing home beds according to the need methodology. The county had an occupancy rate of less than 89% in 2004, and has a shortage of non-institutional alternatives. Jefferson has only 20 slots of non-institutional services per 1,000 seniors, which is significantly below the statewide average of 33 slots per 1,000 seniors. In particular, Jefferson County has no Medicaid assisted living program (ALP) beds, which may explain why so many low-acuity residents are in nursing homes.

MNNY has a viable plan for converting its Madonna Home into an ALP. It would house 15 units per floor, designed as a Green House model. This model includes the construction of homes for 6 to 10 elders who require skilled nursing care, and is designed to create a warm, welcoming community. By reducing its bed complement by 76 beds, MNNY should vacate one existing building on its campus, which should be renovated to house an ALP and adult day health care program (ADHCP) for approximately $1 million, for which the provider will arrange financing. MNNY already warehouses its empty beds for this purpose, and the process to vacate should take fewer than six months.

This recommendation will require the establishment of an adult home for the purposes of creating an ALP. We recommend that the Department expedite this unless quality and competence standards are not met.

Recommendation 3

Facility (ies)

Willow Point (Broome County)

Recommended Action

It is recommended that Willow Point downsize by between 83 and 103 RHCF beds to approximately 280 to 300 RHCF beds, rebuild its facility in a configuration that reflects today's therapeutic milieu, and add a 30-slot ADHCP.

Facility Description(s)

Willow Point is a 383-bed residential health care facility owned and operated by Broome County. It provides baseline services. While the facility enjoyed fairly high occupancy (96-98% in the 2002 to 2004 period), it is plagued by several problems. First, Willow Point is financially unstable and is a financial burden on the county. In 2000-02, it lost over $6.4 million. Second, the facility has quality problems. It had 12 survey deficiencies, which is significantly above the regional average of 5, and a few immediate jeopardy citations of life-threatening situations. Some of Willow Point's Medicare quality indicators fall well below statewide averages, including the percentage of residents in pain and who lose continence. The size and age of the Willow Point facility is inappropriate for skilled nursing care. Its long, double-loaded corridors inhibit interactions and do not provide today's therapeutic milieu.

Assessment

There is opportunity for resource shifts in Broome County. While the bed need methodology shows few surplus beds, the 2004 occupancy across the county was only 92.8%. In addition, the county still needs over 650 slots for non-institutional services, especially for adult day health care, for which only 20 slots exists for the entire county.

Because of the age, size, and physical layout of the facility, the Commission recommends that the facility be replaced with a modern, high-quality facility that houses multiple levels of care. The new facility should accommodate an ADHCP on the first floor, perhaps with additional space to expand if future needs warrant. The new facility should be opened for residents in approximately two-and-a-half to three years.

Recommendation 4

Facility (ies)

Lakeside Nursing Home (Tompkins County)

Recommended Action

It is recommended that Lakeside Nursing Home close, and that an 80-bed ALP, a 25-slot ADHCP and possibly other non-institutional services be added somewhere in Tompkins County by another sponsor, pending completion of an RFP process.

Facility Description(s)

Lakeside Nursing Home is a 260-bed propriety residential health care facility in Tompkins county. It provides baseline services. Lakeside does not offer a broad spectrum of services, and does not provide post-acute care or specialty services. Its case mix index was 1.05 in 2003.

Due to severe quality issues several years ago, the Department of Health arranged a receivership of Lakeside Nursing Home by Peregrine Health Management Company in 2000. Quality of care has improved under Peregrine's receivership, although the facility has appeared on the *Consumer Reports* watchlist for the past four years.

The facility operates under Chapter 11 bankruptcy protection, and maintains sizable debts, including to the State. It has had a large operating loss for a number of years. In 2004, the facility ran at less than 85% occupancy, and which has reached as low as 65%.

Assessment

Tompkins County has a documented excess supply of nursing home beds according to the bed need methodology. The county's nursing facilities as a whole operate at only 92.7% occupancy. Tompkins County has 28 non-institutional slots per 1,000 seniors compared to a statewide average of 33 slots per 1,000 seniors, and has no ALP beds or ADHCP slots within its borders.

Due to severe quality concerns and financial distress, Lakeside Nursing Home should close. In its place, the Department of Health should seek development via an request for proposal process of an 80-bed ALP and 20-30-slot ADHCP. Upon selection of a developer and operator, Lakeside should proceed to close.

Recommendation 5

Facility (ies)

United Helpers, Canton (St. Lawrence County)

Recommended Action

It is recommended that United Helpers, Canton downsize by approximately 64 RHCF beds to approximately 96 RHCF beds, rebuild its facility, and add a 48-bed ALP and possibly other non-institutional services.

Facility Description(s)

United Helpers Canton (UHC) is a 160-bed not-for-profit residential health care facility in St. Lawrence County. UHC has a sub-acute care program and provides outpatient physical therapy. United Helpers is part of a broader system that provides a full continuum of services, including independent living and adult home programs, and other skilled nursing facilities. UHC had a relatively high occupancy of 95% in 2004; however, nearly 30% of those beds in 2001-03 were occupied by low-acuity residents, some of whom could likely be served by an ALP if that were available.

Assessment

St. Lawrence County is over-bedded. The bed need methodology indicates a surplus of 158 nursing home beds. It has a dearth of non-institutional alternatives, including no ALP beds or ADHCP slots.

UHC proposed downsizing by 16 beds in its plans for a replacement facility, and to build state-of-the-art "pods" of 12 and neighborhoods of 48. The Commission recommends that UHC further downsize its RHCF beds and convert them to lower levels of care, for which is a significant unmet need in that community.

UHC should submit a certificate of need (CON) application for a replacement facility. UHC is working with a number of local organizations as it plans its replacement facility in Canton. This may include co-locating an on-site child day care center and hospice residence. The Commission recommends that this CON include a 48-bed ALP. No quality and competence issues are anticipated as the United Helpers system already owns and operates adult homes in New York.

HUDSON VALLEY REGION

ACUTE CARE RECOMENDATIONS

Recommendation 1

Facility (ies)

Kingston Hospital (Ulster County)
Benedictine Hospital (Ulster County)

Recommended Action

It is recommended that Kingston and Benedictine Hospitals be joined under a single unified governance structure, provided that Kingston Hospital continues to provide access to the reproductive services currently offered at such hospital at a location proximate to Kingston Hospital. It is recommended that the joined facility be licensed for approximately 250 to 300 inpatient beds. It is further recommended that the Commissioner refrain from either approving any applications that have been or will be filed by either facility or providing any other consent requested by either facility, prior to the execution by the facilities of a binding agreement to join under a single unified governance structure, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff. If Kingston and Benedictine Hospitals fail to execute such an agreement by December 31, 2007, it is recommended that the Commissioner of Health close one of the facilities and expand the other to accommodate the patient volume of the closed facility.

Facility Description(s)

Kingston Hospital and Benedictine Hospital are located in Kingston within blocks of one another. Benedictine, a community hospital sponsored by the Benedictine Sisters, is the larger facility of the two, and has 222 licensed beds. Kingston, a secular community hospital, has 145 licensed beds. Both hospitals provide medical/surgical, emergency, and obstetrics care, and run level I perinatal centers. The two hospitals had a similar number of inpatient discharges and emergency visits, but Kingston had significantly more outpatient visits than Benedictine. Kingston is affiliated with Margaretville Hospital, a federally-designated critical access hospital in Delaware County. Each of the hospitals has approximately 750 full-time equivalent employees.

Assessment

There are too many hospital beds in Kingston. Neither hospital is fully occupied; however, neither hospital can readily absorb all of the other hospital's patients. Sixty-nine percent of Benedictine's 176 available beds were occupied in 2004. Kingston operated all of its 145 certified beds, and had a 73.7% occupancy rate in 2004.

There is unnecessary and wasteful duplication of services in Kingston and in Ulster County. Both Kingston and Benedictine hospitals are designated stroke centers and level I perinatal centers. Both facilities operate emergency departments and provide medical/surgical and maternity care. Although Kingston Hospital has only 9 licensed maternity beds, they had 491 obstetrics discharges; Benedictine Hospital has 16 maternity beds, which is almost twice the number as Kingston, but performed only 376 births. Neither maternity program is financially viable at this low volume, and neither can afford to offer access to the specialized services and amenities that a larger combined program might afford.

Both institutions are financially precarious. In 2003, Kingston Hospital had a -10.4% operating margin; Benedictine's operating margin was -2.1%. Each of the hospitals has (non DASNY) long-term debt of approximately $25 million.

The institutions have drafted an unsigned memorandum of agreement to establish a parent corporation with broad powers over the two hospitals. The new corporation will become the sole corporate member of both hospitals, which will continue as separate and distinct corporations. Kingston Hospital will retain its identity as a non-sectarian institution, and Benedictine will continue to function as a Catholic hospital sponsored by the Benedictine Sisters, conforming to the Ethical and Religious Directives for Catholic Health Care Services. The proposed structure will allow for continued access to a full range of reproductive health services in Kingston.

Reconfiguration will improve the financial standing of both facilities, reduce duplication of services, allow for efficient future investments, and improve the organization's ability to meet the community's health care needs. This arrangement also offers a new model for merging sectarian and non-sectarian intuitions, which potentially could be replicated in other areas of the State.

Recommendation 2

Facility (ies)

Sound Shore Medical Center (Westchester County)
Mt. Vernon Hospital (Westchester County)

Recommended Action

It is recommended that Mt. Vernon Hospital downsize approximately 32 medical/surgical beds, and convert approximately 20 additional medical/surgical beds into a 20 bed transitional care unit. It is further recommended that Mt. Vernon Hospital convert approximately 24 additional medical/surgical beds into a 24 bed mentally impaired chemical abusers (MICA) unit, provided that the Commissioner of Mental Health and the Commissioner of Alcoholism and Substance Abuse Services approve such conversions. It is recommended that Sound Shore Medical Center

decertify approximately 9 pediatrics and 60 medical/surgical beds, and convert additional medical/surgical and obstetrics beds into 5 additional Level III NICU beds and 5 detoxification beds.

Facility Description(s)

Sound Shore Medical Center and Mt. Vernon Hospital are separately licensed facilities within the Sound Shore Health Care System, which also includes a 150-bed nursing home, school of nursing, adult day health program, and a Medicaid managed care organization. Both are teaching hospitals affiliated with the New York Medical College.

Sound Shore has 321 certified beds, of which 240 were staffed in 2004. It is an area trauma center, designated stroke center, comprehensive community cancer center and level III neonatal intensive care unit. Sound Shore has approximately 1,200 full-time equivalent employees.

Mt. Vernon Hospital has 228 certified beds, of which 164 were staffed in 2004. It offers medical/surgical services, and specializes in behavioral health services, including one of two psychiatric units in Westchester county approved to receive involuntary admissions of patients who may be an immediate danger to themselves or others. Approximately 47% of Mt. Vernon's patients come from medically underserved communities. Thirty-three percent of its inpatients were Medicaid-covered or uninsured, and 73% of emergency department visits were Medicaid-covered or uninsured in 2004. A large share of Mt. Vernon's approximately 600 employees reside in the local community, which has a substantial minority population.

Assessment

Sound Shore and Mt. Vernon entered into an affiliation agreement in 1996. Both hospitals share a common parent corporation with authority for strategic planning and system direction. Working through integrated leadership, the system succeeded in a financial turnaround of Mt. Vernon Hospital. According to Mt. Vernon, its operating margin in 2005 was $1.2 million. By affiliating, each hospital saves capital through economies of scale, service reconfiguration and

programmatic changes such as the consolidation of previously duplicative obstetrics departments at the Sound Shore campus and psychiatry departments at the Mt. Vernon campus.

The Sound Shore Health System should further rightsize and reconfigure its services by implementing the following changes:

- Mt. Vernon Hospital should decertify 32 medical/surgical beds, and convert another 44 medical/surgical beds to a 20-bed transitional care unit (a New York State pilot program) and a 24-bed mentally impaired chemical abusers (MICA) unit. Mt. Vernon's total bed complement will be reduced by 32 beds.

- Sound Shore Medical Center should decertify 9 pediatric and 60 medical/surgical beds, and convert additional medical/surgical and obstetrics beds to 5 additional level III neonatal intensive care unit beds and 5 detoxification service beds. Sound Shore's total bed complement will be reduced by 71 beds.

This restructuring plan eliminates excess capacity by converting beds for underused services to those for needed services, and consolidating service lines and reducing duplication between the hospitals. This restructuring plan will strengthen Mt. Vernon Hospital, which provides essential, accessible care to the residents of the medically underserved City of Mt. Vernon, and the hospital will continue to offer services designed to meet the particular needs of the local community, including emergency, medical/surgical, AIDS, psychiatry, transitional, behavioral and detoxification care.

Recommendation 3

Facility (ies)

Orange Regional Medical Center (Orange County)

Recommended Action

Contingent upon financing, it is recommended that Orange Regional Medical Center close its existing campuses and consolidate its operations at a new, smaller replacement facility that is downsized by approximately 100 beds to approximately 350 beds.

Facility Description(s)

Orange Regional Medical Center (ORMC) was formed in September 2002 by merging the Arden Hill Hospital in Goshen with the Horton Medical Center in Middletown. ORMC's two campuses are eight miles apart. The Arden Hill Hospital has174 licensed beds, and the Horton Medical Center has 276 licensed beds. ORMC provides inpatient medical/surgical, behavioral health and physical rehabilitation services, and outpatient services at 15 locations. Together with Bon Secours Hospital and St. Anthony Community Hospital, ORMC serves the western half of Orange County, and has a 38% market share of County discharges. The St. Luke's/Cornwall system largely serves the eastern half of the County and has a 25% market share of County discharges. Twenty-seven percent of discharges of county residents occur in other counties.

ORMC employs approximately 2,500 people, and is the largest non-governmental employer in Orange County. According to ORMC, its operating profit was $4 million in 2005, and it carries $54 million in outstanding debt. ORMC has clinical affiliations with NY-Presbyterian Hospital, Westchester Medical Center, and the New York University Hospital for Joint Diseases.

Assessment

ORMC's facilities upgraded its technologies, recruited additional physicians, and strengthened its financial position following the merger and system restructuring. Its services include diagnostic imaging, behavioral health, oncology, physical rehabilitation, and diagnostic cardiac catheterization.

ORMC should further rationalize its provision of care to meet the growing health care needs of its community, which is among the fastest growing counties in New York. The two existing hospitals are old and out-dated and cannot accommodate modern technology. Neither hospital has sufficient capacity to absorb the other. If the campuses were consolidated, ORMC would achieve economies of scale in its staffing, supplies, plant operations and equipment.

ORMC acquired a 61-acre site to construct a smaller facility than the two hospitals with approximately 350 licensed beds. The site is located between the existing campuses and at the intersection of major roads. The cost to construct and establish this new facility is approximately $250 million. In addition, the system requires approximately $54 million to retire its outstanding debt. Despite its positive margin, ORMC's creditworthiness relative to other hospitals nationally is low, and it has limited access to capital in the private markets.

Recommendation 4

Facility (ies)

Community Hospital at Dobbs Ferry (Westchester County)

Recommended Action

It is recommended that Community Hospital at Dobbs Ferry close in an orderly fashion.

Facility Description(s)

Community Hospital at Dobbs Ferry (CHDF) is a small general hospital. It has 50 certified beds, 30 of which are operational. It had an average daily census of only 20 inpatients in 2004. CHDF provides only basic medical/surgical services; it does not provide obstetric, pediatric or psychiatric care. It specializes in short-stay surgery, of which it performs approximately 3,000 procedures per year. The hospital's emergency room provided nearly 9,000 visits in 2004. CHDF is located in an affluent suburb, and the majority of the town's residents have commercial insurance or Medicare. The community supports the hospital with fundraising efforts, most recently to support the renovation of its emergency room. The hospital has approximately 150 full-time equivalent employees.

The hospital had many years of operating losses and defaulted on federal loans twice. Riverside Health Care System (Riverside) acquired CHDF at auction for $4.6 million. Riverside operates two acute-care campuses in Yonkers, St. John's Riverside Hospital and the Park Care Pavilion. CHDF operates under a management contract with St. John's Riverside, which also serves as its passive parent.

Assessment

Community Hospital at Dobbs Ferry performs poorly on the Commission's criteria. It has extremely low utilization, provides no specialized services, provides very little care to vulnerable populations, and makes only a small economic contribution to the region's economy. CHDF had approximately 1,696 discharges in 2004. In 2004, only 5% of its inpatients had Medicaid coverage or were uninsured, and 6% of its patients came from medically underserved areas. It has 50 certified beds and an average daily census of approximately 20 patients.

Community Hospital at Dobbs Ferry is a prime example of excess capacity, which the Commission was charged to eliminate. Excess capacity jeopardizes quality of care by dispersing patients over too many institutions, induces unnecessary and costly utilization of services, and causes needless and duplicative capital investment.

Analysis performed by the Commission indicates that patients who currently use CHDF readily could be absorbed within reasonable travel times by neighboring institutions, including St. John's Riverside, Westchester Medical Center, White Plains Hospital and Phelps Memorial Hospital, all of which provide more comprehensive ranges of services. Those urgent/emergent patients using CHDF's emergency department could similarly be absorbed by neighboring hospitals within acceptable travel time limits.

CHDF is only 3 miles north of the St. John's Riverside Andrus site in Yonkers. It has been asserted that surgeons using CHDF do not practice at St. John's Riverside, and would not transfer their business there because of physician and patient preference to avoid Yonkers. The Commission does not find this a convincing argument for maintaining the Dobbs Ferry site. A hospital should not remain open in order to serve the convenience of a small number of physicians.

While CHDF lost money for fifteen straight years, Riverside's CEO reported that revenue generated by CHDF resulted in approximately $700,000 profit to the Riverside system in 2005, and that CHDF absorbed approximately $2 million per year in system overhead expenses. It is uncertain whether CHDF will continue to generate profit for Riverside, especially given its prior chronic losses. The Riverside system is sustainable without the financial contributions of Dobbs Ferry. Furthermore, environmental changes will make positive contributions to Riverside's bottom line. NY State is in the process of approving a certificate of need application for a cardiac catheterization lab that Riverside estimates will ultimately generate approximately $2.5 million in total annual revenues. Reimbursement changes by Medicare will also positively affect Riverside's financial condition.

While the Commission is concerned with the financial viability of the Riverside system, it is not persuaded that an unnecessary hospital should remain open simply to subsidize other hospitals. The argument that we should sustain a hospital that scores so poorly under the Commission's analytic framework in order to shore up another hospital is not supportable within the

Commission's charge, which specifically targets opportunities to rightsize the health care delivery system in order to best meet community health care needs.

Recommendation 5

Facility (ies)

Westchester Medical Center (Westchester County)

Recommended Action

It is recommended that Westchester Medical Center evaluate the clinical and financial viability of reestablishing the Fareri Children's Hospital as an independent entity and determine the impact of such change on access to and quality of care in the Hudson Valley region as well as the impact on both the Medical Center and the Children's Hospital. It is further recommended that Westchester Medical Center conduct a strategic planning process to evaluate its clinical service mix and identify opportunities for reconfiguration that is non-duplicative of services in community hospitals.

Facility Description(s)

Westchester Medical Center (WMC) is an academic medical center affiliated with the New York Medical College in Valhalla. It is the Hudson Valley region's specialty referral center for all tertiary and quaternary levels of care, including organ transplantation. It has the region's only level 1 trauma center, the region's only burn center, the Fareri Children's Hospital, and the state-funded regional resource center for training and preparedness against terrorist attacks and natural disasters.

WMC provided approximately 23,809 discharges, 25,868 emergency visits and 145,290 outpatient visits in 2004. Thirty-one percent of its inpatients and 39% of its emergency

department admissions were Medicaid-covered or uninsured in 2004. WMC reported that 90% of its 635 certified and available beds are occupied. WMC's children's hospital has 120 beds and is fully occupied. WMC has approximately 4,000 full-time equivalent employees across all of its facilities.

WMC is operated by the Westchester County Health Care Corporation, (WCHCC) a public benefit corporation established by New York State in 1997 to assume the function of Westchester County's Department of Hospitals. WCHCC financed itself by issuing serial bonds backed by Westchester County. According to a transition agreement with WCHCC, the County has guaranteed debt to finance WCHCC's working capital so long as WCHCC meets certain performance measures. If WCHCC does not meet these performance measures, the County can compel WCHCC to hire consultants to evaluate and possibly restructure its fiscal affairs, and must offer its recommendations to the County government.

Assessment

The vision of WMC is to serve as a non-duplicative, tertiary referral center for all counties in the Hudson Valley. Although community hospitals have increased their provision of tertiary services, this goal has been largely realized. Today, WMC has among the highest case mix indexes in New York State, which reflects the acuity level of its patients.

WMC has had significant operating and financial problems following its conversion to a public benefit corporation. WMC's operating deficits from 2001 to 2004 total $207 million. These losses triggered an audit by the State government, management changes, hiring of a consultant, and implementation of a financial recovery plan. The current executive management team has competently reduced costs and improved the facility's financial viability. It is renegotiating its contracts with commercial payers to increase payments to the facility. WMC projects a $22 million surplus in 2006, made possible in part due to a county subsidy of approximately $55 million. In addition, WMC recently received the State's commitment to increase its Medicaid payments by $75 million over three years. Independent agencies have raised their ratings of WMC's debt.

WMC's recent fiscal stabilization enables the facility to make clinical and structural changes that could further strengthen the institution. It is especially critical to evaluate the optimal relationship between WMC and the Children's Hospital. Currently, the facilities are fully integrated financially, operationally, and managerially. Of $270 million in total outstanding bonds at WMC, approximately two-thirds - $140 million - is attributable to the Children's Hospital. It has been estimated that the annual operating loss of Children's Hospital is approximately $20 million, or roughly one-third of the total annual operating loss at WMC in 2005. WMC must undertake a comprehensive evaluation of the feasibility of establishing Children's Hospital as an independent facility. Furthermore, WMC must proceed with a strategic planning process to assess their clinical portfolio and their position in the market.

HUDSON VALLEY REGION

LONG-TERM CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

The Valley View Center for Nursing Care and Rehab (Orange)

Recommended Action

It is recommended that Valley View Center for Nursing Care and Rehab downsize by approximately 160 RHCF beds to approximately 360 RHCF beds and add an 80-bed ALP, a 30-slot ADHCP and possibly other non-institutional services in the vacated building. In the remaining buildings, it is recommended that the facility convert 50 RHCF beds to a 20-bed ventilator-dependent unit and a 30-bed behavioral step-down unit.

