ON RESTRUCTURING THE NYC HEALTH+HOSPITALS CORPORATION

PRESERVING AND EXPANDING ACCESS TO CARE FOR ALL NEW YORKERS

A report by Barbara Caress and James Parrott to the New York State Nurses Association (NYSNA)

October 2017

TABLE OF CONTENTS

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EXECUTIVE SUMMARY

The New York City Health+Hospitals (NYCH+H) system may be facing the most profound challenge in its 48-year history. Even before the new Washington administration's threat of devastating changes in Medicaid funding and unraveling of the Affordable Care Act (ACA), the City was projecting a $1.6 billion deficit by 2019, rising to $1.8 billion in 2020. This deficit—nearly one-fourth of its operating expenses—is expected even though the City has raised its total annual level of financial support to NYCH+H from $1.3 billion in 2013 to $1.8 billion this year and to a planned $1.9 billion in 2020. Though the efforts to repeal the ACA have thus far been defeated, ongoing threats of drastic cuts to Medicaid and reduced support for private insurance coverage on the group and individual markets are likely to worsen the NYCH+H deficit projections.

In April 2016, the Mayor released his reconfiguration plan *One New York: Health Care for Our Neighborhoods*, then convened a Blue Ribbon Commission on Health Care for Our Neighborhoods. Meanwhile, the NYCH+H Board authorized its own study and instituted a series of revenue raising and cost-containment actions to deal with the fiscal difficulties. Despite these efforts, the deficit is still expected to reach $1.8 billion and many observers doubt that substantial new federal revenues are likely to materialize.

The Mayor's Commission recently released its *Recommendations on NYC Health+Hospitals' Transformation* along with three issue briefs that provide more detail on the system's clinical infrastructure and challenges. These latest documents, however, continue to misconstrue the relevant NYCH+H operating cost data and fail to situate NYCH+H's challenges in the broader context of New York City's overall healthcare system which is 70 percent publicly supported, and in which the private hospitals heavily rely on the public system. Within the broader hospital sector, public funding covers more than two-thirds of expenditures.

NYCH+H's fiscal problems cannot be fixed by closing hospitals, laying off staff, and cutting services. In fact, evidence suggests that there are few immediate financial benefits to closing a hospital. Nor can the solution be increased reliance on and payments to the costlier and less responsive private hospital system. Unfortunately, given the current alignment of reimbursement policies, it is very unlikely that NYCH+H will be reimbursed adequately for the cost and quality of services it provides.

Fiscal relief can come, in part, from other sources. The private healthcare system needs to be made more accountable for the care of all New Yorkers—regardless of ability to pay or medical problem. The broader hospital system in New York City is essentially a single system with multiple managements. The private or voluntary sector is making money, the public sector is not, but not because it is high-cost or provides poor quality health services. No solution to NYCH+H's fiscal woes will succeed without understanding and acknowledging NYCH+H's interaction with the city's broader healthcare system. Nor will success happen without recognition that the burden of caring for the neediest and most vulnerable should be more equitably distributed.

In the following report, we reach several conclusions.

1. *NYCH+H's structural deficit is not an expense problem. It's a revenue problem.*

NYCH+H spends more for care than it is reimbursed. This is because of its role and function within the broader healthcare delivery system in New York City, and not because it is failing as a system.

NYCH+H provides the bulk of under-financed medical care to the city's uninsured, Medicaid patients with poorly-reimbursed health conditions (substance abuse and psychiatric disorders), and Level One emergency trauma care. It is not adequately compensated for the care it provides—that the private hospitals do not.

2. *The NYCH+H System's cost structure is reasonably efficient and its care of good quality*

NYCH+H testimony before the City Council Health Committee this spring and the recently released Blue Ribbon Commission Report are both premised on the argument that NYCH+H has an unsupportable and high cost structure. This assumption is directly related to the unstated premise that public hospitals (like the common perception of government services) are less efficient, costlier and of lower quality than private sector service providers.

These spoken and unspoken premises are not supported by the facts. NYCH+H costs for treating patients are comparable to or lower than those of voluntary hospitals. As a group, NYCH+H hospitals are among the lower-cost NYC hospitals. The majority have payroll expenses per adjusted discharge (a widely used standard) in the lower half of NYC hospital costs.

Nor is the quality of care inferior to that provided by private hospitals, particularly the large Academic Medical Centers (AMCs). For example, surveys by the Leapfrog Group, which is a national hospital industry quality measure organization that rates hospitals on a set range of patient safety metrics, have consistently found that NYCH+H hospitals as a group provide higher than average quality. According to the Leapfrog report issued in November 2016, the only hospitals to receive a grade of "A" or "B" were five NYCH+H institutions. In the March 2017 report, six of seven NYC hospitals rated higher than a "C" were NYCH+H.

3. *Private hospital networks prosper, in part, at the expense of the public hospitals*

The fact of the matter is that NYCH+H increasingly picks up the costs of a wide range of services and populations that private sector providers can avoid precisely because NYCH+H is there to assume this load. Despite their nonprofit charitable charters, NYC's private hospital systems have been shifting the burden of caring for the uninsured and for people with psychiatric and substance abuse diseases to the public system. Even as the number of uninsured New Yorkers declines, NYCH+H's share grows.

It is, in part, the very existence of NYCH+H that enables the large private hospital networks to operate with huge surpluses. In 2016, the five major private systems reported net operating revenues (profits) totaling $877 million while NYCH+H has faced recurring and mounting losses. These "nonprofit" entities have been recording significant operating surpluses while enjoying substantial tax exemption benefits, excessive payments from state and federal indigent care pools not proportionate to the amount of charity care they provide, while paying generous compensation to scores of executives.

This year might mark a unique moment in the history of New York City's hospital system. A fiscal crisis in the public hospital and safety net care systems and an uncertain future for full federal support of Medicaid and for the uninsured converge with a near universal recognition that the U.S. healthcare system is failing to provide the care we need at a price we can afford. Both the Mayor and the Governor have committed very significant resources to the continued support of NYC's necessary safety net institutions. We need to take advantage of this confluence of factors to reshape the system for the 21st century.

Recommendations

1. A reshaped public care system based upon need

Creating a public health system that reflects and responds to low-income and vulnerable New Yorkers through a newly created community-based care network (NYCH+H working with Deptartment of Health and Mental Hygiene) while maintaining a geographically dispersed community hospital network. This must include maintaining sufficient capacity (and staff) in the public hospital system to fulfill its mission as provider to both residents of adjacent communities as well as the unique populations served by NYCH+H. The future system needs to be reshaped based on local needs—some communities will need increased services, and others might need less. Most of the data necessary to construct a rational system has been collected and analyzed. Now is the time to use it.

2. A more equitable distribution of healthcare burdens and resources

The major private hospital systems need to take more responsibility for the needs of all New Yorkers. This will require that current funding formulas be revised. City and State governments need to be proactive. First, distribution of the state-specific Indigent Care Pool, as well as the state-administered Medicaid and Medicare charity care add-ons, should be modified to recognize NYCH+H's significant contribution to caring for the uninsured, especially immigrants, and the underinsured. Second, those hospitals that do not operate Level 1 trauma centers and depend on NYCH+H and others to maintain these costly operations should contribute to a trauma center funding pool. Third, the State and the Medicaid payers it regulates must change the reimbursement weighting system that underpays the cost of treating psychiatric and substance abuse disorders and fails to financially acknowledge the critical contribution of social services and use their bully pulpits to influence commercial payers to do the same.

3. City/State actions to push private hospitals to do or pay their fair share

The City and State should consider whether tax benefits, permitting, and zoning exceptions awarded to private, nonprofit hospitals ought to be based on a demonstrated contribution to caring for the sick, regardless of ability to pay.

Property tax and commercial income tax exemptions are awarded to charitable enterprises. Are all of NYC's private healthcare networks entitled to these exemptions? A Morristown, New Jersey judge recently revoked a local hospital's nonprofit status—finding that the hospital behaved more like a business than a charity.

The City might consider a program like one implemented by San Francisco. The Charity Care Ordinance of 2001 tied local approval of construction permits to demonstrated provision of charity care. As related by Elizabeth Rosenthal in her book, *American Sickness*, Sutter's California Pacific Medical Center had to promise $1.1 billion in concessions before the city would issue the required permits. Among the items the hospital promised were a freeze on prices charged to city employees' insurance plans, operation of a nearby safety net hospital, affordable housing investments and upgrading of nearby transit facilities and sidewalks. New York City might want to broaden the scope of such a program to include conditional property tax forgiveness.

4. City leadership on creating an NYC health system for the 21st century

A transformation plan that focuses only on the NYCH+H hospital system's finances, without considering the role that it plays in the broader healthcare system, is doomed to failure. NYCH+H cannot become self-sustaining because it absorbs the costs that the private providers are unwilling to shoulder.

The NYCH+H system thus has a symbiotic relationship with the private providers, absorbing costs and assuming obligations for services that the City needs but that the other hospitals can avoid because of the existence and role of the public system.

Given this dynamic, any restructuring of NYCH+H or path toward sustainability must include maintenance of effort to support NYCH+H's quality of care. The alternative is a vicious downward cycle of cuts that affect quality, causing further loss of market share and more revenue losses, which in turn cause more cuts in service and further losses.

The City working with the State must also take on a more assertive role in shaping the structure of the entire public and private hospital care system. The goal of any restructuring merely cannot be to fix the finances of NYCH+H but to create an integrated city-wide healthcare system in which the private and public provider systems work together to provide health services to the people of New York.

Key Findings

1. **Financial pressures facing the NYCH+H** are mounting as the public system's share of Medicaid funding in NYC declines and additional reductions estimated at $1.2 billion loom in federal safety net funding over the next two years. The outlook was dire even before the new administration in Washington launched its ongoing efforts to slash federal healthcare funding and increase the number of uninsured. Though efforts to repeal the ACA have been defeated thus far, we can expect ongoing attempts to reduce total federal healthcare spending that will add to the projected financial crisis faced by NYCH+H.

2. **The future and finances of NYCH+H** need to be rethought in a broader context that recognizes the important role of the public hospital system in NYC's $125-$150 billion healthcare landscape.

   - In a city with 40 percent of the population covered by Medicaid and 700,000 uninsured (many of them undocumented), NYCH+H has long served as the safety net provider, assuming the burden of serving those the private sector cannot or is unwilling to serve.
   - NYCH+H plays a traditional and vital role of a public system—providing essential services that most private hospitals choose not to provide. Its hospitals disproportionately provide care for the uninsured, Medicaid patients with poorly reimbursed health conditions, and substance abuse and psychiatric patients who need social as well as medical services.
   - Public hospitals are major providers of high-cost Level 1 trauma capacity serving residents, visitors and uniformed service members, relieving most private hospitals of that obligation and cost.
   - NYCH+H has resumed direct responsibility for providing healthcare services for both prisoners and jail employees in the City's jail system.
   - NYCH+H, together with the New York City Department of Health and Mental Health, is the first-line protector of the public's health. For example, public hospitals took the lead in the early days of the AIDS epidemic and as the city reacted to the re-emergence of TB and SARS. In 2015, Bellevue was the epicenter of the local response to Ebola.

3. **Even prior to the passage of the ACA**, a host of changes in technology, the practice of medicine and funding have reduced the need for hospital beds and driven the delivery of healthcare services toward outpatient and community settings.

   The large private hospitals have grown into multi-site healthcare networks and have positioned themselves to benefit from changes in the healthcare sector. While NYCH+H downsized by 30 percent in the late 1990s and has made many changes since then, it clearly has further to go in reorienting itself to better serve NYC's 21st century healthcare needs. NYCH+H, however, should neither be expected nor designed to compete with AMCs. Its unique role should be recognized and appropriately compensated.

   The resurgence of AMCs and their associated networks over the last decade is primarily due to four interconnected factors:

   - A net loss of 5,000 hospital beds due to closure/merger and consolidation resulting in greater pricing leverage with commercial insurers.

- A hugely increased pool of insured patients with the wherewithal to pay the cost of high technology/tertiary services.
- AMCs' ability and willingness to shift resources and change service, payor and personnel mix to focus on more profitable services and to exploit new reimbursement offerings and methodologies.
- An accelerating shift of underinsured and uninsured patients and of poorly reimbursed services to the public system and the few remaining unaffiliated, financially struggling safety net private hospitals.

In comparison with the private networks, NYCH+H has been slow to transform itself, and while it might need to adjust bed capacity in some facilities and develop more community-oriented ambulatory care capacity (and retrain portions of its workforce), NYCH+H cannot and should not adopt the same revenue maximizing model. Instead there is a need to rethink and possibly reconfigure the overall flows of public financing to more closely align with community healthcare needs.

4. **The financial pressures on NYCH+H** primarily stem from the revenue side rather than the cost side of the ledger.
   - NYCH+H relies on Medicaid for nearly two-thirds of all patient service revenue but, despite the continued growth in overall Medicaid expenditures in the city, Medicaid revenues have been declining at NYCH+H hospitals as the private hospital networks have been more adept at garnering Medicaid reimbursements for the more lucrative services, especially surgery.
   - In recent years, NYCH+H has assumed an even greater share of the burden in caring for the uninsured, but its share of state indigent care pool payments, already inequitable, has not risen along with its greater responsibility.
   - While the City of New York has stepped up the value of its annual NYCH+H support to $1.8 billion in Fiscal Year 2017 (FY 2107) from $1.3 billion four years ago, federal safety net funding is expected to fall off as scheduled Disproportionate Share Hospital (DSH) cuts are phased in under current law. This is projected to widen the operating loss at NYCH+H to $1.8 billion in 2019, or nearly 24 percent of total operating expenses. If the ACA is repealed and federal Medicaid funding is cut back, these projected deficits will be enormous—threatening the existence of many healthcare providers.

5. **NYCH+H hospitals and health centers** are the local healthcare providers to thousands of residents of nearby low-income, demographically diverse communities, primarily communities of color. Its losses can be attributed to meeting the unreimbursed and under-reimbursed health needs of these communities.
   - Many of the city's public hospitals are in the poorest neighborhoods that have relatively few other local healthcare providers. For example, residents of the Bronx, Brooklyn, Queens and Staten Island have less primary care access than 70 percent of Americans. The shortage is even more severe in the boroughs' poorer neighborhoods.
   - While NYCH+H hospitals account for about 20 percent of inpatient discharges city-wide, they disproportionately serve lower-income patients. Thus, NYCH+H accounts for 50

percent of uninsured inpatient discharges, 80 percent of all uninsured hospital clinic visits and half of all Medicaid patients (and these shares have been rising further since 2014).

- NYCH+H accounts for 30 percent to 60 percent of poorly reimbursed inpatient services to people with psychiatric and substance abuse disorders.
- NYCH+H disproportionately serves New Yorkers of color. When looked at side by side, adjacent and nearby private and public hospitals—NYU and Bellevue, and Mt. Sinai and Presbyterian and Harlem Hospital—have patient populations with very different racial makeups. Many of the leading AMCs serve a largely white patient population.

6. **Relative to the city's private hospitals**, NYCH+H facilities are a more cost-effective alternative and of comparable quality. The cost comparisons presented to the recent Blue Ribbon Commission and reflected in its final report rely on a flawed analysis which assumes that public and private hospitals both operate and allocate expenses in a similar fashion. Neither assumption is correct:

   - Payroll expenses (wages, benefits, training) recorded in eight of the 11 NYCH+H hospitals rank in the lower half of all New York City hospitals; the remaining three are in the next quartile.
   - The cost comparisons are further distorted by reliance on flawed acuity and out-patient "adjustment factors" that inflate NYCH+H's relative cost structure.
   - Based on the Inpatient Quality Indicators measure, all but one of NYCH+H's facilities score in the top half of New York City hospitals.

7. **Given the co-dependence** of the public and private hospital systems in NYC, the fact that healthcare is 70 percent publicly funded, and that NYC government provides direct funding for contracted services and indirect subsidies to the private hospital systems, any examination of NYCH+H's financial health should involve a careful analysis of NYCH+H's relationship to the private hospital system and the role that system plays in serving New Yorkers.

   - In FY 2017, the City of New York provided $669 million in real property tax exemptions to private nonprofit healthcare providers, one-third more than in 2011. Likely, the increase is attributable to the major private hospital networks' rapidly expanding affiliated medical physician practices and extension of the exemption to the high-value commercial real estate they occupy.
   - Mainly through the State Dormitory Authority, NYS has permitted the major private hospitals to use $3.9 billion in tax-exempt bond financing that saves an estimated $71 million annually in interest costs.
   - The combined net revenues of the five major private hospital networks were $877 million in 2016, up by over one-third from $650 million for all five in 2014 and 2015.
   - The five private hospital networks benefit from tax-exempt status despite being run by very highly-paid executives whose salaries rival those in the for-profit corporate sector. As of 2015, the five networks reported 108 executives were paid over $1 million each annually, with an average compensation of $2.2 million. The private hospitals as a group have over 150 executives who are paid more than the highest-paid NYCH+H official. At one of the

larger private networks, New York Presbyterian, executive compensation soared 18 percent in 2015 over 2014 and pay packages resemble those on Wall Street, with bonus pay comprising a large part of total compensation.

8. **The city's remaining non-affiliated** private safety net hospitals (Brookdale, Wyckoff, Interfaith, Bronx Lebanon, Flushing and Jamaica) are in a similar position to NYCH+H—absorbing a greater share of under- and non-insured patients and under-reimbursed services not provided by the five large private networks and shouldering the associated losses. The core problem for both public and private safety net hospitals is not incompetent management or inefficient staffing. It is underfinancing of care for the uninsured and for treatment of psychiatric and substance abuse ailments.

ON RESTRUCTURING NYC HEALTH+HOSPITALS

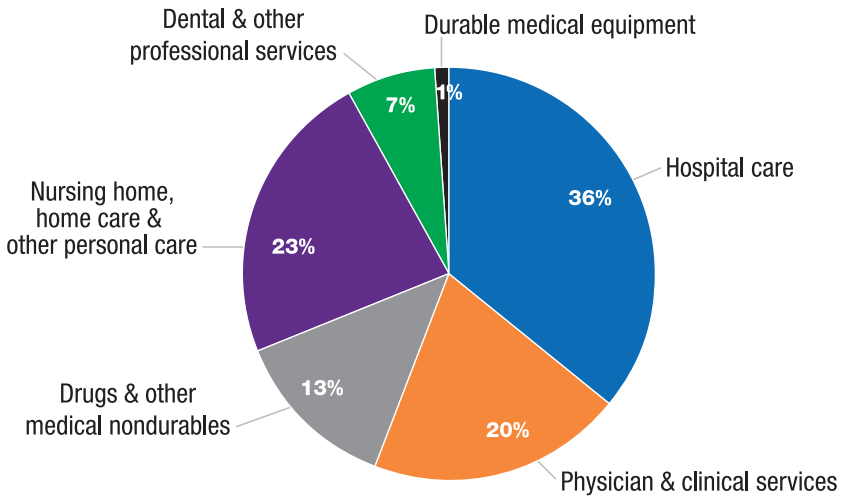
BACKGROUND

New York's health system

New York's health system is unique in many ways. Its size, however, is typical. The city is home to 2.7 percent of the country's population and a proportional number of hospital beds and hospital discharges. What is unusual is the predominance of medical schools, AMCs, and teaching hospitals. Fully five percent of U.S. medical students are studying in one of New York City's six medical schools. By comparison, there are 10 schools in all California—a state with 39 million residents. Every New York City hospital participates in training of medical residents. One-tenth of the doctors-in-training in the U.S. are working/learning at a New York City hospital. Less than half (45 percent) of New York State medical residents plan to practice in New York State upon completion of their programs.[1] Training the country's future doctors is expensive and training and research imperatives have a very large influence on the shape and types of services hospitals provide.[2]

CHART 1

Estimated NYC healthcare spending by service, 2009



Source: Based on data presented in Health Care Costs and Spending in New York State February 2014
Prepared by: Diana Rodin and Jack Meyer. Public Hospital Share based on NYC HHC Financial Plan FY 2010.

1 Center for Health Workforce Studies 2015 New York Residency Training Outcomes A Summary of Responses to the 2015 New York Resident Exit Survey http://www.chwsny.org/wp-content/uploads/2016/06/NY_Residency_Training_Outcomes_2015-1.pdf

2 See for example, Joseph Newhouse "Accounting For Teaching Hospitals' Higher Costs And What To Do About Them" Health Affairs November 2003.

Most of the money that supports the city's healthcare delivery system comes from public sources—Medicare because it covers healthcare expenses of people most likely to use services—the aged and disabled—and Medicaid which, because of ACA expansion, covers 43 percent of New Yorkers. In addition, the City's payments for insurance for its employees, their dependents and eligible retirees tops $7 billion annually. Other public money comes from state and federal government-financed health benefits for their workers who receive healthcare in the city.

PUBLIC SPENDING/ PUBLIC ACCOUNTABILITY

Almost 60 years ago, at the dawn of the Medicaid/Medicare era, the City Commission on the Delivery of Personal Health Services (the "Piel Commission") noted that public financing created an opportunity to shape the health system. "All of the voluntary hospitals are now, or shortly will be, dependent on public funds for half or more of their operating income. Thus, along with the former City hospitals, they will owe much the same accounting of costs and performances to public authority. It is now possible . . . to bring about the integration of public and private resources into a single, high quality health service." (December 1967)

Using Bureau of Economic Analysis data on Medicare and Medicaid transfers in New York City and Centers for Medicare and Medicaid Services estimates of National Health Expenditures, it is estimated that NYC total health expenses for 2015 were approximately $127 billion.[3] The bulk of this spending is used to directly support personal health services—doctors, hospitals, pharmacies, nursing homes, home care agencies, medical supply companies, etc. The rest is spent for public health agencies, the Veterans Administration (VA) and other city, state and local programs. Hospitals consume the largest chunk of healthcare spending—about $40 billion. An estimated 500,000 people work in New York City's private healthcare sector (164,000 work in private hospitals) and another 50,000 provide services in the public sector.

While more New Yorkers are insured than ever before, an estimated 700,000 people are still uninsured. Prior to the ACA there were an estimated 2.3 million uninsured New Yorkers.[4] As of January 2017, 1.6 million had enrolled in an ACA plan—three-quarters covered by Medicaid and another 18 percent in the heavily subsidized Essential Plan. Enrollment in the private plan marketplace was a modest 105,000.[5]

A health system evolving—private system growth—public system losses

In part in response to pressures from payers, the city's health system is changing. While much of the shift in the locus of care began prior to the passage of the ACA, there is no question that post-passage the pace accelerated and the character of change deepened.

To quote the Centers for Disease Control and Prevention:

> The American healthcare system is in the midst of unprecedented change. The U.S. healthcare and public health systems are both now positioned to place greater emphasis on better care, smarter spending, and healthier people.

3 A very rough alternative estimate can be derived by applying the CMS figure for the health expenditure share of national GDP, 17.8 percent for 2015, to the current dollar estimate for NYC Gross City Product as published by the City's Office of Management and Budget in April 2017 ($836 billion). This alternative method would yield an estimate of $149 billion for 2015. Since there is no reason to believe that NYC's share of health expenses should deviate much from the national share, it is reasonable to conclude that total NYC health expenses for 2015 were in the $125-$150 billion range.

4 Fred Blavin, Linda Blumberg, Matthew Buettgens, Uninsured New Yorkers After Full Implementation of the Affordable Care Act: Source of Health Insurance Coverage by Individual Characteristics and Sub-State Geographic Area Revised, May 2013.

5 NY State of Health 017 OEP Number of Enrollees, By Program and County. https://info.nystateofhealth.ny.gov/sites/default/files/2017%20OEP%20Number%20of%20Enrollees%2C%20By%20Program%20and%20County.pdf

> Key elements emerging in this transformation include new structures for integrating and coordinating services, a renewed focus on patient engagement and patient-centered care, and new payment models based on the value of population-based health outcomes rather than the volume of services delivered. This period of change is creating important opportunities to establish effective, more sustainable models to improve population health.
>
> Office of the Associate Director for Policy, April 2, 2017

The large voluntary hospital networks have positioned themselves to benefit financially from change. NYCH+H has done less.

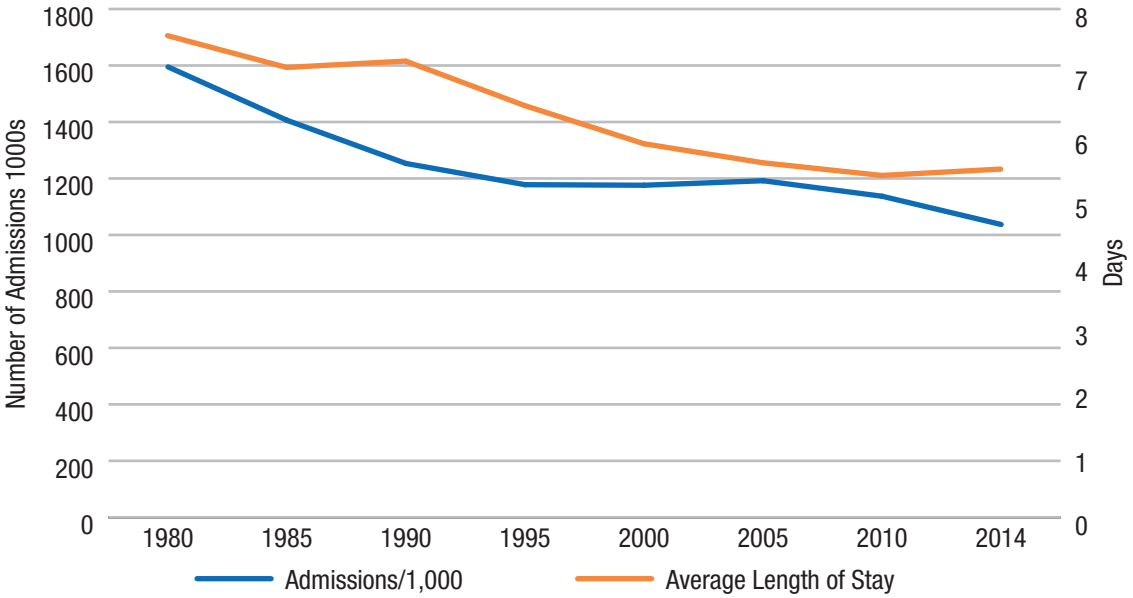
The great 19th century discovery was that illness was often caused by identifiable infectious agents. During the 20th century scientists and doctors perfected methods of preventing and curing those infections. The hospital played a key role as the center of care, health professional classroom, and laboratory for the study of disease. While some people, because they were too poor or the wrong color or ethnicity, were denied full access to the wonders of 20th century medicine, the scourges of the 19th century—TB, maternal death, diphtheria, polio, yellow fever, measles, malaria—were controlled or eliminated. What remained were chronic diseases that killed slowly and debilitatingly. It was soon discovered that heart disease, cancer, hypertension, asthma, diabetes and other similar conditions were not easily cured with one pill or one operation. And the hospital, while still key to treating the most extreme manifestations, was not necessarily the best location of cure for chronic illnesses.