Facility Description(s)

The Valley View is a 520-bed residential health care facility, owned and operated by Orange County. The facility provides baseline services, locked dementia care, an expanding and successful short-term rehabilitation program, and an 8-bed AIDS care center that has been entirely unoccupied since 2003. It coordinates closely with the county's long-term home health care program.

With a new administrator in place, Valley View has over 95% occupancy of its staffed beds, and it has a high case mix index (1.16). It had 17 deficiencies compared to a regional average of 5, but no immediate jeopardies. Valley View's faces significant financial problems. It has lost over

$1 million per year in operations, and had a loss of $2.6 million in 2002. The facility's labor contract requires greater than 50% benefits and includes staff maintenance restrictions.

Valley View operates two buildings, including the Perry building that houses 160 beds with shared bathrooms. Valley View has eliminated beds from the Perry building and intends to close it as soon as feasible.

Assessment

Orange County's population has grown significantly. While the county has a documented bed need of 388 additional nursing home beds, the existing providers are only 92% occupied. Moreover, the county has large unmet need for non-institutional services, particularly ALP beds and ADHCP slots. With more non-institutional options available in the county, the long-term care system will be better balanced for the future population growth.

The Perry building should be closed and converted to accommodate an ALP and ADHCP.

Recommendation 2

Facility (ies)

Andrus-on-Hudson (Westchester)

Recommended Action

It is recommended that Andrus-on-Hudson downsize all 247 RHCF beds and add 140 ALP beds and possibly other non-institutional services.

Facility Description(s)

Andrus-on-Hudson is a not-for-profit, 247-bed residential health care facility that provides baseline and sub-acute services in Westchester County. Its board of trustees tried for seven years to convert their campus into a continuing care retirement community (CCRC), with independent apartments and 48 SNF beds, but was denied building rights by the town of Hastings. They currently have 176 beds occupied (71% of its certified beds, or 89% of "available beds," pending a 50-bed sale to another provider). The facility had been operating at a significant loss until 2006, and receives financial support from the Andrus Family Foundation. The home owes the foundation $13 million, but that sum may not be exchanged. The facility claims that it is now operating in the black.

Andrus-on-Hudson has one of the lowest case mix indexes in the State (0.91). Of their 176 residents, about half have low-acuity conditions. These residents could be better served in an ALP, if that were available. The physical plant is old and in need of capital improvements. The facility has private rooms and baths; and therefore, its conversion to an ALP facility would be economical. The facility has a history of a high number of deficiencies (26 in its 2005 survey), many of which are attributable to the building's deteriorating condition.

Assessment

There are opportunities to shift resources from institutions to other settings in Westchester County. The State's bed need methodology shows an excess of 653 beds. There are over 1,000 PAs and PBs in the existing beds, and county occupancy was only 88% in 2004. There are too many nursing home beds and not enough appropriate residents in Westchester nursing homes. At the same time, Westchester has an unmet need for approximately 1,100 non-institutional slots.

The optimal direction would be to build new ALP homes on the Andrus campus. Should that not be feasible, the Commission recommends a floor-by-floor renovation of the existing building to create ALP apartments and common space out of the nursing floors.

Recommendation 3

Facility (ies)

Taylor Care Center (Westchester)

Recommended Action

It is recommended that Taylor Care Center downsize by approximately 140 RHCF beds to approximately 181 RHCF beds.

Facility Description(s)

Taylor Care Center (TCC) is operated by the Westchester Public Health Corporation, which also operates the Westchester Medical Center. TCC is a 321-bed residential health care facility which provides baseline services, and has a 27-bed ventilator-dependent care unit. TCC offers distinctive sub-acute care for individuals with complex medical needs. The facility fills 42 beds with these complex sub-acute residents, referred by Westchester Medical Center, St. John's Hospital, White Plains Hospital, Montefiore Hospital, and Columbia-Presbyterian Hospital. TCC is licensed for an additional 252 beds, but staffs only 156. Its occupancy rate based on certified beds is only 79%, assuming all 156 staffed are occupied.

TCC has a high case mix index (1.25), and provides solid quality of care. TCC houses 10 uncompensated residents. Very few nursing homes, even county-financed nursing homes, have more than 1 or 2 residents on charity care. Due to its high-intensity care and several uncompensated cases, TCC operates at a significant loss of $6 million per year, which is down from as much as $13 million in previous years.

Assessment

Both the bed need methodology results and the 88% county-wide occupancy provide evidence that Westchester County is over-bedded. TCC in particular competes with some high-quality nursing homes who are finding it difficult to keep their beds filled. Downsizing TCC will strengthen a number of other facilities in the county.

Recommendation 4

Facility (ies)

Achieve Rehabilitation (Sullivan)

Recommended Action

It is recommended that Achieve Rehabilitation downsize by approximately 40 RHCF beds to approximately 100 RHCF beds.

Facility Description(s)

Achieve Rehabilitation is a 140-bed residential health care facility in Sullivan County, providing baseline services. Challenges at the facility include:

- Low occupancy. Only 89% of its beds were occupied in 2004, which, according to its administrator, has not increased since then.
- Quality of care. Achieve had 16 survey deficiencies, including two level 3, actual-harm deficiencies. The regional average for total deficiencies is 4. In addition, Achieve has a much higher rate of substantiated complaints than the statewide average.
- Low acuity. Over one-quarter of Achieve's residents have low-acuity conditions. Some of these residents could be served in a less-restrictive setting.

Assessment

A downsized facility could devote additional resources to solve or mitigate its substantial quality of care problems. Closure of Achieve is impractical because there would be an insufficient number of nursing home beds in Sullivan County should Achieve close. There are only four nursing homes in Sullivan County, and there is a documented deficit of 137 beds in the county according to the state need methodology. The other three nursing homes in the county have very high occupancy rates.

Recommendation 5

Facility (ies)

Sky View Rehabilitation and Health Care Center (Westchester)

Recommended Action

It is recommended that Sky View Rehabilitation and Health Care Center close, downsize or convert, contingent on the determination of the Commissioner of Health, after a comprehensive review of the facility in light of the Commission's analytic framework, that such closure, downsizing or conversion would be consistent with the mandate and other recommendations of the Commission.

Facility Description(s)

Skyview Rehabilitation and Health Care Center is a 192-bed proprietary residential health care facility that provides baseline services in Westchester County. It had an occupancy rate of 93% in 2004. Skyview faces quality and viability issues.

Assessment

This facility was identified as a facility of interest based on the Commission's criteria. The Regional Advisory Committee and Commission repeatedly contacted the administrator of this facility, but have received no response to date. Given the facility's location in the well-served northwest of Westchester, closure, downsizing or conversion may be warranted. The Commissioner's review should be completed by June 30, 2007, and any closure, downsizing or conversion should be completed by June 30, 2008.

LONG ISLAND REGION

ACUTE CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

Eastern Long Island Hospital (Suffolk County)
Southampton Hospital (Suffolk County)
Peconic Medical Center (Formerly Central Suffolk) (Suffolk County)
Brookhaven Memorial Medical Center (Suffolk County)
University Hospital at Stony Brook (Suffolk County)

Recommended Action

It is recommended that Eastern Long Island Hospital, Peconic Medical Center, and Southampton Hospital be joined in a single unified governance structure with full authority to develop a strategic plan which restructures the hospitals to ensure access to services, rationalize bed capacity, minimize duplication of services, create management efficiencies and develop an integrated health care delivery system for the North and South Forks, Riverhead and the communities immediately to the west. It is further recommended that the Commissioner refrain from either approving any applications that have been or will be filed by any of the facilities or providing any other consent requested by any of the facilities, prior to the execution by the facilities of a binding agreement to join under a single unified governance structure, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff.

It is recommended that these hospitals develop an affiliation with University Hospital at Stony Brook in order to gain access to tertiary care services and the other benefits inherent in relationship with an academic medical center.

It is recommended that Brookhaven Memorial Hospital continue joint planning with the three East End hospitals, and explore becoming part of the new entity.

It is further recommended that the hospitals implement the following bed and service reconfigurations:

Southampton Hospital, currently certified for 168 beds, should downsize its certified bed capacity to 125, to be comprised of 103 medical/surgical, 3 pediatric, and 19 obstetrics, for a reduction of 37 medical surgical and 6 pediatric beds.

Brookhaven Memorial Hospital, currently certified for 321 beds, should increase its certified bed capacity to 326, to be comprised of 262 medical/surgical, 14 obstetrics, 10 pediatric, and 40 psychiatry, for a reduction of 10 obstetrics and 5 pediatric beds, and an addition of 20 psychiatry beds.

Eastern Long Island Hospital, currently certified for 80 beds, should expand its certified bed capacity to 85, to be comprised of 37 medical surgical, 5 alcohol detox, 23 psychiatry, and 20 alcohol rehabilitation, for an addition of 5 psychiatry beds.

Peconic Bay Medical Center, currently certified for 154 beds, should downsize its certified bed capacity to 140 beds, comprised of 114 medical/surgical, 8 obstetrics, and 18 physical medicine rehabilitation beds, for a reduction of 32 medical surgical beds, and a transfer of 18 certified physical medicine rehabilitation beds from University Hospital at Stony Brook.

University Hospital should downsize 18 certified, but not available physical medicine rehabilitation beds. These 18 beds should be added to Peconic Bay Medical Center.

Facility Description(s)

The "East End" hospitals, Eastern Long Island, Peconic, and Southampton hospitals, historically have served the easternmost part of Long Island, including the south and north forks, Riverhead, and communities immediately to their west. Brookhaven Memorial is close to the East End hospitals, located on the south shore of Suffolk County. Recent changes in the area's demographics, including a 7% growth in population in the four hospitals' joint service area, has prompted a four-way joint planning effort to meet the needs of their shared community.

(2004 data)	**Eastern Long Island Hospital**	**Peconic Hospital**	**Southampton Hospital**	**Brookhaven Hospital**
Certified Beds	80	154	168	321
Staffed Beds	80	154	120	251
ADC	62	74	69	231
Discharges	3,084	6,079	6,844	14,254
ED Visits	7,980	23,809	24,886	58,832
Operating Margin (2003)	-1.6%	-0.3%%	-3.4%	0.4%
% Medicaid/Uninsured	24%	17%	15%	20%
FTE	267	621	639	1,452

Eastern Long Island, Peconic and Brookhaven hospitals are clinically affiliated with SUNY Stony Brook. Southampton Hospital is developing a similar affiliation. Each of the hospitals has an active, supportive relationship with Suffolk County's network of health centers that serve as the outpatient healthcare safety net in Suffolk.

All four hospitals provide medical/surgical and emergency services. Peconic, Brookhaven and Southampton hospitals provide obstetric and pediatric services. Eastern Long Island Hospital has expertise in psychiatry and substance abuse services. Brookhaven Memorial, the largest of the four institutions, has an approved certificate of need to build a diagnostic cardiac catheterization lab.

Assessment

Because of the topography of the East End, the distribution of population, and distance and drive times between the hospitals, particularly in summer, access to emergency and acute inpatient care must be maintained at all three locations. None of the East End hospitals is a viable candidate for closure.

The size of the East End's population, however, makes it impracticable to maintain three small, independent community hospitals, all of which aspire to provide a comprehensive range of health services. Competition for patient volume in this sparsely populated area further will clinically and financially weaken two and possibly all three hospitals. It is imperative to rationalize and consolidate service delivery to improve the hospitals' quality of care and fiscal standing.

The three East End hospitals, together with Brookhaven Memorial Hospital, have developed a proposal to reconfigure services and joint governance. Given this proposed cooperative venture, the hospitals have withdrawn certificate of need applications for competitive services. The detailed plan includes: the growth of centers of excellence in obstetrics, primarily at Southampton and Brookhaven hospitals, with a smaller program at Peconic hospital, an expanded behavioral health program at Eastern Long Island and Brookhaven hospitals that will serve all four hospitals, additional physical medicine rehabilitation services at Peconic Bay to serve all four hospitals, overall reductions in medical/surgical and pediatric bed capacity at all four hospitals. Additionally, the hospitals recognize the need for expanded outpatient services.

Three of the hospitals developed a collaborative relationship, the Peconic Health System (PHS), in 1997, but they dissolved this relationship in 2006. PHS disbanded because there was a lack of capital for investment, and the hospitals ultimately disapproved of its governance structure. The lack of capital restrained the system from making required investments to rationalize services and from realizing economies of scale. In addition, the PHS board of directors required supermajority ratification process for many proposals, and had insufficient delegatory powers from the individual hospital boards that had remained in place. This structure made it difficult for

meaningful change to occur; therefore, the interests of the individual hospitals were favored over the collective interests of all the East End hospitals.

The current four-member planning group has hired a consultant to propose the most effective governance structure for the new entity. The Commission believes that this new governance structure should include representation not only of the founding members, but also of other community members who did not serve as a trustee of any of the hospitals and who share a broad definition of the communities to be served.

University Hospital at Stony Brook and these community hospitals have conducted discussions to form a larger health network. The community hospitals would gain Stony Brook's assistance as an academic, tertiary partner, thereby improving the provision of care to Suffolk residents. These discussions should continue. Patients must have access to tertiary services that cannot be efficiently provided at a community hospital. University Hospital, as the regional academic health center, should assume this role.

Recommendation 2

Facility (ies)

University Hospital at Stony Brook (Suffolk County)

Recommended Action

It is recommended that University Hospital at Stony Brook be given the operational and governance freedom to enter into meaningful partnerships with other hospitals so as to create a health care delivery system that will better serve the needs of the region.

Facility Description(s)

University Hospital at Stony Brook is Suffolk County's only academic medical center and its only tertiary care provider. At 504 certified beds, it has the county's only open heart surgery program, comprehensive cancer center, comprehensive epilepsy center, and level III neonatal intensive care unit. The hospital has a level I trauma center. It had approximately 29,954 discharges, 64,727 ED visits and 269,815 outpatient visits in 2004. Medicaid-covered and uninsured patients represented 22% of its discharges and 32% of its emergency department admissions. University Hospital at Stony Brook had approximately 4,055 full-time equivalent employees in 2003.

Assessment

University Hospital at Stony Brook is an important regional provider of tertiary health services, and a health care delivery leader in Long Island. It has not sufficiently strengthened its relationships with surrounding community hospitals. As a publicly financed academic medical center, University Hospital must enter into health system partnerships with other hospitals to strengthen its regional role. Compared with University Hospital, the two other SUNY hospitals in Syracuse and Brooklyn have relatively stronger ties to their neighboring community hospitals.

The Commission recognizes the overarching importance of the provision of medical education at the University. University Hospital should continue align itself with SUNY, but also have the operational and governance independence to enter into meaningful partnerships with other hospitals so as to create a health care delivery system that will better serve the needs of the region. The intellectual and financial assets of University Hospital, which include the expertise of its staff, the depth of its clinical programs, and the hundreds of millions of dollars already invested in equipment and facilities, must be leveraged for a greater good. The failure to expand University Hospital's regional role would result in a lost opportunity to better serve the residents of Long Island and strengthen the community hospitals upon which it is dependent for referrals. In addition, a failure to create a stronger relationship may encourage community hospitals to pursue the development of alternatives with other health systems, which may diminish

University Hospital's regional influence and increase the likelihood of the need to subsidize the hospital, which is a burden that will ultimately fall on all New York State taxpayers.

Recommendation 3

Facility (ies)

St. Charles Hospital (Suffolk County)
J.T. Mather Memorial Hospital (Suffolk County)

Recommended Action

It is recommended that St. Charles Hospital downsize 77 medical/surgical beds, convert the remaining 37 medical/surgical beds to psychiatric and alcohol detoxification beds, provided that the Commissioner of Mental Health and the Commissioner of Alcoholism and Substance Abuse Services approve such conversions, and discontinue its emergency department. It is further recommended that J.T. Mather Memorial Hospital convert all 37 of its psychiatric and alcohol detoxification beds to medical/surgical beds, provided that the Commissioner of Mental Health and the Commissioner of Alcoholism and Substance Abuse Services approve such conversions. It is further recommended that the Commissioner refrain from either approving any applications that have been or will be filed by either facility or providing any other consent requested by either facility, prior to the implementation of the foregoing service reconfiguration, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff.

Facility Descriptions

These two hospitals are located less than a mile apart on adjacent parcels of property in the town of Port Jefferson. Their location in Suffolk County is not easily accessible, as Port Jefferson is a

distance north from the Long Island Expressway, which is the major thoroughfare in Nassau and Suffolk Counties.

J. T. Mather is a free-standing community hospital with 248 certified beds. St. Charles is a member of the Catholic Health Services of Long Island with 289 certified beds.

St. Charles' services include physical medicine and rehabilitation, obstetrics, alcohol rehabilitation, orthopedics, general medical/surgical services and pediatric beds, several outpatient rehabilitation centers and an emergency department. J.T. Mather focuses on acute medical/surgical care and also maintains 37 beds for psychiatry and alcohol detoxification. In addition to general medical/surgical beds, both hospitals operate emergency departments. The Mather emergency room volume is approximately twice that of St. Charles. Perhaps reflecting their differences in clinical configuration, Mather's uncompensated care cost was $21,216,477 versus St. Charles' uncompensated care of $1,789,004.

Mather Hospital generated a modest surplus from operations for the past several years, but is now reporting operating losses and declining utilization. St. Charles has fiscally stabilized, reduced expenses, and has operated at essentially break even for one year, following several years of significant operating losses. Information supplied by St. Charles showed bottom line losses as follows: $25 million in 2000, $24.5 million in 2001, $12.6 million in 2002, $8 million in 2003, $8.9 million in 2004, and $614,000 in 2005. St. Charles has debt service costs on $72 million, of which $69.1 is DASNY debt. Mather has debt service costs on $32.2 million, $28.3 million of which is DASNY debt.

Both hospitals have suffered volume losses from program investments made by SUNY University Hospital at Stony Brook and from shifts in physician participation in insurance plans. In this area, discharge volumes are decreasing at Mather, St. Charles and St. Catherine of Siena while Stony Brook is experiencing an increase in discharges.

Mather and St. Charles share a common medical staff. Each of the hospitals employs approximately 1,300 full-time equivalents.

Assessment

In the past, these hospitals voluntarily created an alliance to distribute services so that both could survive and focus on niche roles to better serve their communities. The goal of the Mather - St. Charles Health Alliance was to avoid the competitive duplication of costly services and technologies and permit more resources to be invested in clinical program development. It was also structured to accommodate the Ethical and Religious Directives for Catholic Healthcare Organizations. Mather focused on acute medical/surgical services and St. Charles pursued a specialty rehabilitation hospital strategy in addition to operating orthopedic and obstetrical services. Duplication however remains for medical/surgical and emergency services and other services, such as behavioral health, are split between the facilities.

In recent years, reimbursement reductions and the movement of care from inpatient to ambulatory and niche providers have created an imbalance in the Alliance which makes it difficult to maintain and build on the relationship. There is pressure on both hospitals to continually invest in facilities and technology to remain competitive. Recently, for example, both hospitals launched competitive bariatric surgery programs. Competition for medical/surgical services, including orthopedics and neurosurgery, is ongoing.

The debt of St. Charles Hospital is part of the obligated group for the Catholic Health Services of Long Island (CHS). The CEO of CHS has proposed a new strategy for St. Charles focusing on the niche services of acute rehabilitation, obstetrics, alcohol rehabilitation, hospice, and other specialty programs. Accordingly, CHS recently moved substance abuse beds from Mercy to St. Charles. It was reported by CHS leadership that there are financial issues facing several of the other CHS hospitals so it is preferable to continue to operate St. Charles as a niche provider rather than to cease operations.

The Commission believes that the goals of the previously constituted Alliance between the two hospitals as it was envisioned approximately 10 years ago represents the most feasible approach to meeting the health care needs of the community. Market changes, competition for

medical/surgical services and the influence of Stony Brook have created challenges to meeting these goals. Although only one full service hospital is theoretically required to meet community needs, both Mather and St. Charles have been the beneficiaries of substantial capital investment. The proposed action will create one such full service hospital operated between two campuses and two sponsors.

The duplication of medical/surgical services in Port Jefferson must be eliminated to end the medical arms race for those services, avoid expending scarce resources, and prevent the progressive weakening of both St. Charles and Mather. With this realignment of beds and services, both hospitals will continue to serve the market without duplication and can develop and provide complementary, non-duplicative clinical programs into the future. In particular, St. Charles should pursue development of its plans for niche services for rehabilitation, obstetrics, psychiatry, alcohol rehabilitation, palliative care and hospice and can pursue its desire to utilize remaining excess facilities for other than Article 28 services. J.T. Mather should enhance its position as the main acute care hospital with the emergency department and free up its behavioral health and alcohol detoxification beds to accommodate the medical/surgical needs of the local community.

Recommendation 4

Facility (ies)

Nassau University Medical Center (Nassau County)

Recommended Action

It is recommended that Nassau University Medical Center downsize its certified capacity of 631 to 530 certified beds, to be comprised of 173 medical/surgical, 26 pediatric, 30 obstetrics, 25 physical medicine rehabilitation, 120 psychiatry, 13 child psychiatry, 20 alcohol detoxification,

30 substance abuse rehabilitation, 10 burn care, 33 intensive care, 6 pediatric intensive care, 28 NICU, and 16 prison health beds. This represents a downsizing of 133 medical/surgical, 20 pediatric, 6 obstetrics, 5 physical medicine/rehabilitation, and 10 NICU beds, together with an addition of 30 psychiatry, 13 child psychiatry, and 30 substance abuse rehabilitation beds, provided that the Commissioner of Mental Health and the Commissioner of Alcoholism and Substance Abuse Services approve such additions.

Facility Description(s)

Nassau University Medical Center, a 631-bed community teaching hospital, is part of the Nassau Health Care Corporation (NHCC), which also includes the A. Holly Patterson Extended Care Facility (AHP), an 889-bed skilled nursing facility, and six Article 28 diagnostic and treatment centers that are located in communities with high health care needs.

NUMC is the principal safety net hospital for low income and uninsured residents of Nassau County. Located in East Meadow in central Nassau County, the Medical Center had approximately 22,728 discharges 75,022 emergency department visits, and 196,398 outpatient visits in 2004. Medicaid-covered and uninsured patients represent 51% of discharges and 57% of emergency department admissions. The Medical Center had approximately 3,019 full-time equivalent employees in 2003.

NHCC receives a substantial subsidy from Nassau County to compensate it for the major role it plays in providing acute care access to many Nassau County communities with documented health disparities and large proportions of low income or underinsured residents. NHCC was created to assist Nassau County in addressing a budget shortfall by purchasing the assets from the County and transferring those assets to a newly formed public benefit corporation. NHCC financed the purchase with additional debt that was guaranteed by Nassau County. The establishment of a public benefit corporation was also intended to provide increased flexibility to operate the constituent facilities free of government-owned restrictions.

Assessment

NUMC has faced great challenges and obstacles before and since it achieved financial stability in 1999, when its ownership was transferred from the county to NHCC. Unstable leadership and shifting strategies have punctuated its precarious operating history. NUMC operates in the same competitive marketplace as do other Long Island hospitals, but it is burdened by operational constraints due to the county's prior ownership. The increased debt load, which is secured by Nassau County funds, coupled with a disproportionately heavy Medicaid payor mix, has intensified government oversight and involvement. Accordingly, the Nassau County government retained consultants to help stabilize NHCC's finances, and has recently appointed new management and governance of NHCC.

The continued existence of NUMC as an acute care hospital is critical to the residents of Nassau County; it is the county's main safety net provider. Poverty in NUMC's primary service area is almost double the rate in the county overall. Compared to other Long Island hospitals, NUMC's patients are disproportionately racial minorities and are foreign-born, non-English speaking residents. According to NUMC, it had over 50% of all Medicaid inpatient discharges from Nassau County hospitals. While other providers in Nassau County play an important role in providing access to Medicaid, uninsured and underserved populations, many of these hospitals operate their staffed beds at relatively high occupancy rates and have long wait periods in their emergency departments for inpatient beds. If NUMC were to close, neighboring hospitals could not absorb NUMC's 75,000 emergency visits and approximately 21,000 inpatient admissions.

The leadership of NHCC understands that it must redefine its mission and develop appropriate strategies given its and its competitors' fiscal and operating situations. NHCC developed a plan that redefines its mission and strengthens its core clinical services. In July 2006, NHCC negotiated a $40 million bail-out plan with the State, including an agreement to rescind most of the subsidy cuts originally proposed, to increase reimbursement for its nursing home, and to provide additional state aid for treating uninsured patients. In exchange, NHCC recommitted itself to its mission to serve the surrounding communities of East Meadow, Westbury,

Hempstead, Freeport, Roosevelt and Uniondale, most of which have large minority and uninsured populations.

NUMC must focus on being a high-quality community teaching hospital providing for the health care needs of the communities that are dependent on it for primary, emergent and acute care. It should continue to provide certain tertiary services: trauma, burn, and neonatal care. It should not invest in tertiary services that require significant investment to develop. It should continue to develop collaborations with alternate facilities that offer those tertiary services NUMC does not provide.

NUMC has three vacant floors of raw space that could be used for program expansion or consolidation. NUMC should modify its existing space to its most efficient use before any new construction. This is particularly important with respect to the rebuilding of A. Holly Patterson Nursing Home.

Recommendation 5

Facility (ies)

Long Beach Medical Center (Nassau County)

Recommended Action

It is recommended that Long Beach Medical Center downsize its bed capacity to approximately 145 beds. Contingent upon New York State's development of new reimbursement options and alternative institutional models, Long Beach should reconfigure as a smaller facility focused on emergency and ambulatory care services with a more limited number of inpatient beds and linkages to a more comprehensive partner.

Facility Description(s)

Long Beach Medical Center (LBMC) consists of a 203-bed community hospital and a 200-bed sub-acute and skilled nursing facility. LBMC is located in the city of Long Beach on a south shore barrier island accessible to the mainland by three drawbridges located at the east, west and middle of Long Beach Island. LBMC is located adjacent to the central drawbridge that connects to Nassau County. The closest hospital to Long Beach is South Nassau Communities Hospital which is located 5 miles to the north over the adjacent drawbridge. Seven miles to the west is St. John's Episcopal Hospital and nine miles to the west is Peninsula Hospital. While these distances do not appear to be a barrier to alternate access, all three drawbridges are frequently up during summer, snarling traffic and blocking emergency access.

LBMC had 5,621 discharges, 14,743 emergency department visits, and had an average daily census of 117 patients in 2004. The hospital reported 76% occupancy of its available beds for 2005. LBMC's inpatient payor mix includes a high percentage of Medicare (59%), and Medicaid and Uninsured (28%) patients. LBMC had approximately 970 full-time equivalent employees in 2003. The hospital has $28 million in long-term debt, approximately $22 million with DASNY.

LBMC had break-even operational margins between 2001 and 2004. Its revenue has recently, and most likely temporarily, lost approximately 12% of its revenue due to requirements imposed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) that LBMC cease treating inpatient substance abuse patients until OASAS licenses LBMC to resume. LBMC has submitted required certificate of need applications to provide inpatient substance abuse services.

Assessment

There are approximately 40,000 residents in Long Beach and its adjacent island communities. There is a relatively large concentration of nursing homes, adult homes and assisted living facilities in Long Beach, and 16% of the population is over 65 years old. Because of the concentration of healthcare and housing facilities for the elderly, summer-time surges in

population, recreational and boating facilities, geographic isolation, and dependence on drawbridges to access the mainland, LBMC, despite its size and unstable financial situation, must remain open so that the community has appropriate access to emergency services and acute care. Eighty-eight percent of LBMC inpatients who are Long Beach residents were admitted under an emergent classification, and 68% of Long Beach residents who were admitted to other hospitals also were categorized as emergent.

While the Long Beach community seeks emergency and acute care at LBMC, Long Beach residents travel off the island for elective treatment. There were approximately 6,000 discharges in New York State of Long Beach residents, and of these, approximately 3,000 were discharged from LBMC. The remaining 50% sought care at mainland hospitals, including South Nassau Communities Hospital, St. Francis Hospital, North Shore University Hospital and Mercy Medical Center for acute inpatient, surgical and maternity care that LBMC does not provide.

LBMC cannot compete in the medical arms race. LBMC would benefit from reconfiguration and support from or integration with a strong partner or health system. The hospital has attempted to join a larger system; however, the hospital's largely medical, low-acuity case mix and its financial situation make it an unattractive acquisition target or potential partner.

The City of Long Beach needs a health care facility, and changes in the reimbursement system and an affiliation with a strong partner would improve LBMC's financial standing. LBMC will likely benefit from the proposed changes in Medicare's reimbursement, but will not solve the hospital's structural financial problems. Should there be changes in reimbursement, LBMC should be reconfigured as a new type of provider, with relatively few beds, and with a focus on emergency and ambulatory care, with a limited number of clinical services, with adequate capacity to stabilize and transfer patients with more complicated cases. Pending such changes, LBMC should eliminate its excess capacity by decertifying and downsizing to 145 certified beds, a level that accommodates its average daily census at reasonable occupancy, and permits the hospital to add adequate beds to accommodate periods of peak census in the summer.

LONG ISLAND REGION

LONG-TERM CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

A. Holly Patterson Extended Care Facility (Nassau County)

Recommended Action

It is recommended that A. Holly Patterson Extended Care Facility (AHP) downsize by approximately 589 RHCF beds to approximately 300 RHCF beds, and transfer its sub-acute services to the empty floors of the Nassau University Medical Center (NUMC), provided that such sub-acute services continue to be operated by AHP. It is further recommended that AHP rebuild a smaller facility on its existing campus, and add a 150-bed ALP and possibly other non-institutional services.

Facility Description(s)

A. Holly Patterson Extended Care Facility (AHP) is an 889-bed residential health care facility owned and operated by the Nassau County Health Care Corporation, a public benefit corporation. It provides baseline services, and operates an 80-bed subacute service, a 20-bed AIDS unit, and provides ventilator care.

AHP's occupancy rate of 60% is one of the lowest occupancy levels in the State. In 2002, it filled 84% of its beds. Approximately 23% of its beds are filled with low-acuity residents, some of whom can be served in a less-intensive setting if such services were available. Quality of care

is of concern at AHP. The number of deficiencies cited by State surveyors ranged from 5 to 16 over the last three years, whereas the regional median is 3. Some of AHP's quality indicators are far below the regional average, including percent of residents losing bowel and bladder control, residents experiencing pain, and short-stay residents obtaining pressure sores.

Assessment

Nassau County has excess nursing home capacity. Despite a paper need for more than 1,200 nursing home beds, the county operates at a meager 90% occupancy rate. Even when AHP eliminated its unused beds, the remaining providers ran at about a 6% vacancy rate in 2004. Such excess capacity hurts the providers financially. Providers lose bed-hold payments, are forced to accept lower-acuity individuals than they might otherwise, thereby reducing total Medicaid revenue through a lower CMI, and must spend valuable funds on marketing efforts to capture the available admissions.

AHP should transfer its sub-acute residents to the Nassau University Medical Center (NUMC) campus. The NUMC building has 3 empty floors that could be remodeled to satisfy nursing home regulations to accommodate AHP's sub-acute services. The Commission does not recommend moving the remaining long-term AHP program off the current campus because the development of an ALP and perhaps independent-living on the campus with the SNF has tremendous value.

The Commission recommends that the State immediately decertify 309 of AHP's licensed beds. None of these beds is currently not in use. Nassau County Health Care Corporation should concomitantly contract for the development of a 150-bed Medicaid ALP on the campus, to be completed within 24 months. Upon completion of the ALP construction, the State should decertify 120 further beds over the first 12-month period, and the remaining 160 when the ALP is operational.

Recommendation 2

Facility (ies)

Cold Spring Hills Center for Nursing and Rehabilitation (Nassau County)

Recommended Action

It is recommended that Cold Spring Hills Center for Nursing and Rehabilitation downsize by approximately 90 RHCF beds (one building) to approximately 582 RHCF beds, and add a 24-bed Ventilator unit, an evening ADHCP, and a 12-station hemo-dialysis center on the existing campus.

Facility Description(s)

Cold Spring Hills (CSH) is a 672-bed proprietary residential health care facility housed in several buildings. It houses a sub-acute program, a 50-slot gerontological-psychiatric adult day program, and a long-term home health care program. It has a high case mix index of 1.18. The facility was placed in receivership in 1996, and purchased in October 2004. Since the purchase, there have been quality and occupancy improvements at CSH. According to the provider, it ran at 94.5% occupancy in 2005.

CSH has been cited for between 6 and 12 deficiencies over the last three years, while the regional median is 3. It was cited with a level 3 deficiency in its last survey, falling in the bottom quintile for the region. Community reputation has been described as poor. The facility's recent affiliation with the North Shore-Long Island Jewish Health System, however, may strengthen both quality of care and community reputation.

Assessment

Nassau County has excess nursing home beds. 2004 county occupancy was 90%, and nearly 900 PA/PB level residents occupy SNF beds in the county. Nursing homes in the county informed the Commission that it is difficult to keep beds filled, particularly with the recent new facilities established in the area. In addition, CSH borders Suffolk County, which has a stronger occupancy level (96%), but also a small number of calculated excess beds (48). A downsizing at CSH could strengthen providers in both counties.

CSH is among the largest nursing homes in the State. The recommendation to downsize will maintain CSH in its current reimbursement peer group and will ease surplus capacity in the region. An entire building should be closed to maximize efficiencies and gains from downsizing. CSH, with its clinical affiliation with North Shore-LIJ, should be bolstered in its ability to serve a post-acute role.

The Commission recommends approving its application for 24 ventilator beds and for the creation of an on-site, 12-station hemodialysis center. The Commission further recommends that CSH's application for a 50-slot shift of evening adult day care be approved to provide additional non-institutional resources for the community,

Recommendation 3

Facility (ies)

Brunswick Hospital Center, Inc. (Suffolk County)

Recommended Action

It is recommended that Brunswick Hospital Center, Inc. downsize all 94 RHCF beds and close as an Article 28 long term care facility. It is further recommended that a 50-bed ALP and possibly

other non-institutional services be added somewhere in Suffolk County by another sponsor, pending completion of an RFP process.

Facility Description(s)

Brunswick Hospital Center, Inc. is a proprietary health care corporation that operates a 64-bed physical medicine and rehabilitation facility (the "Brunswick Physical Medicine and Rehabilitation Hospital", also recommended for closure), a 94-bed nursing home (the "Brunswick Nursing Home"), and a 124-bed psychiatric facility licensed under Article 31 of the Mental Hygiene Law (the "Brunswick Hall Center for Behavioral Health & Wellness"). These facilities share a campus in Amityville, which neighbors Broadlawn Manor, a 320-bed residential health care facility.

Previously, Brunswick Hospital Center, Inc. also operated an emergency room and medical/surgical unit licensed for an additional 192 medical/surgical beds, but those beds were decertified and those units discontinued pursuant to a petition for reorganization under Chapter 11 of the United States Bankruptcy Code filed in October 2005. That case is pending.

The Brunswick Nursing Home had been in receivership from 2001-05. The facility saw admissions decline in this period. It currently runs at 95% occupancy, and makes a profit. Even though Brunswick's emergency room and medical/surgical unit ceased operations, Brunswick Nursing Home maintains its hospital-based Medicaid rate.

This nursing home has raised some quality concerns. It was cited for 15 deficiencies in its most recent survey, compared to a regional median of 3. It has poor performance measures on pressure sores, weight gain, and continence. Some of its survey deficiencies are due to its physical plant, which is housed in two cottages dating from 1938 and the early 1950s. The operator plans to move the nursing home operation into the general hospital building. While this would provide in-wall gases for ventilator-dependent residents, the hospital building is 120 years old, and would not provide state-of-the-art long-term care.

Assessment

New facilities in Suffolk County have increased the supply of nursing home beds and competition for appropriate residents. With nearly 1,000 low-acuity residents in Suffolk nursing homes, non-institutional alternatives must be established.

Brunswick Nursing Home does not appear to have a strong referral base from local hospitals. Good Samaritan and North Shore hospitals refer their patients to this nursing home and to their own affiliated facilities. Notably, Good Samaritan may work more closely to refer to Catholic Health System facilities and North Shore recently entered into an affiliation with CSH.

The creation of the ALP for Suffolk County should proceed through an RFP process.

NEW YORK CITY REGION

ACUTE CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

New York Methodist Hospital (Kings County)
New York Community Hospital of Brooklyn (Kings County)

Recommended Action

It is recommended that New York Methodist Hospital and New York Community Hospital of Brooklyn merge into a single entity with two separate campuses. It is further recommended that Methodist downsize by 60 to 510 beds, and that NY Community Hospital downsize by 40 beds to 90 beds and add ambulatory services.

Facility Description(s)

New York Methodist Hospital is a community teaching hospital in Park Slope, Brooklyn. It has 570 certified beds, all of which are in service. The hospital had approximately 32,179 discharges in 2004. In 2004, over 66,000 patients were treated in the emergency department, which is a designated stroke center. Its special services include interventional and surgical cardiology, a modern birthing center, and inpatient and outpatient rehabilitation. It draws patients from throughout the borough, and provides an extensive array of ambulatory services and sites including family health centers in Downtown Brooklyn, Canarsie, and Red Hook

Approximately 32% of its discharged patients in 2004 were either covered by Medicaid or were uninsured. The hospital has been financially stable for the past 15 years. It is affiliated with the Weill Cornell College of Cornell University and is a member of the NY-Presbyterian Healthcare System. New York Methodist employed approximately 2,738 full-time equivalents (FTEs) in 2003.

New York Community Hospital of Brooklyn is located in Midwood, Brooklyn, and has 134 certified beds, all of which are in service. The hospital provides only acute medical and surgical services, with approximately 6,327 discharges in 2004. The emergency department had approximately 15,783 visits in 2004, and is a designated stroke center. The hospital does not have outpatient clinics. It draws patients primarily from southern Brooklyn, including from Sheepshead Bay and Coney Island.

NY Community has been financially stable for the past 10 years. It is affiliated with the Weill Cornell College of Cornell University and is a member of the NY-Presbyterian Healthcare System. NY Community employed approximately 476 FTEs in 2003.

Assessment

The Commission supports a full asset merger of NY Methodist and NY Community Hospital into a single institution with one operating certificate and governing board. The integration will allow each of the two sites to reduce the number of beds. NY Community will eliminate 40 beds, and NY Methodist will eliminate 60. This reduction would take place over a three-year period, and enable the institutions to achieve economies of scale and reduce operating costs.

The population of southern Brooklyn is growing, and there is a deficit of outpatient services in the area, particularly for maternal and child health. NY Community Hospital does not have the space to provide ambulatory services, and its neighboring hospital, Beth Israel Kings Highway Division, also lacks outpatient services. The only hospital that provides ambulatory care in southern Brooklyn is Coney Island Hospital. The proposed merger will allow NY Community Hospital to reconfigure empty space from the bed reduction to create an ambulatory care center.

Recommendation 2

Facility (ies)

Victory Memorial Hospital (Kings County)

Recommended Action

It is recommended that Victory Memorial Hospital close in an orderly fashion. Following this planned closure, it is further recommended that the site be converted under new sponsorship to a diagnostic and treatment center and/or as a facility offering a continuum of long term care services that would be compatible with the remaining Victory Nursing Home.

Facility Description(s)

Victory Memorial Hospital is a 243-bed hospital in the southwest section of Brooklyn. It provides adult medical/surgical and obstetrics services. All of its certified beds are staffed. The hospital's 2004 certified bed occupancy rate was 62%, and the hospital had 23,808 emergency visits. Medicaid-covered and uninsured patients represented 34% of total inpatients in 2004. The hospital carries approximately $32 million in long term debt, approximately $26.9 million of which is DASNY debt, secured by the Federal Housing Administration's Hospital Mortgage Insurance Program. The hospital employed approximately 1,025 FTEs in 2003. The hospital has an adjacent, hospital-affiliated nursing home with 150 beds.

Assessment

Victory Memorial declared chapter 11 bankruptcy in November 2006 following years of severe financial trouble. Victory continues to default on its obligations and has difficulty making payroll. The hospital is attempting to raise capital through a short-term loan, and sale of its property and its long-term home health care ("Lombardi") program. These short-term cash infusions, however, will not adequately ameliorate the facility's financial problems.

In 2005, in an effort to stabilize the institution, the Department of Health and Maimonides Medical Center structured a plan to stave off Victory's bankruptcy. As part of this bail-out plan, Victory received a $2 million grant from the Department of Health, a $1 million grant from the NYS Senate Speaker's fund, and a $5 million loan from Maimonides Medical Center, which included a five-year partnership between the two medical centers as a condition of the loan.

Despite these efforts, Victory has entered chapter 11 bankruptcy proceedings. Its reported medical/surgical volume has steadily and sharply declined. Patients and physicians have defected to neighboring hospitals, primarily to Lutheran Medical Center. Cash flow is a major problem.

As part of its partnership agreement, Maimonides hired a consultant to develop a restructuring plan for Victory. The consultant found that even a smaller hospital would continue to lose money, even with unlikely increases of discharges. Maimonides then proposed evaluating whether Victory could be converted to either a diagnostic and treatment center (D&TC), providing needed primary care and outpatient obstetrics and mental health services to the community, or to a site for a continuum of long-term care services.

Victory can close as an inpatient facility without disruption to access to or availability of care. Were Victory to close, it initially appeared that approximately 25-35 patients may be difficult to accommodate at Victory's coverage partners, which include Maimonides, Lutheran, NY Methodist and Coney Island hospitals. A number of factors, however, mitigate this concern:

- Victory's 2004 average daily census was inflated by long lengths of stay relative to the borough average. If patients were treated instead at Victory's coverage partners, which have more appropriate lengths of stay, then many more patients could be covered by the remaining hospitals.
- Volume at Victory has declined further since 2004. Its average daily census has dropped to approximately 130. Surrounding institutions can definitely absorb Victory's current inpatient volume should Victory close.

- Physician referral patterns have already changed. Doctors have begun redirecting patients to other area hospitals.

Notably, the two recent Brooklyn hospital closures, St. Mary's and Brooklyn Hospital's Caledonian campus, were in the northern part of the borough. The primary service areas of those hospitals do not overlap with that of Victory.

The community does need access to comprehensive ambulatory care services. In 2004, Victory Memorial had approximately 85,000 outpatient visits. The community's access to outpatient care should be preserved when Victory closes. When Victory Memorial closes, efforts should also be made to ensure Victory Nursing Home's continuing survival.

The Commission recommends the immediate decertification of all inpatient beds at Victory. The entrance of the institution into bankruptcy proceedings is likely to place the interests of a creditors' committee in opposition to those of community health.

Recommendation 3

Facility (ies)

Peninsula Hospital Center (Queens County)
St. John's Episcopal Hospital South Shore (Queens County)

Recommended Action

It is recommended that Peninsula Hospital Center downsize by approximately 99 beds to approximately 173 beds and that St. John's Episcopal Hospital downsize by approximately 81 beds to approximately 251 beds. Contingent upon financing, it is recommended that Peninsula Hospital Center and St. John's Episcopal Hospital merge and rebuild a single facility with

approximately 400 inpatient beds, and provide comprehensive emergency, inpatient, psychiatric and ambulatory services.

Facility Description(s)

Peninsula Hospital Center is a community teaching hospital located near the east end of the Rockaway Peninsula in Queens. The hospital is certified for 272 beds, of which 173 are available. In 2004, the hospital had approximately 5,707 discharges, 26,430 emergency department visits, and 33,929 visits at its primary care family health center. Medicaid-covered and uninsured patients represented 24% of discharges and 68% of emergency department visits. It offers medical/surgical, pediatric, and traumatic brain injury services. Peninsula has stroke center designation for southeast Queens, and is the acute care hospital affiliate of the Addabbo Family Health Center, one of two federally qualified health centers in Queens. Peninsula has improved the efficiency of it operations and reduced its length of stay. The hospital operates at a near break-even margin, and has little long-term debt (approximately $3 million). Peninsula employed approximately 1,066 people in 2003, most of whom are local residents. Peninsula also runs an adjacent 200 bed hospital-based skilled nursing facility with a short-term rehabilitation unit, respiratory therapy, Alzheimer's disease and high-acuity services.