As the demand for medical care changed, so did practice and technology. At midcentury, hospital beds were filled by women giving birth, people recovering from surgery, those who survived bouts of infectious disease, strokes and heart attacks, and people whose ailments were mysterious and who were undergoing invasive diagnostic procedures. All these types of inpatient admissions were transformed in the subsequent 50 years. Postpartum care, for example, went from nine days to 48 hours. With the development of quick-acting anesthesia and perfection of surgical techniques and micro-surgery, upwards of three-quarters of surgeries are now done on an outpatient basis. A profound change in care and treatment of heart attack and stroke took place—the protocol is no longer bed rest but up-and-about and non-hospital rehabilitation.

And lastly, the development of machines that can see inside the body (CATs, MRIs, PETs, etc.) has completely transformed diagnostic testing. The net result—relatively fewer admissions to the hospital and shorter stays.

CHART 2

Changes in admissions & length of stay, 1980-2014



Sources: AHA Trendwatcher Chartbook 2016, p. A-26. Trendwatch Chartbook, 2002 p. 96.

While our understanding of the most effective preventive strategies and treatment protocols moved ahead, the system remained rooted in reimbursement methods and payment incentives developed 40 years ago. Even though the paradigm has shifted to emphasize community and home based care, the most generous payment is made for inpatient care. As Dr. Don Berwick, former Centers for Medicare & Medicaid Services (CMS) administrator commented in 2011, "Today, a hospital [still] makes money from keeping beds full, not from keeping them empty."

There are payment paradigm changes underway. CMS, which regulates Medicare, is moving toward a reimbursement system that will tie half of all payments to value (processes and outcome) rather than volume (visits and procedures) within the next two years. Value-based payments mean that a hospital can maximize its revenue when its patients are receiving the types of services that have been shown to improve/advance healing, such as post-discharge care, home care and social services (or by avoiding taking on patients who don't/can't fully benefit from non-hospital services because they are homeless, addicted, or inadequately housed). The new model of care is being extended to Medicare's payment to physicians. A key element of the 2016 Congressional action on physician payment (MACRA) is the inclusion of value modifiers that will significantly affect the amount a physician will be paid.[6]

Likewise, the NYS Department of Health issued a "Roadmap" to chart its plan to move Medicaid payment away from fee-for-service.[7] In fact, NYS's Delivery System Reform Incentive Payment (DSRIP) Program is supposed to finance the building of the infrastructure that will support a new health system—one that delivers "the right care in the right place at the right time." Often that means in the community or in the home.

6 See for example, CMS Hospital Value-Based Purchasing, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html, Delivery System Reform, Medicare Payment Reform Delivery System Reform, Medicare Payment Reform.

7 NYS DOH A Path toward Value Based Payment—New York State Roadmap For Medicaid Payment Reform (June 2015) https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

What might these changes mean for NYC's inpatient hospital system? No question, the health systems of the future will need to shift their focus from inpatient service and provide many, many more community and home-based services. Despite enormous differences in history, operations and stated mission, the city's large AMCs have staked out remarkably similar courses. Desperate to secure their place in the health system of the 21st century (and to keep filling their well-regarded, still well-paid tertiary and quaternary care beds), NYC's five large voluntary hospital systems—Montefiore, Mt. Sinai, NY Presbyterian, NYU, and Northwell—have each acquired a vast array of smaller hospitals, physician practices, freestanding diagnostic, laboratory, surgical and other treatment facilities. [See the maps, Appendix B] They are engaged in a race for control of resources, facilities and, not least, market share and public approval. Witness their robust and quite extensive advertising campaigns. Despite the costs of acquisitions, newly announced building programs and significant investments in new, esoteric technology and world-renowned specialists/surgeons, each ended 2016 with a surplus (up more than a third compared to 2015).

The changes wrought by new medical practices, technologies, and public policies over the past decade have resulted in the closure of over 20 New York City hospitals and the consolidation of many of the remaining ones into five major private hospital systems. The five private systems have been adept at transforming themselves to take advantage of new reimbursement offerings as they shift greater responsibility for the care of under- and un-insured patients and under-reimbursed services to the public system.

Hospital Advertising & Branding

"Another Day, Another Breakthrough"
–Mt. Sinai

"Amazing Things Are Happening Here"
–New York Presbyterian

"Look North" *–Northwell*

"Made for New York" *–NYU Langone*

"Doing More" *–Montefiore*

NYCH+H—PUBLIC HOSPITALS

The New York City Health+Hospitals network consists of 11 acute care hospitals, five longterm care facilities, and a network of neighborhood health centers and clinics. In addition, NYCH+H operates a home care agency and MetroPlus, a health insurance company. The network is both a vital safety net provider for New Yorkers who might otherwise not have access to healthcare services and a key and unique component of the entire NYC healthcare system. It delivers many services that the private sector cannot or will not take on. Indeed, it is the existence of the NYCH+H system that allows many of the large and growing private hospital systems to flourish.

The importance of the public hospital system to the broader healthcare delivery system in New York City is evident from the scale of services provided by NYCH+H. More than 1.1 million individual New Yorkers received care at one of New York City's public hospitals in 2016. Many of these patients are not welcome elsewhere because of their insurance status, medical condition or background. Though NYCH+H is quite large, its $7.8 billion annual spending is dwarfed by the $127 billion in spending on the overall health system in New York City.

A little history

From their earliest beginnings, New York State's public hospitals were first and foremost charged with caring for the city's most vulnerable people—the poor, the sick, the aged, new immigrants and prisoners. It continues to play this vital role today.

- In 1736, Bellevue, the first public hospital in the US, opened its doors on the City Common (now the site of City Hall) as an almshouse.
- A century later (1836) Lincoln Hospital was founded by local philanthropists as the Home for the Colored Aged. It moved to the Bronx, changed its name to Lincoln, and became a public hospital in 1899.
- Elmhurst was created in 1832 adjacent to a penitentiary the City constructed on the southern tip of Blackwell (now Roosevelt) Island. In 1862, the federal government paid the City to care for wounded Union soldiers there. Elmhurst Hospital was moved to Queens as the City government's first post-WWII construction project. It opened in March 1957.
- Harlem Hospital opened in 1887 in a three-story wooden building, located at the foot of East 120th Street and the East River in New York City, with 54 beds. Initially it was used as a reception center for patients awaiting transfer to Ward's Island, Randall's Island and Bellevue Hospital. At the turn of the 20th century the City acquired the land at 136th Street and Lenox Avenue and constructed a 150-bed hospital. It opened in 1907.
- Metropolitan Hospital Center, first on Ward's Island, joined Elmhurst on Blackwell Island in 1894. It had been founded in September 1875 as the Homeopathic Hospital. Renamed Metropolitan Hospital, it moved to East Harlem in 1955.
- Responding to the passage of Medicare and Medicaid, Mayor Lindsay and Governor Rockefeller proposed the construction of Woodhull hospital in 1967 to replace Cumberland and Greenpoint hospitals, as a modern facility with single-bed rooms and the same amenities found in private hospitals. It opened in 1982.

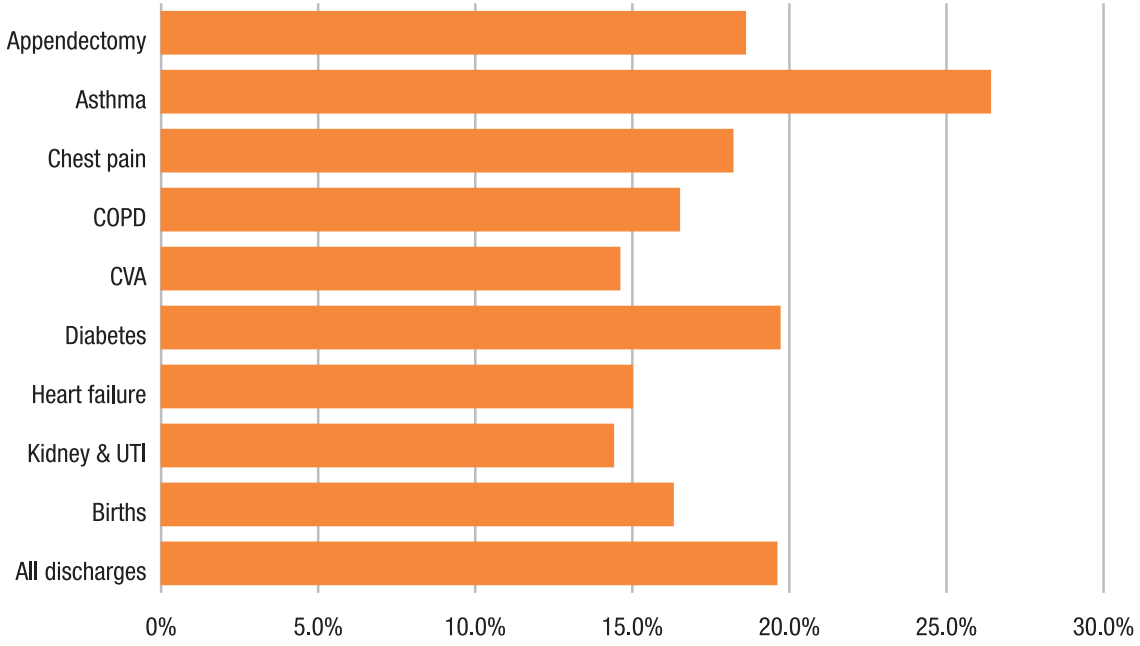
Taking care of the community

The public hospitals are a vital and unique part of the city's health system. They serve as local community providers to many residents of low-income communities. And they do so competently and efficiently.

As they have throughout their history, public hospital providers see their share of patients with those typical illnesses that need inpatient care. As can be seen on the chart below, NYCH+H hospitals cared for one in five inpatients city-wide in 2014. Among selected diagnoses (DRGs), with 7,500 or more discharges, NYCH+H's share ranged from 14 percent to 27 percent—a rate that is generally proportional to its bed share in New York City.

CHART 3

NYCH+H share of common New York City inpatient discharges, selected DRGs, 2014



Source: SPARCS, APR DRG by facility, 2014

The cost of care

The question of how NYCH+H hospital costs compare with other NYC hospitals is a critical one. While there are no readily-available metrics for comparing operating costs between the public and private sectors overall, it does appear that NYCH+H hospital labor costs fall in the lower two-thirds of all NYC hospitals.

Cost per inpatient discharge or inpatient day was once the standard measure of hospital efficiency and utilization. It was a valid measure to compare most hospitals until the 1980s, when hospital activity began transitioning from an inpatient foundation to include more outpatient services.[8] Today it is not unusual for outpatient services to account for half of a hospital's revenue.[9]

8 Since the inception of the NYCH+H outpatient and emergency services have been an important part of public hospitals' operations.

9 *American Hospital Association TrendWatch* Chartbook 2016

In this context, traditional hospital cost accounting methods offered no adequate or standard way to measure costs associated with outpatient compared to inpatient services or to compare costs of hospitals with varying mixes of inpatient and outpatient services. As the share of outpatient services grew, the cost per inpatient discharge became less accurate as a measure of hospital cost structures.

To address this problem, hospitals developed a widely-used and now well-established method based on gross charges for services performed to establish common values across settings. This formula uses the charges (or list prices) for inpatient and outpatient services performed to create a variable named "adjusted discharges" that recognizes outpatient as well as inpatient services. Adjusted discharges is simply the ratio of total outpatient charges to inpatient charges or to total hospital charges. The resulting "outpatient adjustment" factor or ratio is applied to the actual number of inpatient discharges as a multiplier to determine the adjusted discharges for a hospital. This adjusted discharge number is then divided into total hospital costs for all services to yield a cost per adjusted discharge. The "outpatient adjustment factor" and the "adjusted cost per discharge" are thus surrogate measures to account for outpatient activity.[10]

Though widely used, this outpatient adjustment methodology likely underestimates the differences between the NYC public and private hospitals. The City of New York used this methodology to calculate an outpatient adjustment factor of 1.754 for NYCH+H and 1.508 for other New York City private sector hospitals.[11] Gross charges are likely to be consistent within a single hospital system—i.e., NYCH+H could use one chargemaster or price list for all 11 hospitals. But it doesn't work as well between institutions- particularly hospitals with different service mix and operations. Most charges associated with NYCH+H's outpatient gross charges are for clinic and ER visits. NYCH+H accounts for almost half of all clinic visits and a third of ER visits. Typically, these types of visits have a lower chargemaster value with many fewer components that can add to the total charge than the services that make up a large component of the voluntary hospitals' gross charges—outpatient surgery, chemo and other infusions, specialized lab tests, and high-tech diagnostic services.

It should also be noted that hospital charges or prices are subject to huge variations from hospital to hospital and have little or no correlation to the true costs for services or actual reimbursement rates. Government payers generally pay set rates for services and private insurers negotiate rates with each hospital or hospital system. The chargemaster or price list is thus only relevant for "self-pay" patients or for exploiting regulatory loopholes or market power to receive higher payments for particular services or patients.[12] Because of the arbitrary nature of chargemaster rate setting and the incentives and goals flowing from the particular pricing strategies of individual hospital systems, the autonomously determined prices/charges that are used to calculate "adjusted discharges" do not necessarily give an accurate indicator of relative costs between the public and private hospital systems.

Though this methodology likely understates the true outpatient footprint of NYCH+H relative to the private sector hospitals, it still appears that NYCH+H hospitals provide services at the lower end of the cost spectrum. Chart 4 arrays "Payroll Expenses per Adjusted Discharge," a calculation that uses this methodology to estimate labor costs per adjusted discharge for NYC hospitals. The core data variables—inpatient discharges, gross charges for outpatient and inpatient services, and wages and benefit expenditures were compiled from the 2014 Institutional Cost Reports (ICRs) collected by the NYS Department of Health.

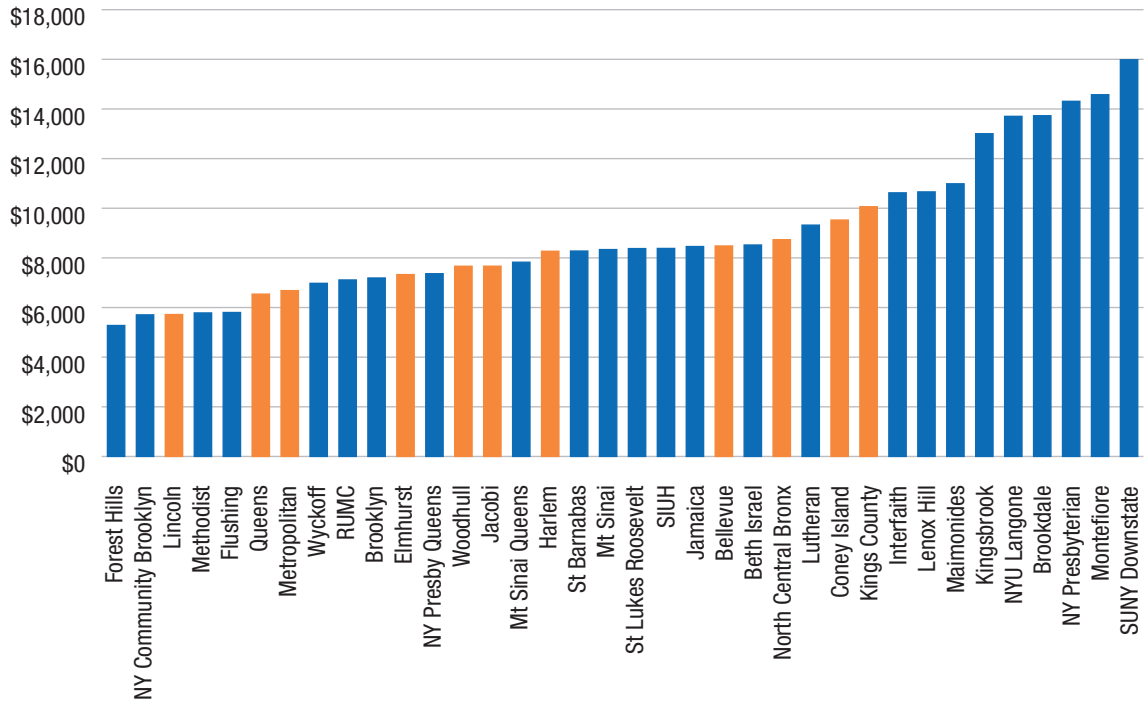
10 The formula is as follows: Adjusted discharges equal actual inpatient discharges multiplied by the outpatient adjustment factor. The outpatient adjustment factor is the ratio of outpatient charges to inpatient charges or of outpatient charges to total hospital charges (1+ (gross outpatient charges/total charges)). The resulting "adjusted" discharges are then divided into total costs to yield the cost per adjusted discharge that is the basis for comparing hospital cost structures.

11 See Footnote 15 below.

12 See: Reinhardt, U.E., "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy" Health Affairs, Jan/Feb 2006; Ge Bai and Gerard F. Anderson, "US Hospitals Are Still Using Chargemaster Markups To Maximize Revenues" Health Affairs, Sept 2016; Alex Kacik, "Stricter chargemaster regulations needed to rein in healthcare pricing" Modern Healthcare, April 22, 2017 http://www.modernhealthcare.com/article/20170422/MAGAZINE/304229971

CHART 4

Payroll expense per adjusted discharge, 2014



Sources: SPARCS Discharges by facility, 2014 adjusted and NYS DOH Institutional Cost Reports Exhibit 35, 2014

Chart 4 does not adjust for case mix because we do not believe that the variable Case Mix Index (CMI) as presently devised allows for a valid comparison between public and voluntary hospitals. Since 2007, CMI has been calculated based on Medicare Severity Diagnosis Related Group (MS-DRG), Medicare's basic reimbursement tool. Most Diagnosis-related group's (DRGs) have three subtypes: (1) no complication/co-morbidity, (2) complication/co-morbidity, or (3) major complication/co-morbidity. It takes considerable documentation to locate a patient in the third and best reimbursed category. A study by Mendez et al. reported that "CMI underestimates the true severity of illness of patients seen at public hospitals because there is a diminished motive to maximize financial reimbursement at public hospitals [because of the relatively small number of Medicare patients], and such hospitals lack the resources needed to implement coding and documentation improvement."[13]

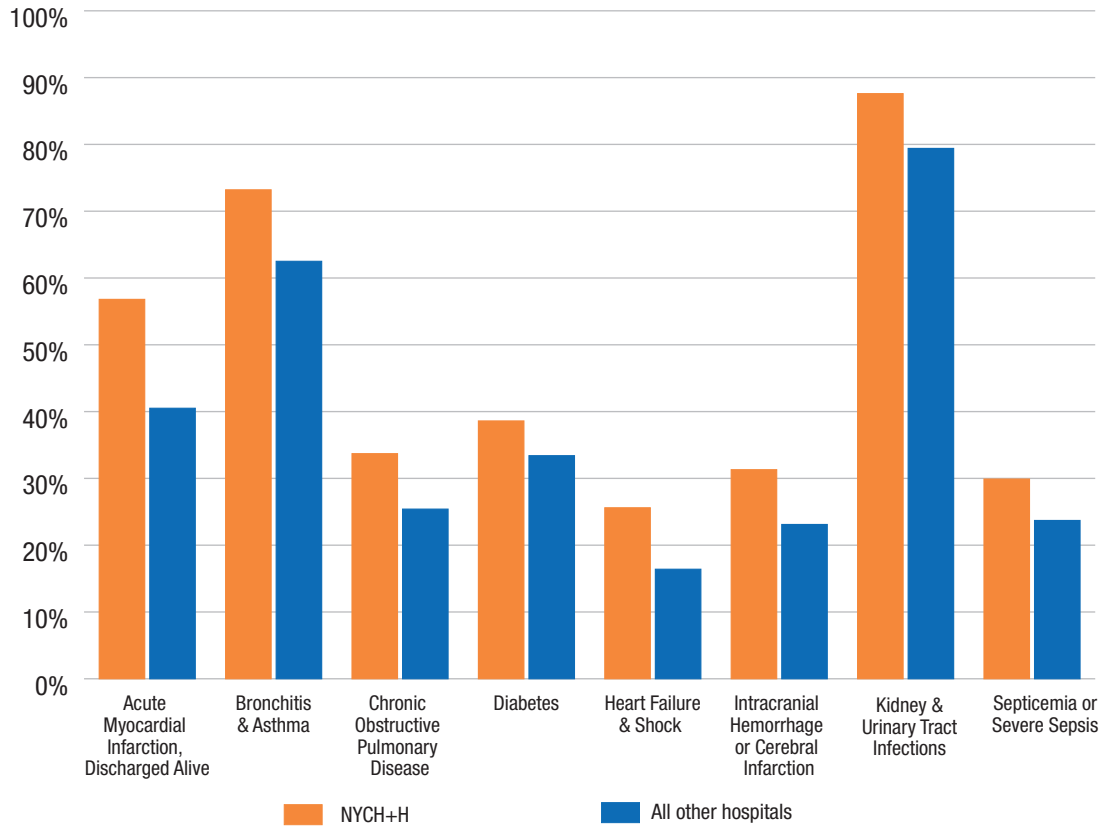
To test whether the Mendez finding should be applied to NYC public hospitals, we looked at the prevalence of "no complications" assessments among NYCH+H patients admitted with common emergency diagnoses compared to patients with the same DRGs admitted to NYC voluntary

13 Mendez, C. M., Harrington, D. W., Christenson, P., & Spellberg, B. (2014). Impact of Hospital Variables on Case Mix Index as a Marker of Disease Severity. Population Health Management, 17(1), 28-34. http://doi.org/10.1089/pop.2013.0002

hospitals[14]. There is no systematic reason why people brought to one of NYCH+H's emergency rooms would be less likely to have a major or minor complication for any of these conditions. If anything, it should be opposite because most NYCH+H hospitals are designated Level 1 trauma centers, while few of the city's voluntaries are willing to assume that obligation. As can be seen on Chart 5, there are consistently fewer patients coded with complications among NYCH+H patients—likely indicating that NYCH+H does not fully "capture" the CMI or acuity of its patients and that the CMI adjustments do not accurately reflect the public hospitals' relative costs.[15]

CHART 5

Discharges with selected MS-DRGs—% without complications or major complications, 2014



Source: SPARCs DRG by facility, 2014

14 Each DRG condition or illness that presents in a hospital setting is ranked in one of three tiers, depending on the seriousness or acuity of the condition – 1. No complications; 2. Complications; 3. Major Complications. A patient presenting with major complications will be assigned a higher acuity rating than a patient with no complications, leading to a higher CMI average.

15 The City produced relative cost estimates finding that NYCH+H costs per discharge, adjusted for both outpatient services and for average CMI data, were on average more than 22 percent higher than those of private sector hospitals in the city. See: NYCH+H Labor Committee presentation on July 7, 2016, titled "Cost Benchmarking: Methods and Results" and Mayor's Commission Brief "Reenvisioning Clinical Infrastructure" (March 2017), which presents the same data on page 9, available at http://www.nychealthandhospitals.org/wp-content/uploads/2017/03/CommissionBrief_ReenvisioningClinicalInfrastructure.pdf. The City cost estimates presented in the above reports use an "outpatient adjustment" factor of 1.754 for NYCH+H and 1.508 for the private hospital and a "CMI adjustment" factor of 1.004 for NYCH+H and 1.245 for the privates. The adjusted inpatient discharges are then divided by the city into the total costs of the hospital to arrive at the 22.6 percent higher cost per adjusted discharge for NYCH+H.

Thus, we used the outpatient adjustment factor (even though imperfect) that changed the discharge number to reflect the importance of outpatient activities, but not the CMI adjustment. Our findings resonate with our understanding of NYCH+H's patient mix. There is a smaller proportion of people using the very intense surgical and medical services available only at the city's tertiary or quaternary care facilities; therefore, there are somewhat fewer high paid healthcare workers per discharge. The bottom line is that NYCH+H hospitals spend less on their hospital workers than do many of the voluntaries.

NYCH+H's costs are in the same ballpark as those of their private counterparts. There is no adequate yardstick for what it *ought* to cost. Even relative cost comparisons are often elusive.

The most meaningful and accurate method might be comparing the actual cost to care for a similar patient in different hospitals. But this is extremely challenging. The NYS Department of Health collects both hospital institution-wide cost (ICR) and patient-specific discharge data (SPARCS). It marries the two with a very significant caveat.

> When interpreting New York's data, it is important to keep in mind that variations in cost may be attributed to many factors. Some of these include overall volume, teaching hospital status, facility specific attributes, geographic region and quality of care provided. Additionally, costs derived from billing data are based upon a ratio that is submitted by a facility to the state and may not necessarily reflect a final price of the service delivered. Cost data presented in this dataset was calculated using facility specific audited RCCs [ratio of cost-to-charges] file.[16]

With these limitations in mind, the State produced reports comparing costs for specific common diagnoses. For example, the median cost of a patient discharged in 2014 after a cesarean delivery with minor severity ranged from $18,620 reported by NY Presbyterian Downtown to $6,985 at Mt. Sinai Roosevelt. NYCH+H's hospitals stretched along that continuum from a high of $17,117 (Harlem) to a low of $8,700 (Elmhurst).[17] It is extremely difficult to explain why care at one hospital appears to be nearly three times the cost of care at another. We suspect that there are only modest differences between Harlem Hospital and Elmhurst Hospital labor and delivery care protocols, staffing and unit costs. Rather, the enormous reported cost differences reflect differences in the ways the two institutions allocate and report costs.