St. John's Episcopal Hospital is located at the far eastern end of the Rockaway Peninsula. It is certified for 332 beds, of which 251 are available. Its inpatient services include medical/surgical, maternity, psychiatry and detoxification services, and the hospital offers provides psychiatric outpatient services, a continuing day treatment program, home-based crisis intervention program, and outpatient services in adult homes. It is designated to receive emergency involuntary psychiatric admissions. In 2004, the hospital had approximately 10,708 discharges and 27,898 emergency department visits. Fifty-one percent of its inpatients and 48% of its emergency department visits were either Medicaid-covered or uninsured. The hospital showed an operating margin of 4% in 2004, and has long-term (DASNY) debt of approximately $14 million. Like Peninsula, it is a major employer for the Rockaway community. St. John's Episcopal Hospital is part of Episcopal Health Services Inc., which also owns and operates two Rockaway-area nursing homes and the St. John's Medical Services PC.

Assessment

The optimal solution to meet the health care needs of the Rockaways is the establishment and construction of one new hospital with an appropriate configuration of needed services and number of beds in a convenient location for the bulk of the population. Neither of the two hospitals runs at full capacity, yet neither can fully absorb the other's patient load. The mix of services between the two hospitals is relatively complementary, but they have unnecessary overlaps in medical/surgical capacity. Their medical staffs overlap. Both facilities are old and in need of extensive capital renovation. Neither has an adequate physical plant in the optimal location to serve the needs of this growing community. In an effort to avoid assuming more debt than it can comfortably carry, Peninsula Hospital has made steady but relatively small investments in its physical plant. St. John's has renovated part of its outmoded facility but more needs to be done.

This optimal health care delivery solution has major barriers to implementation, including considerable capital needs to cover construction costs, estimated at $1 million/bed in the New York City region, and an apparent unwillingness by either of the providers to merge or consolidate.

This recommendation is shaped by the particularities of the Far Rockaways area, including:

- The Rockaways are located on an isolated barrier peninsula accessible by two bridges to Brooklyn and Queens, and by one road into Nassau County.
- 40% of the residents are African-American, compared to 25% in NYC as a whole.
- The NYC Department of Health and Mental Hygiene identified the Rockaways as an area with income and health disparities.
- It is difficult to attract and retain physicians to practice in the community.
- The middle-class population of the peninsula is growing, and there is an influx of younger families with children. Approximately 15-20,000 new residents are expected to

move into housing currently under construction. There is a migration of Orthodox and Russian Jewish and Hispanic immigrants from Central America into the community.

- The Peninsula is oversaturated with nursing home and adult home beds, which account for nearly 60% of the combined nursing and adult homes in Queens. There are 17 nursing homes and 12 adult homes on the Rockaway peninsula.

Recommendation 4

Facility (ies)

Queens Hospital Center (Queens County)

Recommended Action

It is recommended that Queens Hospital Center add approximately 40 medical/surgical beds.

Facility Description(s)

Queens Hospital Center, a member of the NYC Health and Hospitals Corporation, is a 243-bed community hospital serving primarily the neighborhoods of Jamaica and southwest Queens. The hospital provides medical/surgical, maternity, and behavioral health services. It was recently renovated and downsized from 408 beds. Queens Hospital Center is an important safety-net provider to low-income communities with compromised access to health care services. Medicaid and uninsured patients represent 79% of inpatients and emergency department admissions. While Queens Hospital Center has 5% of the total certified beds in the borough, it has 19% of the alcohol detoxification beds, 26% of the drug detoxification beds, and 9% of the psychiatric beds. Queens Hospital Center employed approximately 1,911 FTEs in 2003. The hospital's strategic priorities include the development of a comprehensive cancer center, and the completion of a new ambulatory care pavilion.

Assessment

Queens Hospital Center developed its plans for the recently completed modernization prior to the St. Joseph's Hospital closure in 2004. Consequently, Queens Hospital Center's downsized bed capacity does not meet the needs of its community. On days of peak census, the hospital exceeds its certified capacity despite a relatively low 4.2 day length of stay. Its ED and inpatient units are overcrowded. An ambulatory pavilion construction project is underway, which could be modified to include a 40-bed inpatient expansion.

Recommendation 5

Facility (ies)

Parkway Hospital (Queens County)

Recommended Action

It is recommended that Parkway Hospital close in an orderly fashion.

Facility Description(s)

Parkway is a 251-bed proprietary, for-profit community hospital located in Forest Hills, Queens. It operates 140 beds, and provides only adult medical/surgical care. It does not offer maternity, psychiatric, or pediatrics services. In 2004, it had approximately 9,365 discharges and 13,973 emergency department visits. Most of its patients have private coverage or Medicare. In 2004, the hospital's occupancy based on available beds was 66%, and it had an average daily census of 146. According to the hospital's administration, average daily census in 2006 further declined to 130. Its operating margin is approximately -5%.

It is one of only two for-profit hospitals in New York State. Parkway is the primary hospital for several physician group practices, many of which are owned by the hospital operators. These practices are located throughout Queens and Brooklyn. According to the hospital, in the first quarter of 2006, Parkway employed 570 full-time equivalent employees, down from 696 in the fourth quarter of 2004.

Parkway Hospital filed for Chapter 11 bankruptcy protection in June 2005. While the hospital hoped that it would emerge from bankruptcy in the third quarter of 2006, its losses for the first quarter of this year totaled $4.7 million, which was $2.5 million more than the hospital budgeted. Bankrupt Parkway Hospital lost $810,542 in June 2006 alone, and patient revenue in June 2006 was $5.5 million, which was under expected budget by $825,000 due to of lower revenue from Medicaid and Medicare. In 2004, the hospital had approximately $13 million in (non-DASNY) long-term debt. If the hospital emerges from bankruptcy, it must file a certificate of need application with DOH for change of ownership.

Assessment

Using the Commission's framework criteria, Parkway Hospital is the only hospital in New York State to receive below-average scores on all six of the criteria: service to vulnerable populations, quality of care, utilization, viability, availability of services, and economic impact. The NYC RAC agreed that "using the need criteria …and particularly considering this hospital's past problems with financial and administrative mismanagement, and more importantly, quality of care, Parkway is a prime candidate for closure."

Parkway's low occupancy rate and poor finances indicate that it is unneeded and cannot stand as a viable, stand-alone entity, surrounded by larger, more comprehensive facilities. Analysis using 2004 data, which is more favorable to Parkway than current data, to measure Parkway's capacity to close suggests that it might be difficult to accommodate all of Parkway's patients at other area hospitals. This concern, however, is mitigated by various factors. Parkway's extended lengths of stay inflated its 2004 average daily census. Reductions in lengths of stay would substantially reduce the number of occupied beds and patient days so that patients would be accommodated at

the hospital's coverage partners. Furthermore, Parkway's inpatient average daily census has declined since 2004, indicating that patients already have chosen to seek care in alternative facilities.

Recommendation 6

Facility

New York Westchester Square Medical Center (Bronx County)

Recommended Action

It is recommended that New York Westchester Square Medical Center close in an orderly fashion.

Facility Description(s)

Westchester Square Medical Center (WSMC) is located in the eastern Bronx. It is certified for 205 beds, of which 163 are staffed. The hospital provides only adult medical/surgical care and no specialty services. WSMC is a certified stroke center. The hospital claims it had 7,852 discharges and emergency room volume of 23,000 in 2005. WSMC operates at a near-breakeven operating margin. It is a sponsored member of the NY Presbyterian Health System (NYPHS). It employed approximately 575 FTEs in 2003.

Assessment

Westchester Square represents excess capacity in the system. It functions largely as a feeder to tertiary hospitals in NYPHS. An analysis measuring its capacity to close confirms that WSMC's patients could be absorbed by surrounding hospitals, including St. Barnabas Hospital, which

NYPHS also sponsors. Its principal neighboring coverage partners include Montefiore/Weiler Campus, Jacobi , Montefiore/Moses Campus, Our Lady of Mercy, and St. Barnabas hospitals.

Using the Commission's framework criteria, WSMC scored low on service to vulnerable populations, utilization, viability, and availability of services. Relative to regional institutions, its payor mix includes few Medicaid-covered and uninsured patients even though the hospital's service area in the south and northeast Bronx encompasses some federally designated medically underserved areas (MUAs). Twelve percent of the hospital's inpatients in 2004 were Medicaid-covered or uninsured. Moreover, it is underutilized and provides no specialty care. Its certified bed occupancy rate in 2004 was only 51%. WSMC provides only general medical/surgical services; it provides no maternity, psychiatric, or substance abuse care.

Recommendation 7

Facility (ies)

Cabrini Medical Center (New York County)

Recommended Action

It is recommended that Cabrini Medical Center close in an orderly fashion.

Facility Description(s)

Cabrini Medical Center (Cabrini) is an acute care hospital in Manhattan's Gramercy Park neighborhood. Cabrini's campus occupies an entire city block in downtown Manhattan, and contains five buildings. Two buildings are used for clinical care, and the remaining buildings are used primarily for hospital administration. It has a total of 474 licensed beds, of which, according to the hospital, 338 are in service. Approximately 25% of its certified and 73% of its available beds were occupied, and its medical/surgical volume has been in steady decline.

Cabrini offers inpatient medical/surgical, psychiatric, and rehabilitation services, and is a State-designated AIDS center. Its emergency department and outpatient clinics are well utilized. Cabrini had approximately 9,800 total discharges, 18,674 ED visits and 55,052 outpatient visits in 2004. It has a clinical affiliation with Mt. Sinai Hospital. The hospital employed approximately 1,357 FTEs in 2003.

The facility has been in financial difficulty for years, and missed payroll twice. While its recent financial condition has somewhat improved, it continues to struggle with fiscal problems. These improvements are largely attributable to efficiency gains, including a reduction in what had been a 14-day average length of stay. The 2004 operating margin was approximately -4%. The hospital reported that its losses in 2005 totaled approximately $10 million. It has incurred approximately $36 million debt to service, and $44 million in unserviced debt to its sponsor, the Sisters of Cabrini. The hospital has no DASNY-insured debt, and it recently retired its debt to the NYS Housing Finance Authority with a private refinancing.

Assessment

Cabrini Medical Center should close. According to the Commission's framework criteria, Cabrini scored poorly on utilization, quality of care, viability, and availability of services. Its score for the service to vulnerable populations criterion was average for the region.

In public presentations, Cabrini leadership acknowledged the strong arguments that support its closure:

- "We are located in 'Bed Pan Alley' with one of the largest concentrations of medical/surgical acute care hospitals in the country.
- The need for inpatient hospitalizations continues to shrink.
- We recognize Manhattan will unlikely ever again need the same number of medical/surgical beds. There is excess capacity and the continued arms race to fill beds among the existing competitors is not healthy.
- Like our neighbors, our financial picture has been troubled for over five years.

- We do not provide tertiary and quaternary services provided by our neighboring institutions.
- We sit on a very valuable piece of real estate that could easily be sold off for more condominiums.
- There is a growing consensus in many public arenas that the smaller institutions should either close or restructure.
- Virtually all providers are struggling and the responsible thing to do is to shrink or restructure over-capacity before we see even bigger and more catastrophic collapses and resulting declines in quality of care."

The Commission's capacity to close analysis confirms that Cabrini's patients readily could be absorbed by its coverage partners, including Beth Israel Petrie Division, Bellevue, NYU Tisch, and Mount Sinai hospitals. The NYC RAC concluded "There is no continuing need for an inpatient medical/surgical capacity at this facility. While the administration and the board have been very aggressive in attempting to preserve Cabrini as a hospital, and have been creative in developing different configurations including reducing medical/ surgical beds, it appears to us that the surrounding hospitals can easily absorb inpatient admissions from this market area."

Cabrini's leadership impressed the Commission with its realistic self-assessment, candor, and their creative efforts to reconfigure the institution. The Commission is not persuaded, however, of the need to maintain Cabrini either in its current form or in the new form proposed by Cabrini leadership. Provisions must be made, however, to ensure continued access to certain services, especially psychiatry, outpatient, and emergency services. These services provided at Cabrini can and must be transferred to surrounding institutions without creating access problems for the community:

- **Psychiatry** – Neighboring Beth Israel Medical Center is prepared to assume all of Cabrini's psychiatric beds, pending the State's certificate of need approvals for such a transfer. Cabrini has 78 licensed inpatient psychiatric beds, including 28 recently approved geropsychiatric beds. Beth Israel has a comprehensive psychiatric program, including inpatient, outpatient, and community-based care. Under the proposed plan,

Beth Israel would convert the majority of its current inpatient detoxification beds to psychiatry, and transition approximately 75% of the inpatient detoxification program to outpatient clinics. This transition is consistent with trends in substance abuse care and with state policy objectives. Beth Israel's detoxification beds are located in a separate pavilion, together with the hospital's existing inpatient psych services.

The Commission also consulted with the leadership of NYU Medical Center. NYU-Tisch Hospital currently operates 22 inpatient psychiatric beds, and Bellevue Hospital operates 339 psychiatric beds at full capacity. NYU has space and resource constraints, but expressed a willingness to evaluate the expansion of inpatient psychiatric care should it be necessary in order to accommodate patients displaced by a Cabrini closure.

- **Outpatient services** – Beth Israel Medical Center's 300,000-square-foot Phillips Ambulatory Care Center is located within an easy walk to Cabrini, at the major public transportation hub of Union Square. Beth Israel easily can absorb an additional 50,000 outpatient visits at this site. In addition, NYU Medical Center plans to expand its primary care and general medical/surgical capacities at its nearby Hospital for Joint Diseases.

- **Emergency services** – Analysis evaluating Cabrini's capacity to close demonstrated that Cabrini's urgent/emergent patients can be absorbed at neighboring Bellevue, NYU Tisch, Beth Israel Petrie, and St. Vincent's Manhattan hospitals, all within appropriate travel times. In addition, the nearby NYU Tisch Hospital filed a CON application to double its emergency department's size and bed count.

Cabrini has relatively little debt for an institution of its size, and no DASNY debt. According to Cabrini, the real property on which the hospital sits is estimated to be worth approximately $130 million, which easily will cover the hospital's debts and leave funds to support the overall health care mission of the sponsor.

Recommendation 8

Facilty (ies)

Beth Israel Medical Center - Petrie Campus (New York County)

Recommended Action

It is recommended that Beth Israel–Petrie Campus convert approximately 80 detoxification beds to approximately 80 psychiatric beds, provided that the Commissioner of Mental Health and the Commissioner of Alcoholism and Substance Abuse Services approve such changes.

Assessment

This action will preserve community access to psychiatric beds currently located at Cabrini Medical Center.

Recommendation 9

Facility (ies)

North General Hospital (New York County)

Recommended Action

It is recommended that North General Hospital enter into a passive parent corporate relationship with Mount Sinai Medical Center.

Facility Description(s)

North General Hospital (NGH) is a community hospital in central Harlem in upper Manhattan. It has 200 certified beds, 152 of which were available in 2004. Sixty-four percent of its certified beds were occupied in 2004. In 2004, the facility had approximately 8,132 discharges and 31,709 emergency department visits. NGH provides inpatient medical surgical, psychiatry and alcohol detoxification services. In 2004, approximately 67% of its discharges were medical/surgical patients, 21% were substance abuse patients and 12% were psychiatry patients.

NGH is a safety net provider. Medicaid-covered and uninsured patients represented approximately 65% of inpatient cases, and 72% of inpatients live in federally-designated medically underserved areas (MUAs). About 60% of its patients are African-American, and about 40% are Hispanic. NGH's relatively high case mix index reflects the poor health status of its surrounding community. NGH employed approximately 921 FTEs in 2003.

Following years of clinical affiliations with a variety of partners, NGH entered into an affiliation in 2004 with The Mount Sinai Hospital. The affiliation includes collaborative clinical programs in anesthesiology, cardiology, dentistry, emergency medicine, gynecology, urology, ophthalmology, radiology, general surgery and vascular surgery.

Assessment

According to the Commission's analytic framework, NGH scored low on quality, viability, availability of services and quality of care. It scored high on service to vulnerable populations. While NGH serves medically underserved communities in Harlem, it is neither the only nor the largest provider of care to these communities. A capacity to close analysis demonstrated that NGH's patients could be served by surrounding hospitals, including Mount Sinai, Metropolitan, Harlem, St. Luke's Roosevelt - St. Luke's Division, NY Presbyterian - Columbia University, and Lenox Hill hospitals. NGH may see increasing competitive pressures when Harlem Hospital completes its renovation and modernization.

NGH suffers from a heavy debt load. Established in 1979, NGH was the last hospital built immediately prior to seriously disadvantageous changes in Medicare's capital reimbursement methodology. As a result, it was overbuilt, and the revenue cannot cover its tremendous debt load. In 2004, the hospital had a long-term debt load of approximately $155 million, $141 million with DASNY. Its debt is secured through a state service contract, so that the State is obligated to pay its debt should the hospital default on payments. Over the years, the hospital has consistently received loans and grants from the State in order to ensure its continued existence.

NGH's new leadership has made significant improvements. While it suffered from annual operating losses between 1996 and 2004, it enjoyed a positive margin in 2005, its first in ten years, and it is projecting a surplus for 2006. NGH claims that the improvements are not a result of one-shot transactions, but rather a result of their comprehensive turn-around plan and clinical affiliation with Mount Sinai. NGH claims that inpatient discharges increased by 30% between 2003 and 2005, emergency department visits increased by 15%, and that concomitantly, average length of stay dropped by 7%.

NGH's relationship with Mount Sinai has benefited NGH by allowing NGH to expand its clinical programs and attract new clinical leaders, including nine new chairs and chiefs and a new chief nursing officer. In 2004, NGH and Mount Sinai received approval to convert existing outpatient departments to diagnostic and treatment centers, which generated additional incremental revenue to support their ambulatory operations. Finally, NGH and Mount Sinai received joint approval for a jointly sponsored diagnostic catheterization laboratory at NGH.

NGH and Mount Sinai together have developed a plan for NGH to form a passive parent relationship with Mount Sinai. The two hospitals would continue to share administrative and information technology services, which will improve North General's bottom line. The two hospitals also proposed to reconfigure their clinical services; potentially relocating Mount Sinai's psychiatric to NGH. Finally, they launched a joint community-outreach and education venture to improve the health status of Harlem residents. Under the proposed passive parent relationship, tertiary referrals would presumably flow from NGH to Mount Sinai. This affiliation would

allow NGH to receive better creditor rates for loans, more competitive prices for goods and services, and improve NGH's leverage in rate negotiations with insurance companies.

The Commission supports NGH's restructuring plan. The recent turnaround spearheaded by NGH's CEO and board is impressive, particularly given its decades of struggle and a heavy debt burden. The proposed relationship with Mount Sinai provides the best possible avenue for the hospital to achieve stability and to advance its mission in Harlem.

Recommendation 10

Facility (ies)

St. Vincent's Midtown Hospital (New York County)
St. Vincent's Manhattan (New York County)

Recommended Action

It is recommended that St. Vincent's Midtown Hospital close in an orderly fashion. It is further recommended that approximately 12 psychiatric beds currently operated by St. Vincent's Midtown Hospital be added by St. Vincent Catholic Medical Center system (SVCMC) and operated by St. Vincent's Manhattan, provided that the Commissioner of Mental Health approves such additions. Should St. Vincent's Manhattan deem that to be impracticable, it is recommended that such 12 psychiatric beds instead be added elsewhere in New York County by another sponsor, provided that the Commissioner of Mental Health approves such additions. It is further recommended that ambulatory care services currently provided by St. Vincent's Midtown Hospital be maintained or developed in this neighborhood by SVCMC or another sponsor.

Facility Description(s)

St. Vincent's Midtown Hospital is a non-merged affiliate of the St. Vincent Catholic Medical Center; therefore, it is not subject to SVCMC's current bankruptcy proceedings. Located on the west side of midtown Manhattan, the hospital has 250 licensed beds, of which 149 are available. Its occupancy rate based on certified beds is 34%. The hospital's services include adult medical/ surgical care, a small 12 bed psychiatry unit, and an inpatient detoxification program. According to information supplied by the hospital, it had just over 7,100 discharges and approximately 28,000 emergency department visits in 2005. The hospital employed approximately 670 FTEs in 2003.

Assessment

St. Vincent's Midtown Hospital should close. It is poorly utilized, and area residents are unlikely to receive care at St. Vincent's Midtown, preferring to receive care at its neighboring institutions. The hospital has less than a 10% share of its own primary service area. According to the hospital, more than 50% of patients served by St. Vincent's emergency department are not Manhattan residents, further evidence of low community dependence.

A quantitative capacity to close analysis showed that the average daily inpatient census of 85 patients could readily be absorbed by the hospital's coverage partners, including the two divisions of St. Luke's Roosevelt, Beth Israel Petrie Division, Mount Sinai, Bellevue, St. Vincent Manhattan, NY Presbyterian/Columbia, and Lenox Hill hospitals.

Patients seen in the St. Vincent's Midtown emergency department could also be absorbed elsewhere within reasonable travel times. According to the hospital, only about 10% of the 28,000 patients that arrive at the St. Vincent's Midtown emergency department are admitted to Midtown. Another 800 are transported downtown to St. Vincent's Manhattan on 12th Street. Furthermore, a major emergency department expansion project at the St. Luke's Roosevelt - Roosevelt Division, which is within ten blocks of St. Vincent's Midtown, will easily accommodate potential patients displaced from a St. Vincent's Midtown closure. The Roosevelt

emergency department is expanding from16, 500 to 27,000 square feet, from 27 to 51 treatment stations, and from a capacity of 54,000 to an estimated capacity of 100,000 visits. The renovation has the potential to include an urgent-care facility to treat the bulk of patients who do not require admission. This expansion will be able to absorb the St. Vincent's Midtown emergency department volume. Finally, St. Vincent's Midtown's physical plant is inefficient and is spread across two sides of a street.

St. Vincent Midtown had approximately 53,000 outpatient visits in 2004, excluding visits to its methadone programs. The Commission carefully evaluated whether alternate outpatient facilities could absorb St. Vincent's Midtown outpatient visits. St. Vincent Midtown and a federally qualified health center (FQHC) are currently negotiating for the FQHC to assume management of St. Vincent's ambulatory care operations. Furthermore, an additional FQHC is within blocks of the hospital and it too can absorb a significant portion of this volume.

The hospital lost $1 million in 2005 and has very little cash on hand. While St. Vincent's Midtown nears a breakeven operating margin, the SVCMC leadership reported that the service mix currently provided at the site cannot sustain the hospital's viability and solvency. The medical/surgical inpatients generally are low-acuity, and the majority of its detoxification patients could and should be treated in an outpatient setting.