Based on these difficulties, we conclude that the most reliable yardstick for comparing costs at one institution with those at another is payroll costs per adjusted discharge.[18] Of all the categories of data required by the Institutional Cost Report (ICR), labor is one with clear instructions: "count everyone and every expense including those jobs and workers who are subcontracted or on other payrolls."[19] Wages, benefits and training costs are typically 65-70 percent of total hospital operating expenses. NYC public hospitals array towards the bottom of NYC hospital costs. We understand that patient acuity as well as intensity and setting of service (i.e., inpatient versus outpatient) drive differences in staffing, but because of measurement limitations the available data do not allow a precise and accurate measure. *Nevertheless, within these parameters we can conclude that public hospitals are neither particularly expensive nor especially inexpensive.*

16 See: NYS Department of Health, Hospital Inpatient Cost Transparency data, available at https://health.data.ny.gov/Health/Hospital-Inpatient-Cost-Transparency-Beginning-200/7dtz-qxmr

17 Cesarean Delivery: Hospital Inpatient Median Costs and Median Charges: Latest Data NYS DOH Statistical Reports and Briefs https://health.data.ny.gov/Health/Cesarean-Delivery-Hospital-Inpatient-Median-Costs-/fr8u-haei

18 Adjusted discharge=inpatient discharges x (1+ (gross outpatient charges/gross inpatient charges)). We did not case mix adjust because it has been shown that public hospitals systematically underestimate DRG complexity compared with non-public institutions. See, for example, Mendez, C. M., Harrington, D. W., Christenson, P., & Spellberg, B. (2014). Impact of Hospital Variables on Case Mix Index as a Marker of Disease Severity. *Population Health Management*, *17*(1), 28–34. http://doi.org/10.1089/pop.2013.0002

19 2010 Instructions Institutional Cost Report (NYSICR) https://health.data.ny.gov/api/assets/329F8BC6-D396-4902-A9C2-F6B27E143924?download=true

On the issue of comparative costs, we should also note that reimbursement rates to hospitals generally support our conclusion about the costs of NYCH+H hospitals. Medicaid and Medicare payments for services are still tied to the cost of providing care. Thus, the payment rate for relatively expensive services like complex surgery is higher than the rate for simple pneumonia. However, rates paid by commercial payors are subject to negotiation between the insurance company and the hospital and reflect non-cost related issues including reputation and relative market share. In this case, NYCH+H hospitals receive among the lowest payments regardless of the service provided, according to a recent study commissioned by the NYS Health Foundation.[20] All study hospitals were grouped into five relative price groups. Eight of the nine NYCH+H hospitals included in the study were in the lowest price group and the ninth (Lincoln) was in the second lowest.

Comparing quality

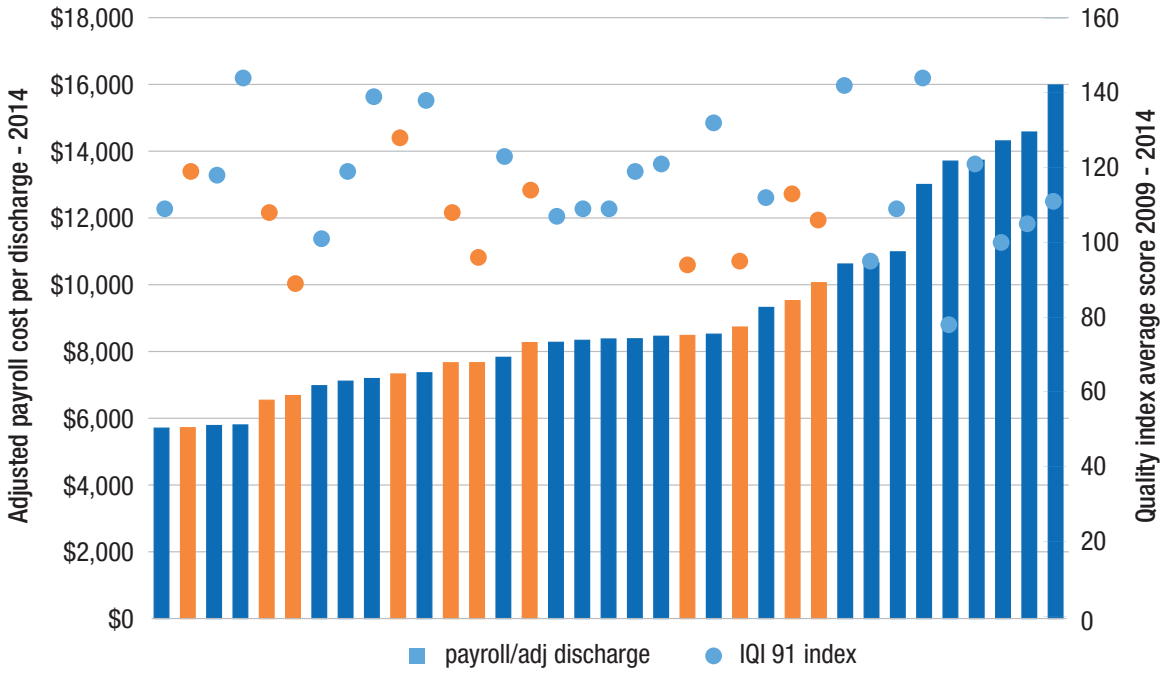
Spending a lot does not necessarily produce high quality. Cost and quality are rarely correlated. Like cost, quality is difficult to assess. However, as medical care reimbursement transitions from fee-for-service to value-based purchasing, numerous new, validated measures of the quality of care have been developed and adopted by public and private payors. Among the most tested are the tools incorporated into the Inpatient Quality Indicators program first developed by CMS/AHRQ for Medicare and adopted by New York State. For the most recent reported years (2009-2014), all but one of NYCH+H's Inpatient Quality Indicator scores have been in the top half of NYC hospitals.[21] There is no apparent correlation between quality and cost. See Chart 6, which shows the hospitals' payroll cost per adjusted discharge (with NYCH+H hospitals represented by the orange bars and the private hospitals represented by the blue bars) and the quality index scores (with NYCH+H hospitals represented by orange dots and private hospitals by blue dots, in which lower scores indicate better quality). NYCH+H tends toward the higher quality and lower cost areas.

20 Gorman Actuarial, Inc. Why are Hospital Prices Different? An Examination of New York Hospital Reimbursement, December 2016

21 The IQIs are a set of measures that provide a perspective on hospital quality of care using hospital administrative data. These indicators reflect quality of care inside hospitals and include inpatient mortality for certain procedures and medical conditions; utilization of procedures for which there are questions of overuse, underuse, and misuse; and volume of procedures for which there is some evidence that a higher volume of procedures is associated with lower mortality. See Appendix for full chart.

CHART 6

Labor costs and quality scores



Source: SPARCS All Payer Inpatient Quality Indicators (IQI) by Hospital 2009-2014. The average of the observed-to-expected mortality ratio for IQI 91—acute myocardial infarction, heart failure, acute stroke, gastrointestinal hemorrhage, hip fracture, pneumonia; and Institutional Cost Report, Exhibit 35, 2014

A recent report by RAND on the association between healthcare cost and quality reviewed 61 major studies published between 1990 and 2012. They found that 21 showed a positive correlation between spending and quality, 18 negative, and 22 no correlation. The authors noted that "the associations were of low to moderate clinical significance in many studies."[22]

Further evidence of the relatively good quality provided by NYCH+H hospitals can be found in the patient safety ratings published by the Leapfrog Group, an independent nonprofit organization founded a decade ago by the National Business Group on Health. In the fall 2016 report, only five New York City area hospitals received a quality rating of "A" or "B"—all five were NYCH+H facilities. In the spring 2017 report, of the seven NYC hospitals that received a "B" (no NYC area hospital received an "A" rating), six were NYCH+H.[23]

NYCH+H—Serving the public in unique ways

NYC's public hospitals do much more than care for residents of nearby low-income communities. They are literally the backbone of the city's hospital system. They serve a disproportionate number of underinsured and uninsured people. They provide most of the Level I trauma care. They form the network of first responders to epidemics and unusual outbreaks. They provide care for the City's jail inmates and prison staff. And, together with the NYC Department of Health and Mental Health (DOHMH), they protect the public's health.

22 The Association Between Health Care Quality and Cost: A Systematic Review. Published In: Annals of Internal Medicine, v. 158, no. 1, Jan. 2013, p. 27-34. Posted on RAND.org on January 01, 2013

23 See: Leapfrog Group, Hospital Safety Grade, at http://www.hospitalsafetygrade.org/search?findBy=state&zip_code=&city=&state_prov=NY&hospital=

Taking care of the uninsured

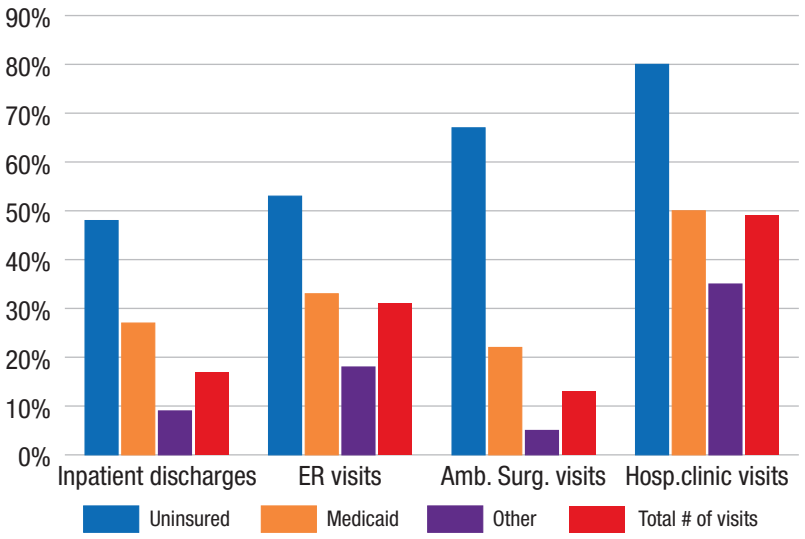
As the ACA has moved to cover much more of the population, care for the remaining uninsured population is increasingly concentrated in the City's public hospitals.

Half or more than half of the uninsured who sought inpatient, outpatient and/or emergency care in 2014 went to one of NYCH+H's hospitals. As Chart 7 shows, while NYCH+H hospitals accounted for 17 percent of all inpatient discharges from New York City hospitals, NYCH+H accounted for nearly half (48 percent) of uninsured discharges, a share that is nearly three times the NYCH+H share of all inpatient discharges.

Further, the inpatient discharge data significantly understates the role NYCH+H facilities play in delivering healthcare services to the uninsured. As the chart below indicates, NYCH+H handled 31 percent of all emergency room visits, and 49 percent of all hospital-based clinic visits in the city. Over half (53 percent) of ER visits by the uninsured are handled by NYCH+H facilities, and two-thirds (67 percent) of ambulatory surgery for uninsured patients is performed by NYCH+H hospitals. An overwhelming share (80 percent) of hospital clinic visits for the uninsured are in NYCH+H hospitals.

CHART 7

NYCH+H share of NYC hospital visits, 2014



Source: City of NY *One New York Health Care For Our Neighborhoods Transforming Health+Hospitals*, April 2016

Taking care of the underinsured—unwanted by the private system

NYCH+H's hospitals function as community hospitals in many underserved neighborhoods and provide a lifeline for the uninsured. Equally important, they are the primary source of care for those suffering from psychiatric and substance abuse disorders and illnesses.

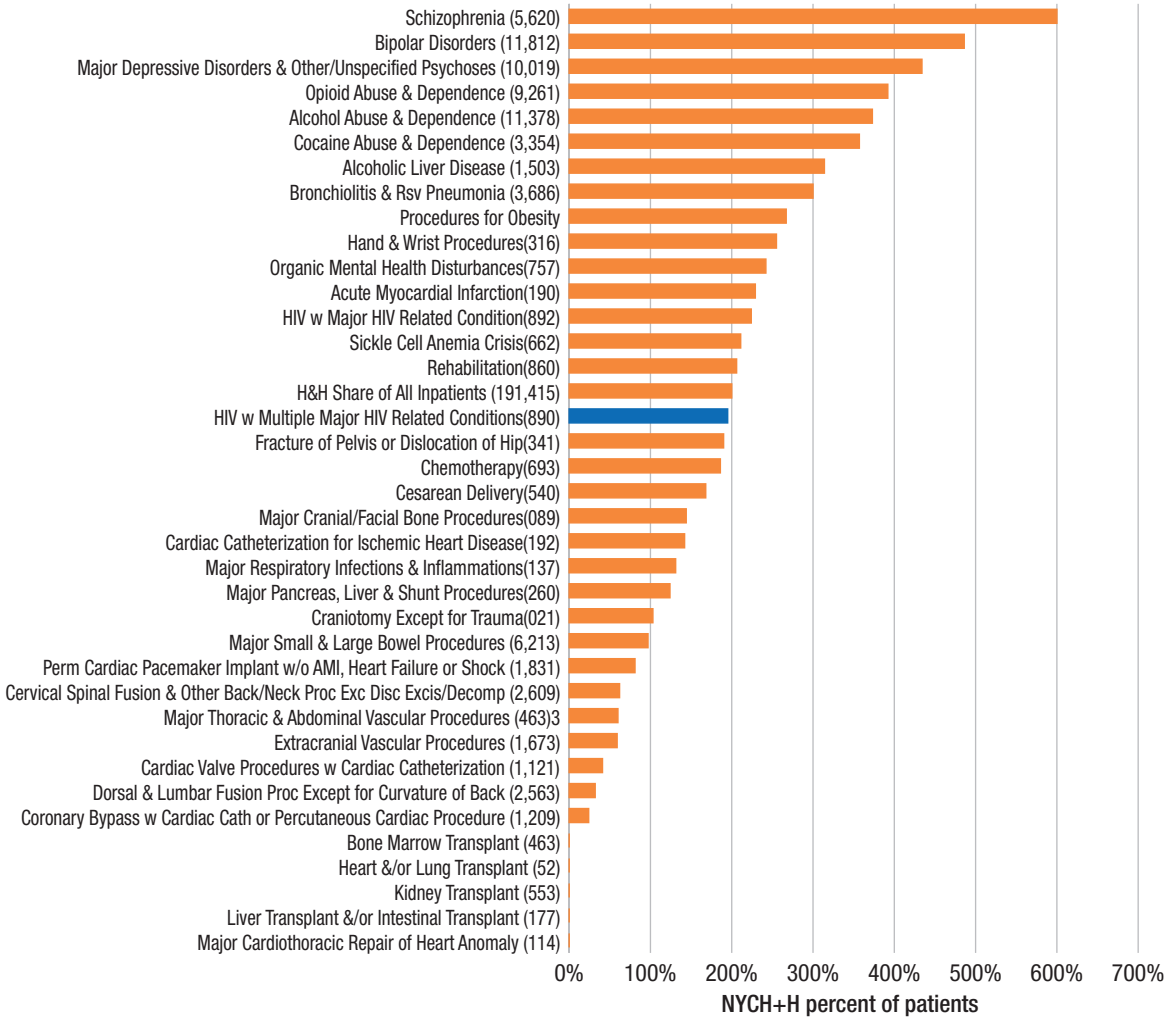
As with other publicly financed services for lower income communities, these conditions are historically underpaid. For example, 2014 base inpatient Medicare reimbursement was $9,476 for an inpatient stay for schizophrenia and $10,249 for someone diagnosed with a major depressive

disorder. Conversely, its payment rates for major surgical services were substantially higher—liver transplants—$80,001, coronary bypass—$33,405, major bowel procedures—$21,532. More important than the difference in payment rates are the (profit) margins. Surgical procedures produce the largest margins—especially when accompanied by surgical complications.[24]

As can be seen on Chart 8 below, where the blue bar represents NYCH+H share of all discharges, the public hospitals did very few of those more complex, well-paid surgical procedures that require well-appointed high-tech operating rooms, highly experienced surgeons and many well-trained (and well-paid) nurses and ancillary personnel. Not coincidentally, these are the types of inpatient services that are most handsomely reimbursed.

CHART 8

NYCH+H share of inpatient discharges—selected DRGs, 2014*



*The values for the last five categories are too small (less than one percent) to show on chart.
Source SPARCS, APR DRG by facility, 2014

24 Average surgical margins ranged from $16,936-$55,953 per case from commercial payers and $1,880- $3,687/case from Medicare https://www.hsph.harvard.edu/news/press-releases/patients-with-surgical-complications-provide-greater-hospital-profit-margins/

Trauma centers—providers of first resort

Most in-patient admissions come through the emergency department.[25] NYCH+H cares for a majority of the City's Level 1 trauma patients—the most grievously ill and seriously hurt. Bellevue is the emergency department of choice for any serious accident or incident that occurs in Midtown Manhattan—at construction sites, on the streets, in hotels, restaurants and theaters. Being the backbone of the trauma response system is an entirely appropriate function for a public hospital system. This role, however, comes at a high cost.

Trauma centers are expensive—the same care is about twice as expensive when provided in a trauma center compared to a non-trauma center.[26] Maintaining a trauma center means having oncall a wide array of professionals and facilities able to respond to just about anything that crosses the threshold.

According to NYS Department of Health Regulations:

> A regional trauma center is a facility with the ability to provide definitive treatment to the full-range of trauma patients including a commitment to trauma research and education. Such a facility has 24-hour availability of specialists in varied surgical and non-surgical fields. A regional trauma center can treat 1,000 severely injured patients per year. The minimum number of severely injured patients treated at a regional trauma center is 400 patients per year.[27]

NYC Adult Level I/Regional Trauma Centers:

Bellevue Hospital Center
Jacobi Medical Center
Lincoln Medical & Mental Health Center
Jamaica Hospital Medical Center
Lutheran Medical Center
New York-Presbyterian/Queens
Richmond University Medical Center
Elmhurst Hospital Center
Harlem Hospital Center
Kings County Hospital Center
NY Presbyterian/Weill Cornell Med. Cen.
Staten Island University Hospital North

The second reason is the fact that capacity invites use. New Yorkers and visitors in need of immediate medical care know about the NYCH+H emergency capacity and know they will not be turned away. Whether suffering from indigestion, a knife wound, a fever or fearing a heart attack, more people, especially residents of poor communities who have a paucity of alternative community-based care, use the 11 public hospitals emergency rooms more often than visit the 36[28] voluntary hospital emergency departments. NYCH+H hosts 1.2 million of the City's four million ER visits. NYCH+H emergency room utilization far outstrips its share of inpatient beds. There are 30 ER visits for every 10 inpatient beds in the NYCH+H system compared to 18 visits for every 10 beds among voluntary hospitals.

From orphans to orphan diseases—the role of public hospitals in public health

NYCH+H hospitals are responsive to yet another kind of emergency—that is, public health emergencies. In the 1980s and early 1990s, it was mostly NYCH+H hospitals, together with the Catholic hospitals, that cared for thousands of New Yorkers afflicted with AIDS. As described by the CDC, HHC was a *Featured Partner* because:

From the start of the AIDS epidemic 30 years ago, NYCH+H has been a leader in HIV/AIDS treatment and care. In 1981, before HIV or AIDS had been identified, Bellevue Hospital reported one

25 Kristy Gonzalez Morganti, et al., The Evolving Role of Emergency Departments in the United States, The Rand Corporation, 2013.O R P
26 R Durham, et al., Evaluation of a mature trauma system, Annals of Surgery, 2006; 243(6):775–83.
27 See: New York State DOH, Listing of Trauma Centers, at https://www.health.ny.gov/professionals/ems/state_trauma/docs/traumastds7085.pdf
28 Many hospitals have multiple sites. There are 55 unique hospital buildings scattered across the 5 boroughs

of the first of the three cases of unexplained immunodeficiency in the U.S. By the mid-1980s, HHC hospitals were seeing growing numbers of patients with AIDS and started developing treatment plans and services, including

- The first hospital-based HIV nutrition program in the country opened at Bellevue Hospital.
- The first long-term care beds in the United States for people living with AIDS were at Coler Memorial Hospital.
- Kroc Day Care Center for Children with HIV operated at Jacobi Medical Center (the nation's first such facility).
- NYCH+H has also participated in important research over the years, such as studies of HIV infection in women at Kings County Hospital in 1986, which led to the development of the country's first guidelines for care of HIV-infected women.[29]

There are numerous examples of special NYCH+H clinics and inpatient units providing care for some new or rare and/or expensive condition.

- Bellevue is one of 16 U.S. hospitals that U.S. Health & Human Services (HHS) designated as a leprosy treatment center. The leprosy clinic sees 25 patients a week. Altogether there are 400 leprosy patients registered for care at the oldest hospital in the city.
- During the recent Ebola panic, NYCH+H took the lead in preparing for any possible outbreak. The one NYC patient was taken care of by the nurses and doctors at Bellevue.
- 10,000 victims of the World Trade Center have been or are being followed/cared for at one of NYCH+H's three WTC Environment Centers—Bellevue, Elmhurst or Gouveneur.

As with its role as a provider of trauma care, it makes perfect sense for NYCH+H to partner with the City's Health Department in responding to new threats to the public's health and to New Yorkers' unusual diseases and injuries. In other cities without robust public hospital systems, these responsibilities, while paid with public funds, are imperfectly apportioned to various parts of the private system. Those places have neither the same quality nor the quantity NYC enjoys. Nor do they have a potential system that could, if properly led and financed, be the catalyst for change. It is only the public hospitals that are motivated by concern for the public's health and for the care of each person who arrives at their door—without regard for illness, station or price.

Race Matters—at least in New York City hospitals

Just as insurance status varies from hospital to hospital, so do the race/ethnicity of the people served by NYCH+H hospitals. The 11 public hospitals are in demographically diverse communities. Bellevue, for example, is in predominately white Kips Bay. Harlem Hospital Center is in the heart of NYC's historic Black community, which has become increasingly diverse over the last decade. The communities around Jacobi in the East Central Bronx and North Central Bronx in the North Bronx are similar—overwhelmingly non-white and about evenly divided between Black and Latino. In each of these cases there is also an adjacent or nearby private AMC.

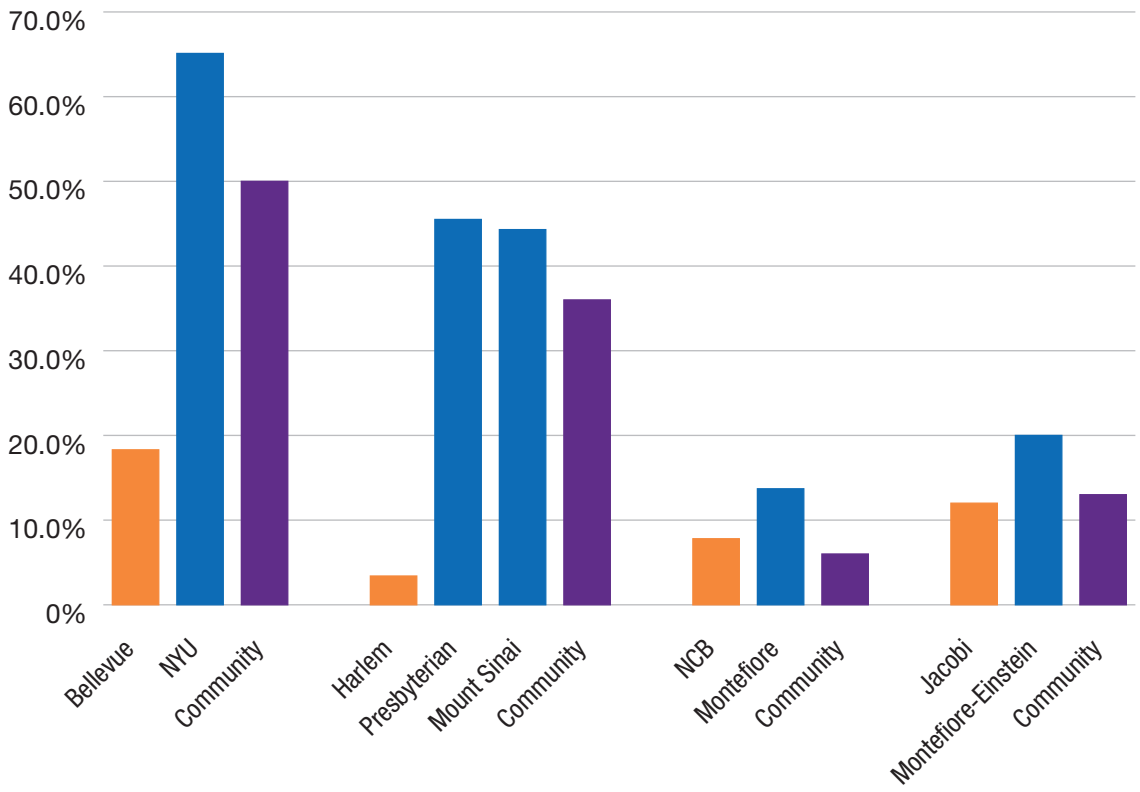
We would expect some correlation between the racial composition of the nearby neighborhoods and that of the hospital. Only the Montefiore/Einstein pairs look similar. The other two are quite different. The patients are predominantly white at NYU Hospital, Mt. Sinai, and NY Presbyterian, while people admitted to the two nearby public facilities are more than 80 percent people of color. These large disparities cannot be due to chance. A recent paper on New York City AMCs reached the same conclusion.[30]

29 See CDC, National Prevention Information Network, Featured Partner, at https://npin.cdc.gov/featured-partner/new-york-city-health-and-hospitals-corporation-hhc

30 RS Tikkanen, et al., Hospital Payer and Racial/Ethnic Mix at Private Academic Medical Centers in Boston and New York City, International Journal of Health Services, Feb. 2, 2017.