The hospital has approximately $49.8 million in long-term debt, approximately $41 million of which it owes to DASNY. Midtown Manhattan real estate values remain high, particularly in the up-and-coming Clinton neighborhood where the hospital is located, and a sale of the building would cover a complete repayment of its debt. According to system leadership, sale of the St. Vincent Midtown campus would generate approximately $90 million.

SVCMC presented an alternate plan for the Midtown campus. SVCMC proposed to further integrate Midtown with the downtown campus, which itself requires major physical and programmatic reconfiguration, including complete overhaul of its hospital once they emerge from bankruptcy. SVCMC proposes to reconfigure services between its two Manhattan campuses, and to reconstruct the Midtown campus to accommodate fewer inpatient beds, an

ambulatory surgery facility focused on orthopedics, and an emergency department with an expanded urgent care facility. They proposed to reduce medical/surgical capacity from 137 to 56 beds, to transfer 33 psychiatric beds from the St. Vincent's Manhattan (downtown) site to the Midtown site, and to transfer a 20-bed acute rehabilitation unit from the downtown site to the Midtown site to support Midtown's proposed orthopedic program. They would discontinue detoxification services.

Rather than endorse SVCMC's restructuring plan, the Commission recommends that St. Vincent Midtown close. The midtown Manhattan community does not need a 56-bed medical/surgical facility. The surrounding community is not dependent on the hospital. Several comprehensive facilities that serve the same patients can readily absorb Midtown's inpatient and emergency department volume, and are within blocks of the current location. Additionally, the transfer of psychiatric beds to St. Vincent's Manhattan or another area sponsor will preserve community access to psychiatric beds. There is little demand within Manhattan for another orthopedic specialty hospital, which would have to compete with Hospital for Joint Diseases, the Hospital for Special Surgery, and the comprehensive Orthopedics programs at other academic medical centers. Finally, sponsors have been identified to ensure continuation of outpatient services.

The State should not sustain an unneeded hospital campus in order to shore up another hospital in a system. Sustaining an unneeded hospital is not supportable within the Commission's charge, which specifically targets opportunities to right-size the delivery system in order to best meet community need.

Recommendation 11

Facility (ies)

New York Downtown Hospital (New York County)

Recommended Action

It is recommended that New York Downtown Hospital decertify approximately 70 medical surgical and 4 pediatric beds, reducing its licensed capacity from 254 to 180. It is further recommended that New York Downtown Hospital discontinue its inpatient pediatric services and that these services be added to other facilities. It is further recommended that New York Downtown Hospital reorganize its outpatient clinics under new sponsorship.

Facility Description(s)

New York Downtown Hospital, located in the heart of the financial district, is the only community hospital in lower Manhattan. The hospital has 254 certified beds, of which approximately 150 are in service. In 2004, it had a 34% occupancy rate of its certified beds, and 80% of its staffed beds. In 2004, there were approximately 11,306 discharges, 30,409 emergency department visits. According to NY Downtown leadership, the hospital had approximately 100,000 outpatient visits in 2005. The hospital's inpatient services include adult and pediatric medical/surgical care and obstetrics. More than 40% of inpatient discharges are obstetrics cases. The hospital employed approximately 1,091 FTEs in 2003.

Approximately half the hospital's admissions originate as emergency department visits. As the closest hospital to Manhattan's growing Chinatown, NY Downtown has a 48% market share of this community and approximately 49% of its patients are Asian. Vulnerable populations constitute a substantial portion of the hospital's patients. Forty-seven percent of inpatients are Medicaid-covered or uninsured, and 56% of patients come from medically underserved areas. Patient volume is likely to increase, as the commercial and residential population of this area is growing and multiple construction programs are underway and planned.

Assessment

NY Downtown Hospital's situation is complex and presents many financial and health delivery challenges. The hospital has a history of operating losses, although the magnitude of these has

been steadily declining since 2003. In 2003, it lost approximately $18 million, in 2004, $15 million, and in 2005, $13 million. NY Downtown projects an operating loss of $9.7 million in 2006 and $7.4 million in 2007. The progressive decline in operating losses has been attributed to management's expense reduction initiatives and the renegotiation of managed care contracts. In 2004, the hospital had long-term debt of approximately $74.6 million, approximately $51 million of which was with DASNY.

Two events severely impacted the hospital's financial standing. First, as the closest hospital to the World Trade Center site, NY Downtown was heavily impacted by September 11th due to the inaccessibility of the hospital due to the area's security measures. Its admissions did not begin to rebound until 2003. Second, in 2004, NYU Medical Center severed its sponsorship arrangement with NY Downtown, and once again, NY Downtown's volume of business declined. Today, NY Downtown is affiliated with the New York Presbyterian Health Care system. The volume of admissions is approaching that of 2000, prior to the two events described above.

NY Downtown has a newly renovated $25 million emergency facility designed to serve the urgent and emergency needs of the growing Downtown community. The emergency department is 28,000 square feet, and includes state-of-the-art individual asthma treatment stations, a chest pain emergency unit, a women's health suite, an expanded PromptCare service to expedite care for non-acute patients, and the largest decontamination facility in the City.

The hospital recently sold an adjacent parking lot for $75 million in cash to commercial developers. The hospital used approximately $55 million of this to pay vendors, invest in a major new IT system, settle claims with NYU arising from the dissolution of the previous sponsorship arrangement, and provide additional cash collateral to DASNY; approximately $20 million has not yet been spent.

Nearly 50% of NY Downtown's patients were Medicaid-covered or uninsured in 2004. The majority of the hospital's inpatients are maternity and medical cases, which are neither highly reimbursed nor particularly profitable, and its high-volume emergency department and clinics serve a large uninsured population. Analysis measuring the impact of NY Downtown's closure

demonstrated that its patients could be absorbed by its coverage partners, including Beth Israel's Petrie Division, Bellevue, NYU Tisch, St. Vincent's Manhattan, Maimonides Medical Center, Lutheran Medical Center and NY-Presbyterian Weill Cornell Division hospitals. Notably, while NY Downtown has developed a strong relationship with the Asian community, St. Vincent's Manhattan and Beth Israel, both of which are located in downtown Manhattan, have also successfully reached out to the Asian population.

Quality of care at NY Downtown is improving. In 2004, it was named as one of 100 most improved hospitals by Solucient, and, in 2006, it won first prize in New York State's patient safety award program. The Leapfrog Group has recognized the hospital for its computerized drug prescribing systems. The medical staff has been strengthened with the recruitment of new physician leadership: a chief medical officer, chiefs of anesthesiology, obstetrics and gynecology, and surgery, and a director of geriatrics.

The Commission carefully reviewed NY Downtown's strategic plan, developed in cooperation with New York Presbyterian Health Care System (NYPHCS), of which NY Downtown is an affiliate. The plan includes achievable initiatives that have the potential to bring the hospital to a break-even position in 2008, including elimination of inpatient pediatrics and consolidation of this service with NYPHCS, and restructure and divestiture of its three outpatient clinics, and without an addition of unneeded tertiary services.

The proposed amalgamation of NY Downtown's pediatric care with that of NYPHCS will improve both NY Downtown's bottom line and its quality of pediatric care. Second, the proposed financial restructure of the hospital's three outpatient clinics will save NY Downtown approximately $2 million a year. The hospital has approached various community clinics, including the Chinatown Health Clinic, and is exploring several options to restructure its outpatient financing while maintaining access to services. NY Downtown also plans to collaboratively develop with NYPHCS an occupational health and preventive services program in a yet-to-be constructed 25,000 square-foot space adjacent to the hospital.

The Commission rejected the possible closure of NY Downtown Hospital. While lower Manhattan may not require a full-service acute care hospital, the community served by NY Downtown does need access to emergency and ambulatory services. NY Downtown fulfills these needs. The services at NY Downtown, the level of investment in its new emergency department, its dedication to the medically underserved populations of Chinatown and lower Manhattan, the strength of the hospital's strategic recovery plan, and its substantial debt argue for the maintenance of this facility. Financing its closure and the necessary reestablishment of many of its services does not make economic sense.

NY Downtown's challenging financial situation exemplifies the need for systemic reimbursement reform. The conversion of NY Downtown to an emergent/urgent care center with a strong ambulatory care presence might best align community resources and needs. Given the current reimbursement methodology, however, such a conversion would leave the hospital's finances dangerously vulnerable. In order to provide emergency and ambulatory care, a hospital must cross-subsidize these services with acute and/or tertiary services for which there is less demonstrable need. Absent changes in reimbursement, it is not feasible to convert NY Downtown to a more appropriately configured and financially viable facility.

Recommendation 12

Facility (ies)

Manhattan Eye Ear and Throat Hospital (New York County)

Recommended Action

It is recommended that Manhattan Eye Ear and Throat Hospital downsize all 150 beds.

Facility Description(s)

Manhattan Eye Ear and Throat Hospital (MEETH) provides treatment for diseases of the eye, ear and throat, and also offers plastic and reconstructive surgery. It is one of two such specialty hospitals in New York City. The hospital is licensed for 150 beds, of which 30 are in service. According to the provider, the average daily census is 3 inpatients with a 10% occupancy rate based on available beds. The hospital's primary service is ambulatory surgery, and it performs approximately 50 outpatient surgeries per day. MEETH provides outpatient clinics in ophthalmology, otolaryngology and plastic surgery. Eighty-five percent of these outpatient visits are for elective plastic surgery. The hospital has lost money annually since 1998, and projects a $7.7 million operating loss in 2006. MEETH employed approximately 241 FTEs in 2003.

Assessment

MEETH's former board of directors sought to close the hospital in 1999. The MEETH medical staff opposed the closure, and the Office of the New York Attorney General required MEETH to find a new sponsor for the institution. In 2000, Lenox Hill Hospital became MEETH's sponsor, holding typical reserved powers, but each institution has retained separate licensure. Lenox Hill has invested approximately $40 million in MEETH.

Lenox Hill seeks to conclude a full asset merger with MEETH and reconfigure MEETH. Prior to implementing this change, the Office of the New York Attorney General required Lenox Hill to issue a request for proposals from all possibly interested institutions to sponsor or take over MEETH. While many health systems expressed initial interest, no proposals besides that from Lenox Hill were ultimately submitted. Lenox Hill's plan for MEETH includes the preservation of its outpatient services, the closure of all of its inpatient beds, the sale of part of MEETH's real estate holdings, and the possible lease of space to Calvary Hospital to establish end-of-life cancer services in Manhattan. The Commission supports this direction.

NEW YORK CITY REGION

LONG-TERM CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

Split Rock Rehabilitation and Health Care Center (Bronx)

Recommended Action

It is recommended that Split Rock Rehabilitation and Health Care Center close, downsize or convert, contingent on the determination of the Commissioner of Health, after a comprehensive review of the facility in light of the Commission's analytic framework, that such closure, downsizing or conversion would be consistent with the mandate and other recommendations of the Commission.

Facility Description(s)

Split Rock Rehabilitation and Health Care Center is a 240-bed proprietary residential health care facility that provides baseline services, and has ventilator-dependent beds and an adult day health care program. It had an occupancy rate of less than 93% in 2004. In addition, there have been quality concerns at the facility.

Assessment

This facility was identified as a facility of interest based on the Commission's criteria. The Commission repeatedly contacted the administrator of this facility, but has received no response to date. Closure, downsizing or conversion may be warranted. The Commissioner's review should be completed by June 30, 2007, and any closure, downsizing or conversion should be completed by June 30, 2008.

NYC Regional Assessment

After careful review, the Commission concludes that the NYC region does not have a significant excess of nursing home beds. In addition, the prime opportunities for right-sizing in NYC are being completed on a voluntary basis through the State's rightsizing demonstration program.

When evaluating the long-term care delivery situation in New York City, the following facts were considered:

- While the NYC region has roughly one third (38%) of all nursing home beds in the State, it also has around half of the State's population.
- Looking at beds per seniors 1,000 seniors, NYC has 48 beds/1000 while NYS as a whole has 52 beds/1000.
- Four out of five counties (boroughs) that comprise the NYC region, except the Bronx, have bed deficits based on the State's bed need methodology.
- Richmond County (Staten Island) has a calculated need for 295 additional beds and its existing beds are over 96% occupied. Additionally, Staten Island is among the fastest growing counties in the State, with a projected population increase of 42% over the next 30 years.
- Queens County has a calculated need for over 1,700 beds. Queen County is also projected to grow rapidly, by over 30% in the next 30 years. Within Queens, there may be some

excess beds concentrated in the Far Rockaways section. The Commission assessed selected facilities in the Rockaways that are implementing needed turn-around plans.

- New York County (Manhattan) has a documented need for 733 additional beds and an occupancy rate of over 97%. Manhattan nursing homes do have a relatively high proportion of low acuity residents but the cost of real estate in Manhattan generally makes the creation of ALPs unaffordable.
- Kings County (Brooklyn) has a documented need for 938 additional beds. Two Brooklyn facilities are under investigation by the State Attorney General and their future is uncertain; their closure could further exacerbate the shortage.
- On paper, Bronx County has a documented excess of over 2,000 beds and provides over 86 beds per 1,000 seniors. However, Bronx beds are 97% occupied, which is one of the highest average occupancy rates in the entire State. There were no Bronx-based facilities that performed especially poorly across the Commission's review criteria.

Furthermore, activities within the NYC market independent of the Commission are rightsizing the region's nursing home bed supply. Specifically:

- Florence Nightingale Health Center in Manhattan recently closed in 2005. Its closure removed 561 beds from the region's supply.
- Menorah Home and Hospital for the Aged and Infirm (Bushwick) in Brooklyn recently closed in 2005. Its closure removed 206 beds from the region's supply.
- A nursing home in Brooklyn is planning to close within months. Its closure will remove 45 beds from the region's supply.
- In Round 1 of the State's Nursing Home Rightsizing Demonstration, NYC-based facilities decertified 571 beds, or 80% of the total beds decertified statewide.
    - Terence Cardinal Cooke Health Center in Manhattan decertified 156 beds
    - Beth Abraham Health Services in the Bronx decertified 72 beds
    - Cobble Hill Health Center in Brooklyn decertified 156 beds
    - Menorah Nursing Home in Brooklyn decertified 21 beds
    - Metropolitan Jewish Geriatric in Brooklyn decertified 156 beds
    - Rutland Nursing Home in Brooklyn decertified 10 beds

- Nursing homes in the NYC region have applied in Round 2 of the State's Nursing Home Rightsizing Demonstration. If approved, these applications would decertify additional beds from the region's supply and create additional LTHHCP and ALP slots.

NORTHERN REGION

ACUTE CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

Bellevue Woman's Hospital (Schenectady County)

Recommended Action

It is recommended that Bellevue Woman's Hospital close in an orderly fashion. It is further recommended that Bellevue Woman's Hospital's maternity, neonatal, eating disorders, and mobile outpatient education and screening services be added to another hospital in Schenectady County.

Facility Description(s)

Bellevue Woman's Hospital is one of two remaining not-for-profit women's specialty hospitals in the nation, and the only one in the State. It has 55 certified beds, 40 of which were staffed in 2004. Its average daily census was 22 patients in 2004. Its chief service line is low-risk obstetrics. It had approximately 2,200 deliveries in 2004. It also had approximately 2,000 ambulatory surgeries in 2004, and houses breast and pelvic care health centers. Bellevue has partnered with a local mental health provider and the local medical college to train specialists in eating disorder treatment. It does not offer high-risk maternity care, medical surgical care, or emergency services. Eighteen percent of Bellevue's patients in 2004 were Medicaid-covered.

Assessment

The hospital's financial situation is dire and its future viability is in serious jeopardy. It has a substantial debt load and its business model is dependent on the provision of poorly-reimbursed obstetrical services. As of 2004, the hospital's (non-DASNY) long- term debt was approximately $15.5 million. Bellevue has tried to address its financial problems by diversifying the hospital's service base and securing philanthropic support. These measures, however, have proven to be insufficient. Financial statements for 2004 and 2005 indicate a negative net worth, significant debt, and losses from operations. The hospital's net deficits at the end of 2004 and 2005 were respectively $1.192 million and $1.320 million, and its total deficit as of the end of 2005 was $17.690 million. Additionally, Bellevue is unaffiliated with any other hospitals or systems that could provide substantial financial or management assistance to improve the current financial situation.

A capacity to close analysis confirms that Bellevue's patients readily could be absorbed by its coverage partners, including St. Clare's, St. Peter's Albany and Albany Medical Center hospitals. Provided that its distinctive level II neonatal intensive care and an eating disorder program services are transferred to one of the other area hospitals, Bellevue's closure will not affect availability of care. Furthermore, most complicated obstetric and neonatal cases are already diverted to the larger area hospitals, so closing Bellevue will not affect provision of these more high-tech services.

Consolidation of services offered by Bellevue with another area hospital will have quality of care and financial benefits. Consolidating all of Schenectady institutions' deliveries (approximately 3,000 annual births in 2004) into a single area hospital would allow investment in a more comprehensive neonatal intensive care unit than is currently offered by Bellevue. Its closure will also improve the viability of the remaining hospitals in Schenectady by allowing them to capture Bellevue's patient base, a high percentage of which is privately insured.

Bellevue employed approximately 275 FTEs in 2003, which was less than 0.5% of the workforce in Schenectady County. If Bellevue closes, its employees will be easily employed by other

institutions because the elimination of services at Bellevue will be accompanied by a transfer of its services elsewhere in the area.

Recommendation 2

Facility (ies)

St. Clare's Hospital (Schenectady County)
Ellis Hospital (Schenectady County)

Recommended Action

It is recommended that St. Clare's Hospital and Ellis Hospital be joined under a single unified governance structure with full authority to restructure the hospitals, rationalize bed and clinical capacity, minimize duplication of services and capital investment, and develop an integrated health care delivery system. It is further recommended that the resulting entity downsize from 568 beds to between 300 and 400 beds, representing a downsizing of between 168 and 268 beds. It is further recommended that the Commissioner refrain from either approving any applications that have been or will be filed by either facility or providing any other consent requested by either facility, prior to the execution by the facilities of a binding agreement to join under a single unified governance structure, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff. If St. Clare's and Ellis Hospitals fail to execute such an agreement by December 31, 2007, it is recommended that the Commissioner of Health close one of the facilities and expand the other to accommodate the patient volume of the closed facility.

Facility Description(s)

Ellis Hospital is a community hospital in Schenectady, located in close proximity to St. Clare's Hospital. Ellis Hospital has 368 certified beds, of which 272 were staffed in 2004. Its average

daily census was approximately 256. Seventy-one percent of its available beds were occupied in 2004. It provides medical/surgical, emergency, inpatient psychiatric, and outpatient services. Its services include a stroke program, cardiac catheterization, angioplasty, and cardiac surgery. It eliminated its obstetrical services in 2000. Ellis has approximately 33,000 emergency room and 34,000 outpatient visits in 2004. Eight percent of its patients were either covered by Medicaid or uninsured in 2004, and its uncompensated care cost is estimated to have cost the hospital $3.4 million in 2004. Ellis employed approximately 1,550 FTEs in 2003, which was just over 2% of the workforce in Schenectady County. There are 82 skilled nursing facility (SNF) beds located within the hospital plant.

After several years of negative balances, Ellis's financial situation improved, and it now enjoys a positive operating margin. In 2004, Ellis spun off a primary care clinic and re-established it as a federally qualified health center (FQHC) to take advantage of FQHC's higher reimbursement rates. Ellis also reduced the number of its full-time equivalent employees. Ellis carried a substantial debt load of approximately $37.9 million in 2004, $33.2 million of which is with DASNY.

St. Clare's Hospital is a Catholic community hospital with 200 certified beds, of which, according to the hospital, 118 are staffed. Its average daily census was 84 in 2004. It offers medical/surgical, emergency, and obstetric services, as well as a 6-bed geriatric unit and an outpatient sleep disorders unit. St. Clare's has approximately 38,000 emergency department and 51,000 outpatient visits per year. St. Clare's Hospital employed approximately 921 FTEs in 2003, which was just over 1% of the workforce in Schenectady County.

St. Clare's is the main safety net provider in Schenectady. Twenty percent of its inpatients are either covered by Medicaid or uninsured. St. Clare's uncompensated care cost in 2004 is estimated to have cost the hospital $7.6 million.

The service and payor mix at St. Clare's has placed the hospital in financial jeopardy. St. Clare's operating margin in 2004 was -5%. In 2004, it carried only $4.5 million of (non-DASNY) debt; however, its pension plan is underfunded by $27 million. The hospital has little cash. It has

limited ability to make the kinds of future investments that are required for it to remain competitive and efficient.

Assessment

Both Ellis and St. Clare's are underutilized. With adequate preservation of the core services provided by St. Clare's to underserved populations, a consolidation of the two hospitals will reduce costly duplication of services and create efficiencies. These savings could be re-invested in other needed services such as primary and preventive care. The efficiencies to be derived by consolidating the expertise of St. Clare's in the delivery of high-volume, low-reimbursement services with Ellis' expertise in the delivery of more specialized, high-reimbursement services will allow greater cross-subsidization, thereby ensuring the ongoing stability of essential services.

The care provided by both Ellis and St. Clare's hospitals is generally adequate. Ellis's stroke and heart attack care is excellent. The consolidation of Ellis and St. Clare's likely will improve the quality of heart attack and heart failure care at both facilities. Similarly, a stronger relationship between the geriatric acute care unit at St. Clare's and Ellis' residential health care facility will improve the area's quality of elder care.

Absent a consolidation of Ellis and St. Clare's, competition between the two major hospitals in Schenectady will continue to erode and destabilize both hospitals. Both hospitals will face mounting financial difficulties, which will likely culminate in the bankruptcy and/or closure of one or the other. A failure to unite the hospitals will necessitate further, otherwise unnecessary infusions of capital, most likely from the State, as private lenders are unlikely to be willing to invest in such an unstable market.

There should be only one hospital or health system providing inpatient care in Schenectady county. The consolidation of Ellis and St. Clare's will improve the viability of both hospitals, support improvements in quality of care, minimize the need for State subsidy, eliminate the duplication of services between those entities and allow services to be rationalized between the

two campuses. This consolidation will reduce costs by eliminating the excess capacity at both campuses, and propel the reuse and conversion of the facilities and capital resources to more appropriate uses.