CHART 9

Percent of white patients among inpatient discharges—NYCH+H and nearby private medical centers and percent white population in the surrounding community[31]



Sources: 2014 SPARCS, Inpatient discharges by race, NYC DOHMH Community Health Profiles 2015

31 The Bellevue/NYU community or service area includes the Lower East Side, Chinatown, Stuyvesant Town and Turtle Bay; Harlem/Presbyterian/Mt Sinai includes the Upper East Side, East Harlem, Central Harlem, Washington Heights and Inwood; NCB/Montefiore includes Kingsbridge Heights, Bedford, Williamsbridge and Baychester; Jacobi/Montefiore includes Morris Park, Bronxdale, Throgs Neck, Co-op City, Parkchester and Soundview.

NYC PRIVATE HOSPITALS

As of January 2017, there were 36 non-public, general care, community hospitals in NYC. All were private, nonprofit voluntary institutions. And all but seven were part of a system organized by one of the five large hospital networks—Montefiore, NY Presbyterian, Mt. Sinai or Northwell (formerly North Shore LIJ, operator of seven NYC-based institutions).

CHART 10

	Number of hospitals	Staffed beds	Patient days	Gross patient revenue ($000s)
Voluntary hospitals	36	18,157	4,397,147	$78,698,134
NYCH+H hospitals	11	4,692	880,046	$10,016,112
NYCH+H share	23.4%	20.5%	16.7%	11.3%

Source: American Hospital Association American Hospital Directory updated 1/1/2017

A decade ago the city's voluntary hospital system was in such serious distress that the United Hospital Fund issued a clarion call:

> New York City's nonprofit hospitals continue to face significant financial hardship, and the survival of many small and safety net hospitals is in doubt. Since 2000, eleven hospitals have closed and an additional six are in, or have recently emerged from, bankruptcy. Per this year's update of hospital financial ratings by the United Hospital Fund ("the Fund"), more than one-half of hospitals (eighteen of thirty-four) were either "in jeopardy" or "at risk" in 2006, and facing such serious financial problems that some will not survive without a significant change in their operations or circumstances.[32]

The Governor and Legislature commissioned a 2006 study of the situation. Its report recommended closure and consolidation of many of the most vulnerable safety net facilities.[33]

Since the Great Recession, the AMCs have reinvented themselves as multi-hospital, geographically dispersed, vertically integrated mini-empires. They merged with, bought or acquired 35 nearby

32 United Hospital Fund, *The Deteriorating Financial Condition of New York City's Nonprofit Hospitals, and Its Effect on Capital Investment*, 2008.

33 It is instructive to recall some of the 2006 conclusions:

The Commission reaches a stark and basic conclusion: our state's healthcare 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.

- Turbulence afflicts our healthcare 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 healthcare struggle under the unintended consequences of bankruptcy proceedings. Patient access to stable healthcare services is at risk.
- Our healthcare providers are in weak financial condition. For the past eight years, the state's hospitals as a group have lost money.
- 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.
- 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.

Commission on Health Facilities in the 21st Century Final Report, Executive Summary, pp. 4-5, https://nyhealthcarecommission.health.ny.gov/docs/final/executivesummary.pdf

hospitals, numerous labs, freestanding surgery and urgent care centers, and many primary care practices. At first, they accomplished this far-reaching transformation with small amounts of capital—more promises than money—grabbing up financially weak hospitals and physician groups looking for a buyer. Over the last several years, the risk has paid off with significantly increased net revenues for both the mother ships (the AMCs) and many of the associated facilities.

Four factors contributed to the turn-about.

1. Reduced competition for paying patients; purchase/merger/consolidation of 35 local area hospitals into one of five networks; and closure of 20+ NYC hospitals since the turn of the century. There has been a net loss of 4,967 beds. The result has been increased leverage with commercial payers and higher reimbursement rates.[34]
2. A hugely increased pool of insured patients with the wherewithal to pay the cost of high technology/tertiary services.
3. AMCs' ability and willingness to shift resources and change service, payor and personnel mix toward more profitable services and to exploit new reimbursement offerings and methodologies—particularly changes initiated by Medicare such as accountable care organization value-based reimbursement.
4. Accelerating shift of under- and non-insured patients and under-reimbursed services to the NYCH+H system and to the few remaining non-affiliated struggling safety net private hospitals (e.g., Brookdale, Wyckoff, Interfaith, Bronx Lebanon, Jamaica).

In addition to the direct payment for services, private healthcare providers are also the recipients of huge indirect subsidies. Medicare and Medicaid, augmented by insurance payments on behalf of public employees and workers comp beneficiaries provide two-thirds of voluntary hospital income. In addition, the City of New York gives sizable real property, income and sales tax exemptions to private nonprofit providers (hospitals, health centers and some nursing home and home care agencies). The real property tax exemptions from the City of New York, totaling $669 million in FY 2017, were up by 34 percent from FY 2011. As the major private hospital networks have rapidly expanded their affiliated physician practices in recent years, it is likely that they have extended those exemptions to the highly valued commercial real estate these practices occupy.

In addition, the big five private hospital systems also benefit from being able to issue tax-exempt bonds through the Dormitory Authority of New York State (DASNY). As of 2014, the five networks reported a total of $3.9 billion in outstanding tax-exempt bonds, generating a conservatively estimated $71 million in annual interest savings.

Public support for hospitals and other healthcare providers is also extended through the exemption of employer-paid health benefits from income taxation. This provides enormous indirect support to the health insurance industry, as well as private employers. In total, between the benefits conferred to charitable institutions and income tax exemptions, it is estimated between 65 percent and 70 percent of all healthcare spending is supported by public funds.[35]

Since the early days of the 21st century consolidation, transformation, generous public financing, good commercial insurance deals and the benefits of "charitable" status have redounded to the benefit of the bottom lines of the major private networks. In 2014 and 2015, the five systems collectively had about $650 million in net revenues each year, and that rose to $877 million in 2016.

34 Gorman Actuarial prepared for the New York State Health Foundation, Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement, December 2016, http://nyshealthfoundation.org/uploads/resources/an-examination-of-new-york-hospital-reimbursement-dec-2016.pdf

35 Public Funds Account for Over 70 Percent of Health Care Spending in California Andrea Sorensen, Narissa J. Nonzee, and Gerald F. Kominski http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/PublicSharePB_FINAL_8-31-16.pdf

CHART 11

Operating revenues and expenditure, five major hospital networks

		NY Presbyterian	NYU Hospitals	Montefiore Med. Ctr.	Mt. Sinai Med. Ctr.	Northwell Health	Total 5 Networks
	in $000s All FYs end 12/31 except NYU 8/31						
2016	Operating revenue	$7,421,079	$3,582,121	$3,905,334	$2,368,257	$9,938,268	$27,215,059
	Operating expense	$7,096,220	$3,303,731	$3,887,351	$2,208,521	$9,842,401	$26,338,224
	Net	$324,859	$278,390	$17,983	$159,736	$95,867	$876,835
	% increase 2015-2016	43.5%	21.6%	1174.5%	51.7%	6.9%	34.5%
2015	Operating revenue	$5,928,217	$2,637,049	$3,672,439	$2,127,173	$8,722,655	$23,087,533
	Operating expense	$5,701,825	$2,408,172	$3,671,028	$2,021,865	$8,632,957	$22,435,847
	Net	$226,392	$228,877	$1,411	$105,308	$89,698	$651,686
2014	Operating revenue	$5,262,742	$2,346,453	$3,472,342	$2,016,551	$7,435,046	$20,533,134
	Operating expense	$5,036,864	$2,131,662	$3,432,175	$1,941,757	$7,347,534	$19,889,992
	Net	$225,878	$214,791	$40,167	$74,794	$87,512	$643,142

Source: audited financial statements

The City subsidizes these growing margins of the voluntary hospitals. Some changes that have taken place in the city healthcare system might suggest there needs to be an assessment undertaken to revisit the continued tax-exempt charitable status of the five major systems. Charitable tax status for private hospitals typically has been based, in significant part, on providing unreimbursed care for the indigent, insufficiently reimbursed Medicaid services, and maintaining high-cost trauma care capacity. The trends described in this report regarding these three criteria all indicate a shift of this charitable burden from the private hospitals toward NYCH+H. Complicating the charitable tax status question are increased advertising expenditures and a growth in the number of highly compensated executives.

Further, despite their tax-exempt status, the five networks are being run by very highly paid executives whose salaries rival those in the for-profit corporate sector. As of 2015, the five networks reported 108 executives were paid over $1 million each annually, with an average compensation of $2.2 million. The private hospitals as a group have over 150 executives who are paid more than the highest paid NYCH+H official. At one of the larger private networks, New York and Presbyterian, executive compensation soared 18 percent in 2015 over 2014, and pay packages resemble those on Wall Street, with bonus pay comprising a large part of total compensation

CHART 12

Compensation for highly paid executives, five major private hospital networks, 2015

Range for highest paid executive at each network	$3.7-$11.1 million
Number of hospital executives with total compensation greater than $1 million	108
Average compensation of $1 million+ plus executives	$2.2 million
Total compensation for these $1million+ plus executives	$234.2 million

Source: IRS 990 Schedule J Compensation

A closer look at compensation practices for New York Presbyterian, the second-largest of the five private hospital networks, reveals that their executive compensation packages look a lot like those on Wall Street, with base pay accounting for 44 percent of total compensation and a very large portion comprising bonuses and other forms of compensation. Moreover, executive pay rose sharply in 2015, with total compensation soaring by 18 percent from the year before for 28 executives working at New York Presbyterian in both years. Executive pay practices appear to be very similar at the other four private hospital networks.[36]

In addition to their favored tax status, private hospitals are beneficiaries of overly generous allocations of public safety net funding. While NYCH+H provides well over half of the care to the uninsured, private hospitals receive 85 percent of the NYS pool created to offset the costs of caring for these patients.[37]

Private hospitals are also at the top of a series of funding pools for distribution of federal payments to institutions that care for higher proportions of Medicaid and uninsured patients—federal Disproportionate Share Hospital (DSH) payments. Created in 1981 to help offset some of the costs of caring for Medicaid and uninsured patients, DSH payments to NYS as a whole are determined annually by the federal government, but the distribution of the total pool of federal funds allocated for New York to individual hospitals is largely determined by the State.

The need for disproportionate share payments was expected to decline as the number of ACA-covered individuals increased. The ACA (which continues to remain in effect despite recent efforts in Washington) calls for a $43 billion nationwide reduction in DSH allocations between 2018 and 2025, beginning with a $2 billion reduction in FY 2018. Currently NYS receives 17 percent of all DSH payments for the entire country. As such it is most vulnerable to the projected cut.

NYS DSH distributions are arranged in five pools. NYCH+H receives funding from three of the pools.[38] The amount in NYCH+H's residual pool depends on how much the State receives. First, voluntary and non-NYCH+H public hospitals are given their mandatory share. NYCH+H receives the rest.

In FY 2017, voluntary and non-NYCH+H public hospitals were guaranteed $995 million. As DSH payments decline, the amount in the funnel left after the non-NYCH+H guarantee becomes smaller and smaller. NYCH+H's budget professionals are expecting its DSH payments to decline from $2.2 billion in FY 2016 to $1.4 billion in FY 2020. Reporting on the allocation of these payments, the Citizens Budget Commission recently recommended

> The State should reconsider its priorities in distributing Medical supplemental payments. The fixed size of available federal funding means that redirection to H+H comes at the expense of other

36 New York Presbyterian IRS 990s for 2014 and 2015.

37 Roos Tikkanen et al. *Funding Charity Care in New York: An Examination of Indigent Care Pool Allocations*. NYS Health Foundation March 2017. P. 11

38 NYCH+H, *One New York Health Care For Our Neighborhoods Transforming Health+Hospitals*, 2016. p. 27

institutions. Pending cuts should not fall only on H+H and adjustments, such as reduced payments to voluntary hospitals with limited reliance on supplementary payments, may be needed.[39]

The large private networks would not have been able to position themselves as beneficiaries of New York City's transforming healthcare system without the public hospital system. NYCH+H hospitals thus contribute directly to the financial health of the private system. They absorb many of the broader hospital system's losses—first as a source of community healthcare to low-income residents of nearby communities, and second as guarantor of the public obligation to take care of the sick and suffering regardless of circumstance or cost. NYC's mammoth private hospital networks report larger and larger gains. They net more than a $1.5 billion (the total of their net income and the value of avoided taxes and expenses). The private hospital networks prosper at the expense of the public system.

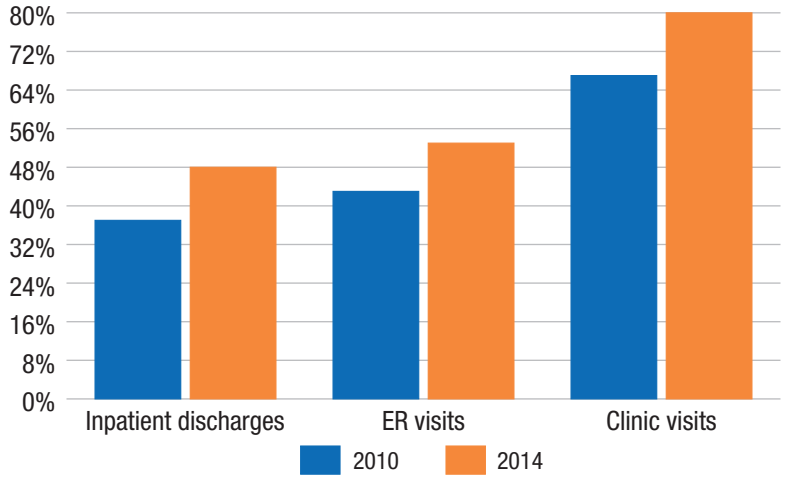
NYCH+H AND THE PRIVATE SYSTEMS MOVING FURTHER APART

The changes brought by the ACA, especially the significant decrease in the number of uninsured New Yorkers, have not lessened the differences between the public and private systems. In fact, the payor and diagnostic mix differences between them have widened in recent years.