NORTHERN REGION

LONG-TERM CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

Ann Lee Infirmary and Albany County Home (Albany)

Recommended Action

It is recommended that Ann Lee Infirmary and Albany County Home merge, downsize by at least 345 RHCF beds, rebuild a unified facility, and simultaneously add or contractually provide financial support for non-institutional services.

Facility Description(s)

Both Ann Lee and Albany County Home are residential health care facilities owned and operated by Albany county. Ann Lee has 175 certified beds, and Albany County Home has 420 certified beds. Both facilities have low occupancy. According to the County, Albany County Home currently occupies only 60% of its beds in 2003, and Ann Lee occupies 91% of its beds. The homes have been operating with substantial financial losses for several years. The County reports having provided more than $5 million in 2005 to subsidize these facilities.

The facilities raise quality of care concerns. According to recent State surveys, Albany County Home had 14 deficiencies and 1 citation for actual harm, and Ann Lee had 5 deficiencies with 1 citation for actual harm. Ann Lee's case mix index from 2003 (0.87) was the lowest in the State.

This low CMI has a tremendous impact on the facility's revenue. If Ann Lee merges with Albany County Home, Ann Lee's CMI and revenues will increase.

Assessment

The County of Albany has a low nursing home occupancy rate (93% in 2004). In addition, nursing homes in the county of Albany lose residents to those facilities in Saratoga County.

Merging Ann Lee and Albany County Home will ameliorate problems associated with the low occupancy of the two facilities. Both facilities are old and out-of-date, and are unsuitable for modern skilled nursing care. Amalgamating the two homes will enable the newly constructed facility to use capital funds more resourcefully. A new facility with a regionally appropriate bed count will improve quality of care and the financial standing of both the newly merged facility and the County, which will no longer have to subsidize two inefficient facilities.

Recommendation 2

Facility (ies)

The Avenue and The Dutch Manor (Schenectady County)

Recommended Action

It is recommended that The Avenue and The Dutch Manor merge and downsize both facilities by approximately 48 RHCF beds to approximately 200 RHCF beds in a rebuilt Avenue facility. It is further recommended that the merged entity add a 50-bed ALP, a 25-slot ADHCP and possibly other non-institutional services in a renovated Dutch Manor facility.

Facility Description(s)

The Avenue and The Dutch Manor are owned and operated by an eight-facility proprietary group. The group runs five facilities in the Northern region. The Avenue is a 224-bed residential health care facility and the Dutch Manor is an 86-bed facility. Both provide baseline services and sub-acute care.

These facilities are located a short distance from each other. Both have weak occupancy. In 2003, the Avenue occupied approximately 48% of its beds, and the Dutch Manor occupied approximately 78% of its beds.

The Avenue has suffered from significant operating losses for the last several years. Approximately 20% of its residents were low-acuity in 2003. Its quality has varied over the years. In its latest survey, the Department of Health cited three deficiencies, including one for actual harm. It is housed in a building from the 1950s, and past scandals have hurt its reputation.

The Dutch Manor, on the other hand, attracts a good private pay market and is profitable. It is housed, however, in an old building that is less than optimal for current skilled nursing care.

Assessment

As with most areas of New York State, Schenectady has enough nursing home beds but insufficient non-institutional alternatives. The Commission calculates that approximately 32 current Schenectady nursing home residents can be cared for in an ALP. Availability of ALP beds will reduce current and future need for skilled nursing beds.

The owner of The Avenue and Dutch Manor nursing homes stated that the homes will submit a certificate of need application to the State for a single replacement facility of both facilities, with an amalgamated downsizing by 68 beds. In addition, the Dutch Manor would need to be renovated to be suitable for an ALP.

Recommendation 3

Facility (ies)

Glendale Home (Schenectady County)

Recommended Action

It is recommended that the Glendale Home downsize by approximately 192 RHCF beds to approximately 168 RHCF beds to be operated in the newest building.

Facility Description(s)

Glendale Home is a residential health care facility owned and operated by Schenectady County. It provides baseline services and some short-term care. The home decertified 168 beds in 2002 resulting in a certified capacity of 360 beds, staffing only 305. Approximately 87% of its certified beds were occupied in 2003.

Glendale Home faces many challenges. Its occupancy is low, which is driven by competition in its geographic area. The facility operates at a substantial operating loss, which the County is required to subsidize. The subsidy in 2005 was $6.4 million, which accounted for 22% of the home's operating budget. The facility had a high case mix index in 2003 (1.10), and correspondingly relatively few of its residents are low-acuity. The home, however, has had quality issues, including 10 deficiencies and two immediate jeopardies in its last survey.

The facility now operates beds in two of its three buildings, one with 137 beds and built in 1934, and one with 168 beds, built in 1979. The remaining building, built in 1960, has no beds, and is instead used for administrative and support services. Much of this building stands vacant.

Assessment

The Glendale Home is having difficulty filling its beds with appropriate residents given its large size. Furthermore, a large number of Schenectady residents seek long-term care in neighboring Saratoga County, which has just received approval for two new facilities. Potential Glendale Home residents also seek care in Albany and Rensselaer counties.

This plan to downsize Glendale Home will use the resources available on its existing campus, which will minimize the dislocation of current residents and mitigate any potentially negative impact on long-term care services in Schenectady County.

WESTERN REGION

ACUTE CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

Millard Fillmore Hospital – Gates Circle (Erie County)

Recommended Action

It is recommended that Millard Fillmore Hospital – Gates Circle close in an orderly fashion. It is further recommended that Millard Fillmore Hospital – Gates Circle's 75 RHCF beds be preserved and transferred to DeGraff Memorial Hospital.

Facility Description(s)

Millard Fillmore Hospital - Gates Circle is a 189-bed, acute care hospital, and is a member of the Kaleida Health Care System. It provides emergency, medical/surgical and outpatient care. Gates Circle has specialized programs in neurology and stroke care, and is a designated stroke center in the Western Region. Gates Circle had approximately 7,800 discharges and 18,000 emergency department visits in 2004. Medicaid-covered and uninsured patients represented 10% of total discharges. Approximately 26% of inpatients live in medically underserved areas. Gates Circle also houses 75 skilled nursing facility beds, which offers subacute short-term rehabilitation care.

Assessment

Erie County, in which Millard Fillmore Hospital – Gates Circle is located, has substantial excess inpatient capacity. The greater Buffalo metropolitan area and Erie County's population continues to shrink. Erie County's population is projected to further decline by 15% between 2000 and 2030. Erie County's inpatient capacity, however, has not correspondingly dropped. As a result, there are numerous underutilized facilities in the Buffalo area. To preserve competitive market balance, it is essential that both of the region's two major hospital systems – Kaleida Health and Catholic Health System – participate in downsizing their facility infrastructure.

Within the Kaleida System, Millard Fillmore Hospital – Gates Circle has been identified as the optimal candidate for closure. Among the Kaleida System hospitals, the Gates Circle campus is outdated and in need of extensive capital upgrades. It is underutilized, and had an occupancy rate of 59% of certified beds in 2004. Analysis measuring Gates Circle's capacity to close indicated that all of its patients could be readily absorbed by its coverage partners, which include Buffalo General (also a Kaleida member), Erie County Medical Center, Sisters of Charity Buffalo, and Kenmore Mercy hospitals.

The hospital's long term debt is part of Kaleida Health 's $191 million indebtedness, including $155 million that is DASNY and HUD insured. Following consecutive losses in its first five years as a system, Kaleida Health had a positive and growing bottom line for the past three years. In 2005, Kaleida Health posted a $26 million profit on $935 million in revenues. Of those amounts, Millard Fillmore-Gates Circle contributed a $14 million surplus on revenues of $170 million. The remaining $12 million surplus was spread across the systems' other four hospitals and its nursing facilities.

Recommendation 2

Facility (ies)

St. Joseph Hospital of Cheektowaga, New York (Erie County)

Recommended Action

It is recommended that St. Joseph Hospital of Cheektowaga close in an orderly fashion.

Facility Description

St. Joseph Hospital of Cheektowaga, New York is a 208-bed acute care hospital, and a member of the Catholic Health System – Buffalo Hospital System. It provides emergency, medical/surgical, and outpatient care. The hospital had approximately 5,842 discharges and 22,477 emergency department visits in 2004. Medicaid-covered and uninsured cases represented just 5% of discharges, and 4% of patients came from medically underserved areas in 2004. St. Joseph's had a 3.4% operating margin in 2003. The hospital has $3.3 million of (non-DASNY) long-term debt. St. Joseph employed approximately 555 full time equivalent employees in 2003.

Assessment

As noted above, Erie County is substantially over-bedded and presents major opportunities for each of the major systems to downsize and reconfigure acute care services. Within the Catholic Health System, the underutilized St. Joseph Hospital has been identified as the optimal candidate for closure. St Joseph Hospital and Sisters of Charity Hospital, another member of the Catholic Health System, are less than 6 miles apart. Both of these hospitals have occupancy rates of less than 50% based on licensed beds. St. Joseph filled approximately 44% of its licensed beds and 58% of its available beds in 2004. Analysis performed by the Commission indicates that St. Joseph's patients could readily be absorbed by the hospital's coverage partners, which include Mercy Hospital and Sisters of Charity Hospital, which are both members of the Catholic Health

System, and by Millard Fillmore Suburban Hospital, Buffalo General Hospital, and the Erie County Medical Center. St. Joseph does not provide unique services and is not a major provider of care to vulnerable populations.

The Catholic Health System has developed creative and productive alternate uses for decommissioned hospitals and there may be potential to redevelop the St. Joseph site. Catholic Health System, for example, has worked with the New York State Department of Health to develop its Mercy Ambulatory Care Center (MACC) program in Orchard Park. The MACC has an emergency room and two inpatient beds for patients who require up to 36-hour length of stay. The campus also includes physician offices, a laboratory, x-ray machines, a pharmacy, and a diagnostic testing facility. Not all providers on the campus are part of the CHS; in fact, many are simply tenants in the facility's "medical mall."

Recommendation 3

Facility (ies)

DeGraff Memorial Hospital (Niagara County)

Recommended Action

It is recommended DeGraff Memorial Hospital downsize all 70 medical/surgical beds and cease operation as an acute care hospital. It is further recommended that DeGraff Memorial Hospital convert completely to a Residential Health Care Facility encompassing its existing 80 RHCF beds and the 75 RHCF beds to be transferred from Millard Fillmore Hospital- Gates Circle.

Facility Description(s)

DeGraff Memorial is a 70-bed acute care hospital, and a member of the Kaleida Health Care System. It provides emergency and medical/surgical care. It also houses an 80-bed skilled

nursing facility unit. DeGraff provided nearly 3,000 discharges and approximately 7,500 emergency department visits in 2004. 7% of its inpatients were Medicaid-covered or uninsured in 2004, and 2% of patients came from medically underserved areas.

Assessment

Using the Commission's framework criteria, DeGraff Memorial performed poorly on quality, viability, and availability of services. Analysis performed by the Commission indicated that its average daily census of 46 acute patients could be readily absorbed by the hospital's coverage partners, which include Kenmore Mercy, Millard Fillmore Suburban, Buffalo General, Saint Mary's, Erie County Medical Center, Sisters of Charity, Millard Fillmore and Women and Children's hospitals. The hospital's long term debt is reported with that of the Kaleida system.

There is an excess of medical/surgical beds in the Western region, and patients' access to care will not be compromised if DeGraff closes. Given the ready access to more comprehensive services at neighboring hospitals, there is no need for the medical/surgical component of DeGraff. However, as described in the long term care report, DeGraff operates a well-utilized skilled nursing facility that should be maintained. The occupancy of its SNF is 97%. DeGraff's physical plant is in good condition. The conversion of DeGraff to a long-term care facility will mitigate the effects of its closure as an acute care facility, and will enable the provision of needed long-term care services in the Buffalo metropolitan area.

Recommendation 4

Facility (ies)

Sheehan Memorial Hospital (Erie County)

Recommended Action

It is recommended that Sheehan Memorial Hospital be maintained as an Article 28 provider. It is further recommended that 69 medical/surgical beds at Sheehan Memorial hospital be downsized. It is further recommended that 22 inpatient detoxification beds currently at Erie County Medical Center be transferred to Sheehan Memorial Hospital, provided that the Commissioner of Alcoholism and Substance Abuse Services approves such transfers. It is further recommended that Sheehan Memorial Hospital enhance its community based ambulatory care services, be licensed to provide methadone maintenance, and be licensed as an Article 31 provider of outpatient psychiatric services, provided that the Commissioner of Alcoholism and Substance Abuse Services and Commissioner of Mental Health approve such actions.

Facility Description(s)

Sheehan Memorial Hospital is a safety net provider, and is located in a poor, underserved community in downtown Buffalo. Although it is licensed for 109 total beds, 69 medical/surgical beds were taken out of service in 2003. It currently operates 30 substance abuse rehabilitation beds and 10 medically managed detoxification beds. As part of its restructuring plan, Sheehan also closed its emergency room.

Sheehan operates at 90% occupancy of its staffed beds. It offers adult and pediatric primary care, diagnostic services, radiology, and has specialty clinics in gynecology, cardiology, orthopedics, pulmonary care, urology, general surgery, and podiatry. Sheehan had approximately 1,100 discharges in 2004. Its current ambulatory care volume is approximately 11,500 visits. With approximately 240 full-time equivalent employees, Sheehan is an important employer in its community and its large campus serves as a neighborhood anchor.

Sheehan is successfully executing a turnaround plan. Sheehan first entered chapter 11 bankruptcy protection in 2002. Following continuing financial and leadership problems, Sheehan reconstituted the Board under new leadership, and again sought chapter 11 bankruptcy protection in 2004**.** Sheehan has since engaged a new chief executive officer, entered into collaborative

relationships with Grace Manor Nursing Home and Kaleida Health, and cut costs by half. After suffering from yearly deficits, Sheehan posted a nearly $4 million surplus in 2005. Sheehan expects to emerge from bankruptcy in 2006 with a remaining $4 million debt service. It has virtually no pension obligations.

Built in 1976, Sheehan is among the newer hospitals in Erie County. The physical plant is in relatively good condition. One of its five floors that had housed medical/surgical beds is currently vacant.

Assessment

Sheehan has voluntarily downsized and reconfigured its services to align with the greatest needs of its community: substance abuse treatment and outpatient services. The closure of its emergency room and medical/surgical beds reduced duplicative services that are now provided by more comprehensive nearby facilities. The refocused Sheehan fills a critical need. In Erie County, Sheehan provides 38% of drug detoxification and rehabilitation services and 44% of hospital inpatient substance abuse services. Residents of Sheehan's service area are 2.3 times more likely to be admitted to substance abuse treatment programs than the County's residents as a whole.

It is feasible to close Sheehan. Sheehan has low utilization and is financially vulnerable. Its inpatients could be absorbed by its principal coverage partner, Erie County Medical Center. Sheehan is small and is not formally linked to a larger partner or system.

However, there are compelling reasons why Sheehan should remain open and be strengthened. Sheehan offers accessible, culturally competent primary and specialty care to a poor, underserved community whose members have higher rates of morbidity than Erie County residents as a whole. Seventy-nine percent of Sheehan's patients are minorities. One third of Sheehan's service area residents live in poverty, compared to 12% for Erie County as a whole. Forty percent of Sheehan's patients do not use a car as their primary means of transportation; many walk to Sheehan for care. Sixty-eight percent of Sheehan's detoxification/rehabilitation

patients have at least one physical co-morbidity, including cardiovascular disease, asthma, diabetes, hypertension, cancer or HIV.

Of the two inpatient substance abuse providers in Erie County, Sheehan and Erie County Medical Center(ECMC), only Sheehan is operating at capacity. At ECMC, substance abuse services are a minor component of the hospital's overall mission. The transfer of Erie County Medical Center's 22 detoxification beds to Sheehan would give patients the benefit of a comprehensive, focused, high quality program in a facility where substance abuse treatment is the major service line.

Sheehan is a vital provider of services to a community with severe health care needs. Following years of mismanagement, the current board and executive leadership is capable and committed. With a consolidation of substance abuse services and expansion of outpatient care, Sheehan provides access to health care for disadvantaged patients and is a public health asset worth preserving.

Recommendation 5

Facility (ies)

Erie County Medical Center/Erie County Medical Center Corporation (Erie County)
Buffalo General Hospital/Kaleida Health (Erie County)

Recommended Action

It is recommended that the facilities controlled by the Erie County Medical Center Corporation and Kaleida Health be joined under a single unified governance structure under the control of an entity other than Erie County Medical Center Corporation, Kaleida Health, or any other public benefit corporation. It is further recommended that this entity consist of a reconstituted single

board including representation of Kaleida Health, the Erie County Medical Center Corporation, the University at Buffalo School of Medicine and Biomedical Sciences, and community leaders. If the Commissioner of Health determines that the single board proposed by the member entities does not meet these requirements, it is further recommended that the Commissioner of Health alter the composition of the board to satisfy these requirements. It is further recommended that this entity have unified management with powers sufficient to compel the service mix provided at any of the individual institutions under its control. It is further recommended that the joined entity utilize existing infrastructure to the extent possible to consolidate all necessary services into clinical centers of excellence, including tertiary, quaternary, psychiatric, and long term care services. It is further recommended that the joined entity develop new infrastructure in which to locate comprehensive heart and vascular services. It is further recommended that the Commissioner of Health:

(i) Refrain from either approving any applications that have been or will be filed by either entity or providing any other consent requested by either facility, prior to the execution by the facilities of a binding agreement to join under a single unified governance structure pursuant to the terms of this recommendation, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff;

(ii) If Kaleida Health and Erie County Medical Center Corporation fail to execute such an agreement by December 31, 2007, close either Buffalo General Hospital or Erie County Medical Center and expand the other to accommodate the patient volume of the closed facility; and

(iii) Present to the State Legislature any necessary draft legislation in a time and manner sufficient to implement this recommendation by June 30, 2008.

Facility Description(s)

Erie County Medical Center (ECMC) is a 550-bed hospital sponsored by a public benefit corporation established in 2004. The hospital is situated on 67-acre, largely undeveloped campus. ECMC provides comprehensive acute care services, including level I trauma, burn care, kidney transplant, psychiatry, physical medicine/rehabilitation, and detoxification services.

ECMC has one of the highest case mix indexes of all New York State hospitals. According to ECMC leadership, ECMC had approximately 12,000 discharges and 48,000 emergency department visits in 2005. Its numerous outpatient clinics had approximately 243,185 visits in 2004. ECMC serves a large number of indigent patients; approximately 25% of its inpatients were Medicaid-covered or uninsured in 2004, and 25% of its patients live in medically underserved areas. ECMC reports that approximately 70% of its 505 available beds are occupied. ECMC's main campus has 125 skilled nursing facility beds. In addition, ECMC operates the Erie County Home, a 586-bed skilled nursing facility. Virtually all of the nursing home beds operated by ECMC are occupied. ECMC has $106 million in long-term debt, most of which is secured by the County. ECMC has approximately 2,787 full-time-equivalent employees.

Recently resolved litigation required that the County subsidize ECMC through 2008. The amount of this subsidy decreases each year: $28 million in 2004, $19 million in 2005, $20 million in 2006, $14 million in 2007. After 2008, the County will provide ECMC with $8 million annually as debt service coverage. ECMC finished in the black including the subsidy in 2005. It is projecting a surplus in 2006 of approximately $16 million.

Buffalo General Hospital (BGH) is a 501-bed member of the Kaleida Health Care System. BGH is located on the Buffalo Niagara Medical Campus, a densely developed site that also houses the Roswell Park Cancer Institute and other research institutions. BGH is the focal point for Kaleida's development of high-tech, tertiary care services. It provides comprehensive medical/surgical, psychiatry and physical medicine/rehabilitation services. It had approximately 17,000 discharges and 38,000 emergency department visits in 2004. Nineteen percent of BGH's inpatients were Medicaid-covered or uninsured in 2003, 23% of its patients live in medically underserved areas. The hospital reports an occupancy rate of 67% of its 501 available beds. BGH's long-term debt is reported together with other components of the Kaleida System. BGH has approximately 2,300 full-time-equivalent employees. Since its founding seven years ago, the Kaleida system has voluntarily decertified 638 beds and eliminated more than 1 million square feet of space.

Assessment

This recommendation is partly shaped by the particularities of Erie County and the Buffalo metropolitan area, including:

- The county is over-bedded, with more inpatient capacity than is required to meet the health care needs of its shrinking population.
- There is duplication of costly tertiary and quaternary services. Redundancy of these services reduces quality of care due to insufficient patient volume.
- Access to critical services, including psychiatry, trauma and burn care, must be maintained.
- There must be sufficient graduate medical education capacity to strengthen the academic mission of the University at Buffalo School of Medicine and ensure an adequate future supply of physicians.
- Erie County and the City of Buffalo both face serious economic challenges. Economic control boards oversee their finances.

A comprehensive plan to reconfigure service delivery in Buffalo must address ECMC. ECMC is burdened with substantial legacy costs from its establishment as a public benefit corporation (PBC) and from high fringe benefit costs embedded within its labor contract with a public employees union. When the Erie County Medical Center Corporation was launched in January 2004, it took over a large healthcare network that serves as the primary safety net provider to residents of Erie County.

The public benefit corporation was established with the assumption that it would provide area residents with quality health care, while reducing the fiscal burden on County taxpayers which in the six years ending in 2003, totaled $119 million in subsidies. Unfortunately, the public benefit corporation model did not resolve the financial crisis for the County. The Office of the Comptroller of NYS criticized the way in which ECMC was created, finding that Erie County had followed the same unsuccessful model used by Nassau and Westchester Counties, i.e., taking a public hospital that was losing significant amounts of money and encumbering it with

significant new debt, and setting it up as an independent agency with no specific new revenue or operational initiatives that would help it achieve self-sufficiency.

Erie County Medical Center and Buffalo General Hospital are both vital components of the local health care delivery system. Analysis of patient discharge data reveals that ECMC and BGH are each other's principal coverage partners. Each of these large facilities provides basic and high-tech services. They are both major teaching facilities for the State University of New York at Buffalo.

As competing institutions, the resources of ECMC and BGH are not leveraged in the most effective manner to benefit the community, contain costs, and drive improvements in quality of care. After considering numerous scenarios for the reorganization of services at ECMC and BGH, the Commission finds that combining ECMC and Kaleida into a new, not-for-profit entity with one board and chief executive is the optimal approach for the people of Erie County. A single entity will be able to reduce duplication of services, enhance quality of care, maintain the provision of public goods, reduce costs, preserve employment, and support an academic mission. While imperfect, the Commission further finds that this approach entails fewer risks, is less disruptive, and can be achieved at lower cost than other proposals that were considered.

ECMC and Kaleida themselves attempted to forge a combined entity on a voluntary basis. This effort broke down due to labor issues involving public and non-public employees and difficulties involved in working within a public benefit corporation structure. However, such a combined entity offers numerous advantages. It makes effective use of scarce resources because it does not demolish and rebuild infrastructure that already exists. The plan protects public goods currently provided by the facilities. The plan also maintains critically needed residency training slots that could otherwise be at risk. The facilities will be retained, maintaining a range of services for the community and preserving jobs. The public benefit corporation, however, would be dissolved, freeing the resulting new entity to compete in the market without the overhead imposed by its debt and excess labor costs.

There are complex challenges involved in dissolving a public benefit corporation and resolving the legacy issues at ECMC. Implementation of this recommendation may require statutory change by the legislature. Any substantive plan for reconfiguring service delivery in Erie County, however, must grapple with ECMC and confront the governance and labor challenges posed by the facility. Failure to do so is an unacceptable lost opportunity.

Recommendation 6

Facility (ies)

Lockport Memorial Hospital (Niagara County)
Inter-Community Memorial Hospital at Newfane (Niagara County)

Recommended Action

It is recommended that Lockport Memorial Hospital and Inter-Community Memorial Hospital at Newfane engage in a full asset merger and reconfiguration of services.

Facility Description(s)

Lockport Memorial Hospital has 134 licensed beds,and a 2004 average daily census of 71 patients. It provides medical/surgical, pediatric, obstetric, drug and alcohol rehabilitation, and outpatient services. It had approximately 4,691 discharges and 14,935 ED visits in 2004. Approximately 11% of inpatients were Medicaid-covered or uninsured in 2004. Its 2004 operating margin was -1%, and the hospital has reported a positive operating margin for 2005. Lockport has $12 million in long-term debt, $8.8 million of which is secured by DASNY and the federal Department of Housing and Urban Development.

Inter-Community Memorial at Newfane has 71 licensed beds, of which it staffs 51. Average daily census in 2004 was 32 patients. It provides medical/surgical, obstetric, pediatric, and

outpatient care. It had approximately 2,565 discharges and 7,837 emergency department visits in 2004. 14% of inpatients were Medicaid-covered or uninsured in 2004. Inter-Community's operating margin since 1994 has been positive. Inter-Community's 2004 operating margin was 1%. Inter-Community has approximately $5.3 million in (non-DASNY) long-term debt.

Assessment

Lockport Memorial and Inter-Community Memorial hospitals entered into an affiliation in 2000. Inter-Community helped stabilize Lockport's finances, and has since granted Lockport approximately $2 million in assistance. The two hospitals are controlled by a unregulated, passive parent, the Eastern Niagara Health System. They share a single executive staff and have consolidated certain operations, such as one clinical laboratory. There is some overlap between their medical staffs. Collectively they report achieving $1.8 million per year in savings through by having consolidated their operations.

The hospitals are approximately 10 miles apart, and share a similar patient base. Each hospital is the other's primary coverage partner. Despite their close proximity, neither facility should close. Eastern Niagara County is rural and lacks public transportation. Travel to both facilities is difficult, due partly to each hospital's dependence on a volunteer emergency medical system. In addition, the two hospital structure helps attracts physicians to serve a community in which parts are designated as medically undeserved.

Recommendation 7

Facility (ies)

Bertrand Chaffee Hospital (Erie County)
TLC Health Network – Lake Shore Hospital (Chautauqua County)
TLC Health Network – Tri-County Memorial Hospital (Cattaraugus County)
Brooks Memorial Hospital (Chautaqua County)
Westfield Memorial Hospital (Chautauqua County)

Recommended Action

It is recommended that Bertrand Chaffee Hospital downsize by at least 25 inpatient beds to less than 25 beds and seek designation as a Critical Access Hospital or sole community provider, and that Brooks Memorial Hospital seek designation as a sole community provider, and that:

(i) Bertrand Chaffee Hospital affiliate with TLC Tri-County and TLC Lake Shore;
(ii) TLC Tri-County downsize 28 medical/surgical beds, convert the remaining 10 medical/surgical beds to 10 detoxification beds provided that the Commissioner of Alcoholism and Substance Abuse Services approves such additions, and continue to provide chemical dependency, emergency and outpatient primary care services;
(iii) TLC Lake Shore downsize all 42 medical/surgical beds and 40 RHCF beds and convert its acute care services to an outpatient/urgent care center with Article 28 diagnostic and treatment center licensure;
(iv) TLC Lake Shore, at its option, either continue to provide mental health services or downsize all 20 psychiatric beds provided that approximately 20 psychiatric beds be added somewhere in southern Erie, northern Chautauqua or northern Cattaraugus Counties by another sponsor, pending completion of an RFP process and provided that the Commissioner of Mental Health approves such additions; and
(iv) Westfield Memorial Hospital downsize all 32 inpatient beds and convert to an outpatient/urgent care center with Article 28 diagnostic and treatment center licensure.

Facility Descriptions

Bertrand Chaffee, TLC Tri-County and TLC Lake Shore are three rural hospitals that form a cluster in the Southeast corner of the Commission's Western region. The TLC Network includes Lake Shore Health Care Center and Tri-County Memorial Hospital. Bertrand Chaffee is located to the east of these facilities, all of which are linked by Route 39. The baseline data on the acute care services offered by these three facilities is as follows:

2004 Data	Bertrand Chaffee	Tri-County	Lake Shore
Certified beds	49	62	62
Available beds	32	116	
Average daily census	16	24	33
Discharges	1,385	3,236	
% Medicaid-covered/uninsured	7%	11%	
Emergency department visits	9,308	17,680	
Operating margin (2003)	-4.8	-8.9	
Long-term debt	N/A	$11.9M (non-DASNY)	
Full-time equivalents (2003)	287	599	

Bertrand Chaffee has 49 certified beds, including a 45-bed medical/surgical unit and a 4-bed intensive care unit. Bertrand Chaffee also operates 80 residential health care facility beds.

TLC Health Network – Tri-County Memorial Hospital has 62 certified beds, including a 38-bed medical unit and a 24-bed chemical dependency (alcohol rehabilitation) unit. Tri-County, located in Gowanda, also operates 3 primary care clinics and 2 dental clinics.

TLC Health Network – Lake Shore Hospital has 62 certified beds, including a 39-bed medical/surgical unit, a 3-bed intensive care unit, and a 20-bed mental health unit. Lake Shore

also operates 160 residential health care facility beds and a 267-slot long term home health care program.

Brooks Memorial Hospital, located in downtown Dunkirk, has 99 licensed beds, and offers medical/surgical and maternity care. Brooks had approximately 3,386 discharges, 14,201 emergency department visits and 78,755 outpatient visits in 2004. Twelve percent of its discharges were of Medicaid-covered and uninsured patients in 2004. The hospital reported that 40% of its certified beds were occupied in 2004, and had a -1.9% operating margin in 2003. Brooks holds $3.3 million of (non-DASNY) long-term debt.

Westfield Memorial Hospital is a 32-bed hospital on the western border of Chautauqua County. It is a member of the St. Vincent Health System in Erie, Pennsylvania. It offers medical/surgical and obstetric inpatient care and outpatient care. Westfield had approximately 1,032 discharges and 6,455 emergency department visits in 2004. Eleven percent of its discharges in 2004 were Medicaid-covered or uninsured. Approximately 23% of its certified beds were occupied in 2004, and its 2003 operating margin was -0.5%. Its average daily census was 7 patients in 2004. Westfield holds $4 million of (non-DASNY) long-term debt.

Assessment

The geographic proximity of these small rural hospitals, coupled with their current clinical specializations, provide a unique opportunity to concentrate medical/surgical, psychiatric and chemical dependency services and to achieve substantial efficiencies. The affiliation of Bertrand Chaffee and TLC Network would include financial and management consolidation and implementation of a single information technology system. At this time, a committee with representation from each board and management as well as physicians, has been established to evaluate the affiliation.

Bertrand Chaffee has had significant financial difficulties and recently appealed to its community for financial support in order to remain open. The facility provides care to residents of Southern Erie County as well as Northeastern Cattaraugus County. The next closest acute care facility is

TLC Tri-County Memorial Hospital, which is approximately 18 miles away. This plan strengthens Bertrand Chaffee by providing the opportunity to become a sole community provider or Critical Access Hospital, thereby increasing reimbursement to the facility. Since the facility has an average daily census of 16, decreasing the number of licensed beds to 25 will not affect the ability of the hospital to provide necessary care to the community.

TLC Tri-County's 62 licensed beds includes 24 alcohol rehabilitation beds and 38 medical/surgical beds. The elimination of Tri-County's medical/surgical beds is essential to allow Bertrand Chaffee to qualify for such increased reimbursement. Moreover, such downsizing will allow Tri-County to expand its current specialization in the area of chemical dependency. Presently, the average daily census of Tri-County's 24 alcohol rehabilitation beds is 22, whereas its medical/surgical beds have an average daily census of only 3. The proposed redistribution of beds allows needed services to continue and expand to be provided in the community. The proposal also recognizes the need for the availability of emergency/urgent care for this rural community.

Lake Shore is located only 17 miles north of Brooks using the New York State Thruway. They share medical staff, and there are frequent referrals between the two. Similarly, Westfield Memorial is located approximately 23 miles south of Brooks via the Thruway. Brooks has had numerous updates over time, including a modernization within the past 4 years. Given Brooks' size and occupancy, it could easily absorb both Westfield's average daily census of 7 patients and Lake Shore's average daily medical/surgical census of 21 patients.

The decertification of both Lake Shore's and Westfield's inpatient beds will improve Brooks' occupancy and margin, resulting in more funds for reinvestment and better access to capital markets. Moreover, it will also allow Brooks to apply for sole community provider status, further improving the hospital's bottom line. This can be accomplished without limiting access to vital services in a rural setting. Both Lake Shore and Westfield should continue to provide urgent and ambulatory care. Given the size and mix of both Lake Shore and Westfield, it is appropriate that they become primarily emergent/urgent and ambulatory care campus. A complete closure of these facilities is not in the best interest of these rural communities.

Recommendation 8

Facility (ies)

Mount St. Mary's Hospital and Health Center (Niagara County)
Niagara Falls Memorial Medical Center (Niagara County)

Recommended Action

It is recommended that Mount St. Mary's Hospital and Health Center or its sponsoring entity and Niagara Falls Memorial Medical Center participate in discussions supervised by the Commissioner of Health to explore the creation of a single unified governance structure to end the medical arms race in Niagara County that is expending scarce resources on duplicative services. It is further recommended that the Commissioner refrain from either approving any applications that have been or will be filed by either facility or providing any other consent requested by either facility prior to the conclusion of such discussions, as determined by the Commissioner of Health, except where such approval or consent is necessary to protect the life, health, safety and welfare of facility patients, residents or staff. If either Mount St. Mary's Hospital and Health Center or its sponsoring entity or Niagara Falls Memorial Medical Center fail to participate in such discussions in good faith, as determined by the Commissioner of Health, it is recommended that the Commissioner of Health close that facility and expand the other to accommodate the patient volume of the closed facility.

Facility Description(s)

Mount St. Mary's Hospital and Health Center (MSM) is a 175-bed acute care facility, which became a member of the Ascension Health System in 1997. It provides medical/surgical, alcohol rehabilitation and maternity care, and has a level I perinatal care designation. In 2004, MSM's occupancy rate was 60.2% based on 175 certified beds and 67.8% based on its 155 available beds. Its average daily census was 105 patients in 2004. MSM's emergency department visits

decreased from 21,121 in 2003 to 20,342 in 2004. The hospital has approximately 722 full–time equivalent employees. Additionally, Our Lady of Peace Nursing Care Residence (OLP) is a separately incorporated affiliate of MSM that operates a 250-bed nursing home on MSM's campus.

Niagara Falls Memorial Medical Center (NFMMC) is a 183- bed acute care facility, which provides medical/surgical care and pediatric and psychiatric services. It too has a level I perinatal care designation. NFMMC's 2004 occupancy rate was 67.5%. NFMMC's 66 licensed psychiatric beds had an average daily census of 54 patients in 2004. NFMMC has had a steady increase in emergency department visits. In 2003, it had 24,296 emergency department visits, and in 2004, it had 24,673 visits. It has approximately 834 full-time equivalent employees.

MSM and NHMMC are located six miles apart.

Assessment

Duplication of services fuels the medical arms race and wastes limited resources. Maternity care is an obvious example of the duplication of services taking place in this area. MSM has ten licensed maternity beds with an average daily census of four, while NFMMC has sixteen licensed maternity beds also with an average daily census of four.

Approximately 9 years ago, MSM and NFMMC formed Health System of Niagara with the intention of combining the two hospitals. That effort met with resistance and the plan ultimately broke down. Today, the hospitals are fierce competitors.

According to MSM, Ascension Health provided NFMCC with approximately $23.5 million to go forward with the talks. After the deal fell apart, Ascension forgave all but $5.0 million of the debt. MSM believes that this situation put NFMMC in a better financial position, which continues today. While MSM had an operating margin of 2.2% in 2002, it decreased to -1.1% in 2003. Conversely, NFMMC had an operating margin of
-6.3% in 2002 which improved to a positive 0.4% by 2003.

The Niagara County community would be best served by an integrated provider with the capacity to rationalize services and ensure that health care needs are met within the community. The issues of religious identity and the amount of debt for each institution are formidable obstacles to overcome. Nonetheless, there is an opportunity to create a direction for the future organization of health services in Niagara County. Regional planning efforts would reduce duplication of services across the two facilities (e.g., emergency departments, medical/surgical beds, maternity, operating rooms), reduce administrative inefficiencies, limit the medical arms race between the facilities and ensure the future of health care availability in the area.

WESTERN REGION

LONG-TERM CARE RECOMMENDATIONS

Recommendation 1

Facility (ies)

Mount View Health Facility (Niagara County)

Recommended Action

It is recommended that Mount View Health Facility downsize all 172 RHCF beds, rebuild a new facility on its existing campus, and add a 100-bed ALP, a 50-slot ADHCP and possibly other non-institutional services.

Facility Description(s)

Mount View is a 172-bed residential health care facility, owned and operated by Niagara County. In addition to baseline services, Mount View operates a 25-slot adult day health care program.

The facility faces many problems, and has recently entered into a contract of sale with Senior Associates of Batavia. According to the County executive, the contract includes a clause that the sale becomes null and void if the Commission makes any recommendation that specifically affects this facility.

Challenges facing Mount View include:

- a very low occupancy (it has occupied less than 80% of its beds since 2004, and is currently runs at approximately 75% its capacity);

- a very outdated building, which was originally built as a school in the early twentieth century;
- a relatively low case mix (1.07), with 15% of its staffed beds occupied by low-acuity individuals; and,
- an uncertain financial viability. The facility loses approximately $2.5 million annually, and requires subsidization from Niagara County, which the taxpayers cannot afford.

According to the Niagara County manager and the facility's administrator, employee benefits comprise 52% of wages, which is unusually high.

Assessment

While the county legislature approved the facility's sale, this area of Niagara county requires the expansion of less-restrictive settings. It has less need for 24-hour skilled nursing care. The Mount View facility is located on an attractive campus, which could be redeveloped to house continuum-of-care services, including adult day care and an ALP. Approximately 125 individuals reside at Mount View, some of whom should be transferred to an ALP when it is established and built.

Recommendation 2

Facility (ies)

Nazareth Nursing Home and Mercy Hospital Skilled Nursing Facility (Erie County)

Recommended Action

It is recommended that:

(i) Nazareth Nursing Home downsize all 125 RHCF beds and the facility be converted for use as part of a PACE program to be added at the former Our Lady of Victory Hospital;

(ii) 10 RHCF beds be added to the 74 RHCF beds currently at Mercy Hospital Skilled Nursing Facility, and all 84 RHCF beds be transferred from Mercy Hospital Skilled Nursing Facility to the former Our Lady of Victory Hospital; and

(iii) 80 adult home beds at St. Elizabeth's Home of Lancaster in Erie County be converted to an 80-bed ALP.

Facility Description(s)

Nazareth Nursing Home, Mercy Hospital Skilled Nursing Facility, St. Elizabeth's Home of Lancaster and the Our Lady of Victory Hospital campus are members of the Catholic Health System of Western New York (CHS).

Nazareth Nursing Home is a freestanding, 125-bed not-for-profit residential health care facility that provides baseline services. Nazareth provides acceptable, quality care; the 2005 survey cited five deficiencies, which is the statewide average. It suffers with financial difficulties. According to the operators, the facility has losses of approximately $1 million annually, and occupancy declined from 96.7% in 2003 to 95.2% in 2004. Its case mix index was 1.09 in 2003.

Mercy Hospital Skilled Nursing Facility is a 74-bed hospital-based residential health care facility that provides baseline services. It has a reputation for providing quality care, is financially stable, and benefits from an extremely high occupancy, which was over 99% in 2003 and 2004.

St. Elizabeth's Home is a 117-bed adult home in extreme financial difficulty. Its operating cost per resident is approximately $60 per day, which is high and is about twice as much as the Supplementary Security Income (SSI) payments available for each resident.

Our Lady of Victory Hospital (OLV) was an acute care hospital prior to closing in 1999. The Catholic Health System (CHS) is converting the former OLV campus to facility that resembles a continuing care retirement community (CCRC), with a full continuum of long-term care services. These services will be provided in a five-building complex that will include a centrally-located Main Street-styled area, with a convenient medical office, retail stores and a park-like green

space. CHS is near completion of the initial phase of the project, which involves the development of 74 low-to-moderate-income senior housing units. CHS has also been authorized to work with the Department of Health to develop a Program of All-inclusive Care for the Elderly (PACE), which is pending. Finally, CHS has filed a pending certificate of need application to move its RHCF beds from Mercy Hospital to the OLV campus.

Assessment

As a whole, Erie County's long-term care delivery system must be restructured. While the average county occupancy in 2004 was strong (95%), there is a documented surplus of beds using the state's need methodology. Taking into account the number of low-acuity individuals in the beds, the county has nearly 200 excess beds. Approximately half of its non-institutional need, however, is unmet, and supportive housing for frail and disabled seniors is in short supply. CHS's plans to reconfigure its long-term care services are supported by the Commission.

This plan will stabilize or reconfigure CHS's facilities. First, the plan will help stabilize Nazareth Nursing Home. Although it changed ownership in 2000 when it was acquired by CHS, a timely certificate of need was not filed, so the facility was unable to take advantage of increased revenue due to its potential rebasing. According to CHS, this has resulted in a steady and crippling financial decline. CHS has stated that it will close Nazareth Nursing Home regardless of potential Commission recommendations. Nazareth's existing residents need to be transitioned before the nursing home closes.

Similarly, CHS has indicated that, absent some extraordinary changes, it will close St. Elizabeth's Home. CHS's overall plan must ensure that adequate community resources are available to address the dislocation that would result from such closures.

CHS plans on establishing a new ALP at St. Elizabeth's. Second, CHS also plans to transfer RHCF beds from the Mercy Hospital skilled nursing facility to a more home-like setting. This will benefit Erie County's acute and long-term care. Space will be made available for additional acute care services at the Mercy Hospital. According to CHS, the additional RHCF beds will

allow for a more efficient staffing and care model at 21 beds per unit. Finally, the conversion of OLV to a PACE will establish needed non-institutional services and provide the necessary bridge between the senior housing and RHCF components.

Recommendation 3

Facility (ies)

Williamsville Suburban, LLC (Erie County)

Recommended Action

It is recommended that Williamsville Suburban downsize all 220 RHCF beds.

Facility Description(s)

Williamsville Suburban is a proprietary 220-bed residential health care facility located in a suburb of Buffalo. It provides baseline services and outpatient physical and occupational therapy. It is part of the Legacy Group, which operates three facilities in Erie County. Williamsville Suburban is the largest facility in the group.

The Legacy Group has not submitted cost reports since 2002 and is in chapter 11 bankruptcy protection. Certified financial and occupancy data for the previous 4 years are unavailable.

For several years, the facility has had quality and survey problems. It has had an extremely high number of deficiencies when compared to the other facilities within the Western region and the entire state. The April 2006 survey recorded 22 deficiencies. The 2005 survey resulted in 26 deficiencies; its 2004 survey resulted in 31 deficiencies, including 2 immediate jeopardies. The statewide average is five deficiencies. Moreover, the facility complaint substantiation rate for 2001-2003 was 38.1%; the statewide average was 5.9%.

Their case-mix index was 1.13 in 2003, and they run a 40-bed sub-acute unit, which is self-reported to be approximately 60-75% full. It provides no other specialized care and no non-SNF services.

According to Williamsville Suburban's recent administrator, the facility improved under his leadership and turned a profit in 2005. This has not been verified; their report was unaudited. This administrator claimed that the most recent occupancy rate is 93%, and that they had approximately 38 low-acuity patients.

Assessment

Erie County's long-term care delivery system must be restructured. While the county's overall occupancy in 2004 was strong (95%), the State's bed need methodology indicates that there is a surplus of beds. After taking into account the number of low-acuity individuals in the beds, the county seems to have over 200 excess beds. Approximately half of its non-institutional need is unmet, and supportive housing for frail and disabled seniors continues to be an issue.

There is strong competition for nursing home residents in the Williamsville area. There are seven nursing homes in Williamsville, and as the population in Erie County declines, excess capacity in its long-term care delivery system will likely grow. The existing residents should be transitioned before Williamsville Suburban closes.

Recommendation 4

Facility (ies)

DeGraff Memorial Hospital Skilled Nursing Facility (Niagara County)
Millard Fillmore Gates Circle Skilled Nursing Facility (Erie County)

Recommended Action

It is recommended that Millard Fillmore Gates Circle downsize all 75 RHCF beds, and upon the closure of the acute care beds at DeGraff Memorial Hospital (see Western Region Acute Care Recommendation), that those 75 RHCF beds be added to DeGraff contingent upon the suitable conversion of DeGraff.

Facility Description(s)

DeGraff Memorial Hospital and Millard Fillmore Gates Circle Hospital are both recommended for closure (see acute care recommendations). Both these facilities house skilled nursing facility (SNF) units (80-beds and 75-beds, respectively), which provide baseline services and sub-acute care. DeGraff's SNF has a very high occupancy (97%) and occupancy at Gates Circle is relatively high, but has fallen in the last few years (from 98% in 2002 to 93% in 2005). Both have survey deficiencies slightly above the regional average of 5 (7 and 6 respectively) and no immediate jeopardy citations. Their financial performance is reported with their respective hospital's financial information.

Assessment

This recommendation would: 1) maintain an appropriate numbers of SNF beds in Erie and Niagara counties, 2) maintain the better skilled nursing service provider in Erie and Niagara counties, and 3) mitigate the impact of hospital closure by converting the DeGraff building to meet long-term care needs. DeGraff is located in a growing area. A SNF in that community would have value. It also would enable the preservation of other health care and health-related services in that community that could be co-located with the nursing home.

VIII. Financing

The Commission's recommendations will provide significant benefits to New Yorkers and various components of the health care system. First, the Commission's recommendations will promote stability of health care providers thereby assuring access to care, supporting the provision of public goods, enabling technology and capital reinvestments, and improving quality of care. Second, the Commission's recommendations will reduce unnecessary public and private health care spending and produce overall cost savings for all payors. Third, the Commission's recommendations will produce numerous opportunities for reinvestment in the system thereby providing substantial financial benefits to health care providers and the patients served by them.

Systemic changes require resources. Investments are necessary to implement the Commission's recommendations. Short term costs must be incurred to produce benefits in the immediate and long terms.

This section estimates the potential savings and costs that can be reasonably associated with the Commission's recommendations. These estimates are based on the experience of similar facility reconfigurations in the past and draw on the combined experience of the State Department of Health, the Dormitory Authority of the State of New York, and the State Division of the Budget. While the estimates are based on some substantial assumptions and carry a "band of error," they represent measurable phenomena and provide reasonable indicators of the order of magnitude of achievable efficiencies and necessary investments. These estimates also provide a useful tool for estimating an appropriate level of State investment in specific recommendations.

Caveats apply to these projections. Estimates of savings and costs are difficult to make absent the sort of detailed knowledge of facility operations possessed only by a facility operator. The Commission had substantial interaction with the operators of the facilities which are the subject of the Commission recommendations and obtained important proprietary information about those facilities. In no case, though, could an operator share all the necessary information with the Commission in light of the competitive interests of those facilities. Some important information may even be beyond the reach of facility operators. For instance, absent some compelling need, it would be unusual for an operator to have a current appraisal of its real property. Furthermore, actual savings and costs will be partially dependent on the decisions made by facility operators during the implementation process. Much of the implementation of

the recommendations will be influenced by the rapidity with which the market responds to such recommendations, the timing of available financing, and other external events impacting the need for facility capacity.

Potential Benefits and Reinvestment Opportunities for Providers

Significant benefits from system restructuring, including closure, downsizing, conversion or affiliation, accrue to health care providers thereby improving stability of the delivery system. Some of these cannot be quantified financially; they include the advantages of shared medical and administrative expertise, quality of care improvements attributable to consolidated volume, and improved access to credit markets. Other benefits can be quantified, including:

- **Transferred Volume:** When a facility closes, its patients will seek and receive services elsewhere. Patient volume will be transferred from closed facilities to other facilities. Such volume increases drive efficiencies, both in terms of finances and quality of care. Higher occupancy rates lead to better margins, and in turn, better access to capital and more funds for reinvestment.

- **Improved Access to State Funding:** Facility closures have direct positive implications on the reimbursement of indigent care, graduate medical education and workforce recruitment & retention. Insofar as closed facilities will no longer draw from the applicable HCRA pools, their allocations will be redistributed to the remaining pool participants.

- **Elimination of Duplicative Costs:** When facilities affiliate under a single unified governance structure, the resulting entity can achieve major efficiencies by eliminating or reducing unnecessary costs. For example, combined institutions can shed duplicative administrative staff and duplicative support services like laboratories, laundries, and food service operations, and can combine costly information technology systems. Some of these savings also benefit payors, to the extent that such savings are reflected in reimbursement rates.

Potential Savings for Payors

System restructuring also provides many savings for payors, both in terms of actual reductions in current expenditures and avoided future costs. Such opportunities for savings include:

- **Reductions in Inappropriate Utilization:** Hospitalizations and the use of expensive procedures increase in relation to the capacity that exists. This is most often regarded as a function of Roemer's Law; namely, the principle enunciated by health care economist Milton Roemer that supply induces demand where reimbursement is guaranteed by a third party. More colloquially, "a bed built is a bed filled".

  Reductions in excess capacity can eliminate inappropriate or unneeded utilization of services, reduce the costs associated with such utilization, and improve care by limiting unneeded and risky procedures. Previous hospital closures have established that some volume from a closed facility will not transfer to remaining facilities. This phenomenon is particularly likely in the highly competitive economic environment faced by hospitals in New York State, and the actual experience of recent closures suggests that its impact is significant. Similarly, the reduction of excess beds in a facility removes the incentive to fill those beds, resulting in greater efficiency and a reduction in inappropriate care.

  While this analysis clearly applies in the case of hospital closures and downsizings, it is less likely that nursing home residents will forego care upon closure of their nursing home. However, not every nursing home resident requires skilled nursing services. In fact, several of the Commission's recommendations are premised on the recognition that many nursing home residents would be more appropriately served in less intensive settings. It is for that reason that the Commission has recommended the conversion of some nursing home beds to less intensive assisted living, adult day health care, or long term home health care slots. These conversions will generate direct payer savings.

- **Avoided Capital Investment:** Physical plants, especially if underutilized, are expensive to maintain. Even empty buildings, wards, and beds carry fixed costs that must be paid. Furthermore, many of NY's health care facilities are old and in need of extensive renovation and capital upgrades. Depending on the age of a physical plant, capital investments are needed to keep current with modern therapeutic and regulatory requirements. The closure or downsizing of a facility generates substantial savings by avoiding capital expenses such as fire code compliance upgrades, improving heating and air conditioning, conversions to single rooms, modernizing elevators and other spaces, and expanding parking. These foregone capital expenses, which would otherwise be reflected in reimbursement rates, are substantial.

- **Leveraged Savings:** Additional savings can be achieved by the targeted reinvestment of the foregoing savings into further savings-generating activities. Similarly, funds currently used by the State to address potential emergency closures can be redirected toward initiatives designed to promote further system efficiencies.

Estimating Benefits and Savings: Transferred Volume and Reduction in Inappropriate Utilization

To ascertain the potential benefits to payers from avoided hospital volume and to providers from transferred hospital volume, the Commission first determined the dollar value of that volume by multiplying the 2004 discharges of each facility recommended for closure by that facility's average Medicaid rate per discharge. This yields a reasonable proxy for the value of the transferred and avoided volume, with three caveats. First, some of that volume was covered by payors other than Medicaid. However, the rates paid by private payers are proprietary and cannot be discerned. Second, some of that volume is uncompensated. However, the impact of that volume will be ameliorated by the fact that the receiving facilities' respective share of the indigent care pool will be increased by the closures. Third, the rates paid for transferred volume will change depending on the average rates of the receiving facilities, some of which are lower and some of which are higher than the closed facility. Recognizing these limitations, the Medicaid rate proxy is an appropriate method for estimating the dollar value of avoided and transferred volume.

To determine the proportions of volume that are likely to be avoided and transferred, The Commission reviewed the impact of several recent hospital closures on patient volume and used that data to generate an appropriate "avoidance factor." That factor was then applied to the dollar value of the discharges from the facilities recommended for closure. In the case of facilities recommended for downsizing, a percentage of that factor representing the percentage of beds being downsized was applied.

A similar process was applied in regard to nursing homes. First, the average regional rate per day for each nursing home recommended for downsizing was used to determine an average annual rate per resident. This figure was further adjusted based on each facility's actual occupancy to yield a dollar value for the volume of patients served by the downsized beds. The downsizings attributable to conversions were then segregated from the "pure" downsizings. The dollar value of those "pure" downsizings represents the provider benefit accruing from them, insofar as that volume is likely to transfer elsewhere. The annual dollar value of the downsizings attributable to conversions was then reduced by the annual cost of the lower acuity slots that will result from such conversions, yielding a figure representing the payer benefit accruing from such conversions.

Similar caveats apply to the nursing home estimates. While it could also be argued that the new low-acuity slots will be filled by individuals not currently receiving any formal long term care services, the result could be in a net increase in annual costs. Such an argument is without merit. Since no lower-intensity service is added without eliminating an equal or greater number of nursing home beds, it is appropriate to assume a net cost savings.

Estimating Benefits: Improved Access to State Funding

To estimate potential benefits to providers, the dollar value representing the likely volume transfer was supplemented by a figure representing the indigent care, graduate medical education and workforce recruitment and retention pool distributions which would otherwise be made to facilities recommended for closure. Under the current iteration of HCRA, such funds will automatically be redistributed to remaining facilities.

Estimating Benefits and Savings: Elimination of Duplicative Costs

To estimate the potential savings attributable to the elimination of duplicative costs at affiliating facilities, each facility's annual expenditure on administrative and general labor costs was obtained from that facility's 2004 cost report. Where facilities have been recommended for affiliation, their expenditures were averaged, and the excess was identified as a potential benefit. The percentage of such costs attributable to patients covered by Medicaid managed care was then identified as a potential benefit to the Medicaid system since those savings will likely be reflected in facility rates, and the remainder identified as a potential benefit to the providers themselves.

Estimating Benefits and Savings: Avoided Capital Investment

To estimate the potential savings attributable to avoided capital investment, first Commission staff identified pending Certificate of Need (CON) projects attributable to such facilities that would be unnecessary or inappropriate in light of Commission recommendations. Then, Commission staff calculated the extent to which the cost of such projects (including both principal and interest costs) would be reflected in those facilities' annual Medicaid rates. The resulting figure represents the capital costs of pending projects that would be avoided by Commission recommendations.

However, the list of pending CON applications is not an exhaustive representation of the capital investments in the hospital and nursing home system that will be necessary in the years to come. In order to accurately reflect such investments on the hospital side, the Commission used each hospital's average age of plant to identify the potential cost of upgrading that hospital to the statewide average age of plant, eliminating any duplication where a hospital already had an application for such upgrade pending Then, Commission staff calculated the extent to which the cost of such projects (including both principal and interest costs) would be reflected in those facilities' annual Medicaid rates.

The analysis on the nursing home side necessarily differed, since the amount of each project to be reflected in the State Medicaid rate is capped by law. Therefore, the Commission estimated the cost of each such project and the amount of the applicable cap before calculating the extent to which the cost of such projects (including both principal and interest costs) would be reflected in those facilities' annual Medicaid rates.

Estimating Benefits: Leveraged Savings

To estimate the potential Medicaid savings attributable to the reinvestment of other calculated savings, Commission staff first identified the ratio of the cost of the Commission's recommendations to the potential Medicaid savings to be otherwise derived from the recommendations. Staff then applied that ratio to those savings themselves in order to identify the further savings to be derived from those reinvested funds.

In order to estimate additional savings that can be derived from funds currently used by the State to address emergency closures, staff identified the average amount of funds loaned each year from the Health Care Restructuring Pool for such purposes. That amount was reduced by the proportion of excess beds being removed from the system by the Commission recommendations, in order to identify a useful proxy for the amount of emergency fundings likely to be necessary after implementation of the recommendations. The difference represents Restructuring Pool funds likely to be available to generate additional costs savings. Those savings were then calculated by applying the same ratio applied to other Commission savings.

Total Benefits and Savings:

The total estimated savings for payors is around $806 million annually or $8 billion over ten years. This includes an annual savings to Medicaid of around $249 million, or $2.5 billion over ten years, and an annual savings to Medicare of around $322 million, or $3.2 billion over ten years. The total estimated benefit to providers is around $721 million annually or $7.2 billion over ten years. Together, these calculations yield a total benefit to payors and providers of over $1.5 billion annually, or $15 billion over ten years.

Potential Costs: General Principles

Implementation of the Commission's recommendations will require capital investments in some instances. Some of the recommendations are essentially cost-free. For example, recommendations in which the Commission has recommended further study and/or discussion carry no measurable cost. Similarly, recommendations that require only the decertification of a number of beds generally have negligible direct costs. Other long-term recommendations are contingent on various factors; unless those factors are fulfilled, no immediate costs will be

incurred. It is also imperative to note that just because a recommendation carries costs, that fact alone does not require that those costs be covered with public funds. In fact, the opposite is true. Insofar as facilities are capable of funding their own closure, conversion, affiliation, or rightsizing, they must do so. Taxpayer funds should be used prudently.

The realization of some Commission recommendations will entail costs, some of which are substantial and which should be estimated. Just like the savings estimates, the potential costs are difficult to ascertain with precision and are necessarily based on some broad assumptions. As with the savings estimates however, they represent measurable phenomena and provide reasonable indicators of the order of magnitude of necessary investments.

Potential Cost Categories: Closure, Construction & Affiliation

The likely costs of implementing the Commission's recommendation fall into three general categories:

Closure costs: These costs associated with closure include the outstanding debt of the facility to be closed, including outstanding capital debt as well as vendor debt, pension costs and any other third party liabilities. Insofar as this cost category includes debt of the Dormitory Authority and/or the Federal Housing Authority, it is particularly important to be cognizant of those debts and ensure their repayment so as not to jeopardize the industry's access to future capital investment. Similarly, insofar as a facility's debt represents a potential obligation of the State (as is the case with facilities participating in the Secured Hospital Program), that fact needs to be carefully considered and the necessary investments made to ensure that the net costs to the State do not outweigh the concomitant benefits. There are also direct costs attendant to the closure process itself, including costs of severance and retraining for employees, maintenance and security for the physical plant, and medical record transfer/storage. Finally, there are also legal and consulting costs associated with the planning and implementation of the closure process. While it is particularly difficult to estimate these latter costs since so much is dependent on variables outside the control of the Commission (e.g., whether or not a facility declares bankruptcy, thereby multiplying its legal costs considerably), some attempt to estimate these costs is warranted.

Construction costs: Such costs encompass not only new construction such as when the Commission recommends that a facility be rebuilt, but also the costs of renovating existing infrastructure such as in the case of bed or building conversions. The Department of Health has extensive experience estimating such costs in the context of the certificate of need (CON) process and is able to do so taking into account not only the difference between new construction and renovations, but also cost variations across regions.

Affiliation costs: This analysis does account for the costs of affiliation planning. Affiliation costs are difficult to project because of wide variation in the circumstances under which the affiliations will occur. In the case of simple affiliations (e.g., affiliation under a passive parent or the further affiliation of facilities already enjoying a close relationship), the costs are likely to be minimal. In more complex cases (e.g., full asset merger or the affiliation of religious and secular facilities), the costs could be considerable. In some cases, such affiliation will also require substantial capital investment and other significant implementation costs. However, the impracticality of defining those capital costs in each instance precludes any useful estimate of those capital costs and they have been excluded for the purposes of this analysis. This exclusion is justified; the efficiencies resulting from affiliation clearly benefit the affiliating entities and it is appropriate to expect the costs of such affiliation to be borne by those entities. In particular cases, however, it may be appropriate for public funding to be directed toward such costs.

Estimating Costs of Closures and Restructuring

Facility cost reports provide a solid basis from which to begin quantifying the likely costs of closures and conversions and each facility's ability to contribute to those costs. These cost reports, and the balance sheets on which they are based, capture many costs inherent in facility closure, including capital debt, vendor debt, and pension costs, as well as the assets available to cover those costs. Since, in a closure scenario, all of a facility's assets can conceivably be used to offset closure costs, it is appropriate to begin the analysis of such costs by identifying a facility's net assets. When those assets are negative, that reflects what it likely to be a net cost of closure. Where those assets are positive, that reflects an available cost offset. In theory, a facility's net assets incorporate both restricted and unrestricted assets. Restricted assets (e.g.,

charitable donations for some restricted purpose) may be available to offset closure costs but also may not. In practice, however, there are few variations between the unrestricted and total net assets of the facilities recommended for closure. Consequently, each facility's total net assets were used as a starting point for estimating closure costs.

As with the savings estimates, caveats apply to these cost estimates. The Commission did not always have access to specific information held by facilities. For example, without knowing the details of specific facilities' loan obligations, the Commission had to assume the presence of full closure costs even when the Commission has recommended a facility's conversion or rebuilding. In these cases, it is possible that a facility will be able to convert or rebuild without triggering the sort of liabilities associated with closure (e.g., without violating a bond covenant or other contractual obligation). In such cases, we have erred on the conservative side and assumed that these costs will occur although they may not.

Real property value is an important piece of a facility's assets. Therefore, where available, the fair market value of facility real property has been included as a cost offset. These estimates are a useful mechanism for identifying those closure recommendations that can be substantially or completely subsidized by the sale of facility real estate. Some cautions are appropriate. First, a facility's balance sheet includes an amount representing real property value but only that property's net book value (generally, the purchase price less accumulated depreciation). In many cases, especially downstate, that value bears little relationship to the property's fair market value. Thus, the values used as offsets were obtained from the facilities themselves. In some, but not all cases, the providers' estimates were based on independent appraisals. Second, it was not possible in all cases to obtain the fair market value of facility real property. In such cases, the potential value of the facility's real property was not included as a potential cost offset. Third, where real property fair market value was included, it was impossible to extract the portion of that value that was already included on that facility's balance sheet. Thus, a portion of that facility's real property value may have been double-counted.

The closure process itself can entail costs. The Commission examined past hospital closures to identify some average transaction costs, as a means of predicting the likely cost of future closures. The analysis of previous closures generated an average per bed, per month cost. The same analysis identified an average length of time within which closures have been completed. The result was a cost per bed figure, easily adaptable to specific hospital closure

recommendations. That number, with some modifications, also provided the basis for an analogous assessment of likely nursing home closure transaction costs. The first modification involves average length of closure; nursing homes typically close much more quickly than hospitals. Similarly, the per bed cost of closure is generally much smaller, owing at least in part to the smaller staffing ratios in nursing homes.

Both hospital and nursing home closures will entail legal and consulting costs. These costs are extremely variable, depending in large part on decisions made by providers and regulators during the closure process. One of the biggest decisions to be made by facilities recommended for closure is whether or not to declare bankruptcy; a declaration that can be extremely costly unto itself. For purposes of the Commission's cost analysis, staff assumed that every facility recommended for closure would declare bankruptcy. In practice, this will not necessarily be true. With this assumption in mind, prior closure experiences were reviewed to generate an average per month legal and consulting cost.

The costs of new construction were relatively easier to determine. These estimates were based on actual experience with new construction and renovations in connection with the certificate of need process. These estimates take into account regional price differences, which can be considerable. The cost estimates do encompass everything directly related to construction, but do not include land or financing costs, or the costs of demolition, where applicable. They also assume the renovation of existing facilities where possible but specific factors may impact an existing structure's appropriateness for conversion. Also, in instances where the new construction is not tied to bed number (e.g., where the new construction is a diagnostic and treatment center), the analysis estimated the necessary bed count and/or square footage and the cost was determined based on that estimate.

The foregoing calculations yield a total cost of approximately $1.2 billion, including approximately $350 million in closure costs, $1.1 billion in construction costs, $11 million in affiliation planning costs, and $300 million in offsets from the sale of facility real property. Not all of these costs will be borne by the State; almost $606 million of that is attributable to two contingent projects that the Commissioner will not be required to implement absent available funding.

Funding: Principles for Investment

Vast and unprecedented sums are available to support the restructuring of NY State's health care system and cover the costs of implementing the Commission's recommendations. The Health Care Efficiency and Affordability Law for New Yorkers (HEAL-NY) allocates $1 billion over four years. HEAL-NY will improve the stability, quality, and efficiency of the health care delivery system by providing capital grant funds to cover expenses associated with physical reconfiguration, conversion, downsizing, or closure of hospitals and nursing homes. Furthermore, the Federal-State Health Reform Partnership (F-SHRP) allocates an additional $1.5 billion for similar purposes. F-SHRP is a five year demonstration that will promote efficient operation of the State's health care system, consolidate and rightsize the delivery system, shift emphasis in long term care from institutional-based to community-based settings, expand the adoption of advanced health information technology, and improve ambulatory and primary care provision.

Although HEAL and F-SHRP are critical to financing the commission's recommendations, they are not and should not be the only sources of funding. Indeed, public funds should be used in the most prudent possible manner. Taxpayer dollars must be used judiciously. Insofar as facilities are capable of funding their own closure, conversion, affiliation, or rightsizing, they should be expected to do so. Additional sources of financing include traditional third-party financing mechanisms, debt restructuring, the HCRA restructuring pool, and others. The Commission believes it to be appropriate that costs will be shared among all the interested parties and that the State need only contribute a portion of those costs. That portion may be determined by the State in light of the following guidance for future funding decisions. By category, the Commission suggests that the following principles should govern State investment in the Commission recommendations:

Closure Costs:

1. Facilities should be expected to self-fund insofar as possible, including through the sale of assets.
2. State funds should be made available only in the absence of other possible funding.
3. If state funds are to be used, this cost category should be given priority for funding under the Federal-State Health Reform Partnership (F-SHRP), since this cost category is most likely to

result in measurable state and federal savings, and the availability of F-SHRP funds is tied to such measures.

4. If State funds are to be used, priority should be given, first, to those facilities that participate in the Secured Hospital Program, then to other DASNY clients, then to those non-DASNY clients that are not part of an obligated group.

Construction Costs:

1. Facilities should be expected to self-fund insofar as possible, including via private third-party financing.
2. State funds should be made available only in the absence of other possible funding.
3. If state funds are to be used, this cost category should be given priority for funding under the Healthcare Efficiency and Affordability Law (HEAL), since this cost category is more clearly eligible for such funding than the other cost categories.
4. If State funds are to be used, priority should be given to those facilities that are not part of an obligated group.

Affiliation Costs:

1. Facilities should be expected to self-fund insofar as possible, except in regard to affiliation planning costs.
2. State funds should be made available only in the absence of other possible funding, except in regard to affiliation planning costs.
3. If state funds are to be used, priority should be given to recommendations for full asset merger or affiliation under an active parent, as opposed to affiliation under a passive parent or some lesser affiliation.