NYCH+H hospitals were already a major provider of care to the uninsured prior to the ACA. Since then its share increased even as the number of uninsured declined. For the period 2010-2014, NYCH+H took on an additional burden of uninsured patients—on the inpatient side its proportion of uninsured patients increased from 37 percent to 48 percent. Apparently, the rate of change accelerated further in 2017. During the first four months of the 2017 fiscal year, the number of uninsured patients *increased* by 4,059 while the total patient volume *decreased* by 9,674. Simple arithmetic shows that NYCH+H lost 13,000 insured patients (probably to private providers) and added 4,000 uninsured in their place.[40]

CHART 13

NYCH+H share of services to the uninsured



Source: SPARCS Discharges by DRG by facilities, 2010 & 2014

39 P. Orecki Medicaid Supplemental Payments The Alphabet Soup of Programs Sustaining Ailing Hospitals Faces Risks and Needs Reform. CBCNY, August 31, 2017

40 NYC Mayor's Office of Operations, Preliminary Mayor's Management Report, February 2017, p. 159.

In the four years between 2010 and 2014, as NYCH+H's share of all inpatient discharges declined slightly, its hospitals have seen an *increase* in their already large share of total psychiatric and substance abuse-related discharges.

CHART 14

NYCH+H share of selected psychiatric & substance abuse discharges, 2010 & 2014

	2009	2014
Alcohol abuse & dependence	38.9%	39.4%
Alcoholic liver disease	26.1%	33.1%
Bipolar disorders	47.0%	49.5%
Cocaine abuse & dependence	29.9%	37.2%
Drug & alcohol dependence	33.8%	34.5%
Major depressive disorders & other/unspecified psychoses	41.5%	44.2%
Schizophrenia	59.7%	59.8%

Sources: SPARCS, DRG by facility 2010 and 2014

A HEALTH SYSTEM FOR THE 21st CENTURY

NYCH+H's financial and fiscal problems can be solved only within the context of New York City's entire health and hospital system. Our 8.5 million people are cared for at 47 general care hospitals, 31 community health centers and thousands of offices and clinics staffed by one or more of the city's 44,000 active physicians, 97,000 nurses and 50,000 other providers. On paper, it looks like enough money to give each person sufficient care. It isn't, because of (1) the profound inequality of healthcare needs; (2) maldistribution of resources among communities; and (3) historic imbalance in the ways healthcare is valued and paid for, particularly services for the poor and disabled.

Health disparities

Not every neighborhood in NYC needs enhanced healthcare service. Some are already well served, while others are in desperate need. The community needs assessments created for DSRIP planning published in December 2014 document many of the variations from neighborhood to neighborhood.[41] While the availability of healthcare does not necessarily lead to better health outcomes, there is little doubt that outcomes cannot improve if there is no access to needed care. Communities suffering excessive amounts of disease and death need more health services than other areas. A 10-year gap between communities with the longest life expectancy and the shortest is not inevitable. It's a consequence of hard lives and poor access to the sorts of services and programs that ameliorate the effects of racism, poverty and need. Or as Dr. Mary Bassett, New York City Commissioner of Health, put it, "This is unfair and avoidable. A person's health should not be determined by his or her ZIP code."[42]

41 See for example, One City Health, NYCH+H Community Needs Assessments http://www.onecityhealth.org/community-needs-assessments/

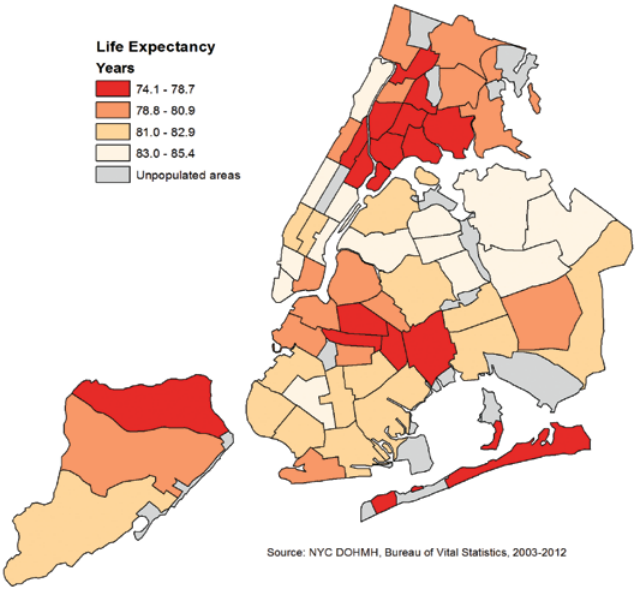
42 Community Health Profiles 2015

CHART 15
Life expectancy at birth

Life expectancy at birth

Highest		Years
1	Financial District	84.5
2	Stuyvesant Town and Turtle Bay	85.3
3	Upper East Side	85.0
4	Greenwich Village and Soho	84.3
5	Elmhurst and Corona	84.1

Lowest		Years
59	Brownsville	74.1
58	Bedford Stuyvesant	75.1
57	Central Harlem	75.1
56	Morrisania and Crotona	75.3
55	Rockaway and Broad Channel	75.9



Reproduced from NYC DOHMH Community Profiles, 2015

Maldistribution of resources

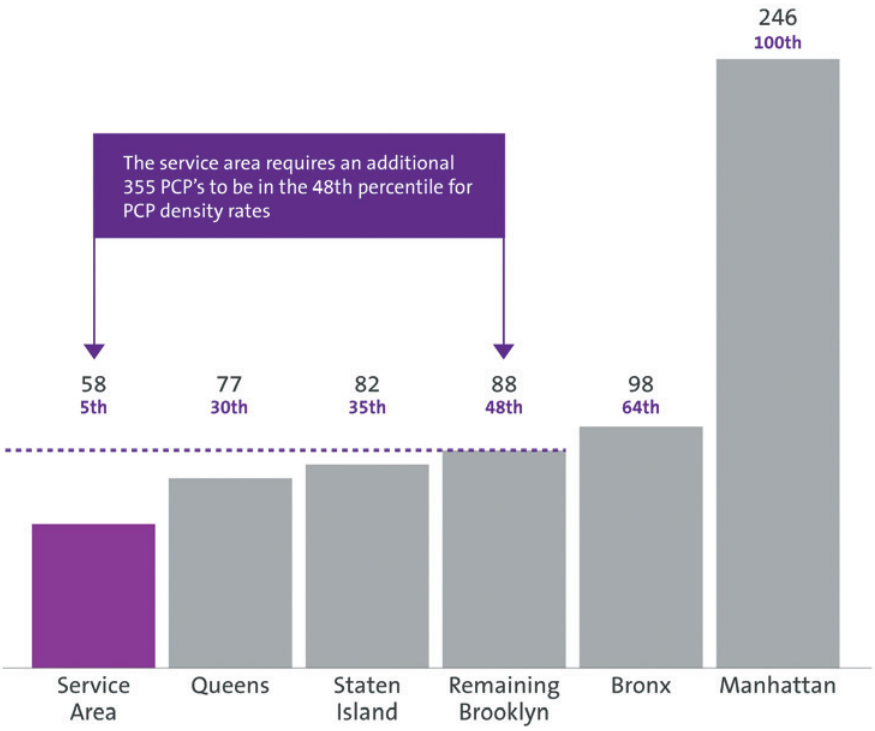
Most people need to be able to visit a doctor/nurse for the acute and chronic problems they encounter every day. Everyone should have quick access to emergency services for both better outcomes and peace of mind. A recent study of hospital closures in California found the *very act of closing down an emergency department* had serious consequences—"that one-quarter of hospital admissions in this period [1996-2009] occurred near an ED closure and that these admissions had 5 percent higher odds of inpatient mortality than admissions not occurring near a closure."[43] For best outcomes, the primary and emergency services should be linked to a local hospital that can deliver a baby, treat a heart attack, stop a stroke, and stabilize a patient who needs transfer for more complex treatment.

The most effective primary care is provided by professionals who know their patients, speak their languages, and are in their community.[44] There are not enough primary care physicians (PCPs) in New York City to provide that type of care. The maldistribution is both geographic and income determined. The Bronx, Brooklyn, Queens and Staten Island have less primary care coverage than 70 percent of Americans. The inequality is further deepened within the boroughs. In Brooklyn, for example, the authors of Northwell's recent study of central and east Brooklyn described such a severe shortage in those low-income neighborhoods that the addition of 355 PCPs in that community would only put the area in the 48th percentile, nationally.[45]

43 Charles Liu, Tanja Srebotnjak and Renee Y. Hsia, "California Emergency Department Closures Are Associated With Increased Inpatient Mortality At Nearby Hospitals," Health Affairs, August 2014, vol. 33 no. 8 (1323-1329).
44 Patient Centered Medical Home. For a summary of current effectiveness research see NCQA *Latest Evidence: Benefits of PCMH Recognition*, October 2016, at http://www.ncqa.org/Portals/0/Programs/Recognition/PCMH/NCQA1005-1016_PCMH%20Evidence_Web.pdf
45 Northwell Health *The Brooklyn Study: Shaping the Future of Healthcare*, 2016, p 76.

CHART 16

Comparison of primary care physician density for service area and NYC counties per 100,000 population, 2015



Source: Northwell Health *The Brooklyn Study: Shaping the Future of Healthcare*, p. 76, 2016

Unfair payment paradigm—you get what you pay for

The average charge for a heart transplant is $1.2 million. There were 175 heart transplants performed in New York City in 2014. New York City has more heart transplant centers than 33 *states* (and the state has just approved two more). On the other hand, Medicare's payment schedule for inpatient treatment of cirrhosis is very modest: $9,782 for a patient with cirrhosis and alcoholic hepatitis with major complications and/or co-morbidity; and $3,682 if the patient has no major complications. Montefiore, NY Presbyterian and Mt. Sinai advertise their transplant services. None has a sign out welcoming someone suffering from serious alcohol-related illness.

Worse than the distortion inherent in payment schemes is the absence of fair reimbursement for the social and personal services that have proven to make and keep people healthy. "We have the wrong balance of social and medical spending," according to a recent Brookings blog post, "if one of our priorities is improving health overall and measures such as infant mortality and life expectancy. This pattern from the international evidence is reflected in data from within our own borders. States with a higher ratio of social to health spending also have significantly better health outcomes for such conditions as adult obesity, asthma, mental health indicators, mortality rates for lung cancer, high blood pressure, heart attack, and Type 2 diabetes."[46]

46 Stuart M Butler, et al., "Re-balancing medical and social spending to promote health: Increasing state flexibility to improve health through housing," February 15, 2017 https://www.brookings.edu/blog/up-front/2017/02/15/re-balancing-medical-and-social-spending-to-promote-health-increasing-state-flexibility-to-improve-health-through-housing/

RECOMMENDATIONS

NYCH+H's fiscal problems cannot be fixed by closing hospitals, laying off staff, and cutting services. Nor can the solution be increased reliance on and payments to the costlier and less responsive private hospital system. Unfortunately, given the current alignment of reimbursement policies, it is very unlikely that NYCH+H hospitals will be reimbursed adequately for the cost and quality of services it provides.

Fiscal relief can come, in part, from other sources. The private healthcare system needs to be made more accountable for the care of all New Yorkers—regardless of ability to pay or medical problem. The hospital system in New York City is a single system with multiple managements. The voluntary sector is making money, the public sector is not, but not because it is high-cost or provides poor quality. No solution to NYCH+H's fiscal woes will succeed without acknowledging NYCH+H's interaction with the city's broader healthcare system. Nor will success happen without recognition that the burden of caring for the neediest and most vulnerable should be more equitably distributed.

1. A reshaped public care system based upon need

We must create a public health system that reflects and responds to low-income and vulnerable New Yorkers through a newly created community-based care network (NYCH+H working with DOHMH) while maintaining a geographically dispersed community hospital network that's welcoming to all community residents. This must include maintaining sufficient capacity in the public hospital system to fulfill its mission as provider to both residents of adjacent communities as well as the unique populations served by NYCH+H. The future system needs to be reshaped based on local needs—some communities will need increased services, and some might not. Most of the data necessary to construct a rational system has been collected and analyzed. Now is the time to use it.

2. More equitable distribution of healthcare burdens and resources

The major private hospital systems need to take more responsibility for the needs of all New Yorkers. This will require that current funding formulas be revised. City and State government needs to be proactive. First, redesigning the distribution of the state-specific Indigent Care Pool, as well as the state-administered Medicaid and Medicare charity care add-ons, to recognize NYCH+H's significant contribution to caring for the uninsured, especially immigrants, and the underinsured. Second, those hospitals that do not operate Level 1 trauma centers and depend on NYCH+H and others to maintain these costly operations should contribute to a trauma center funding pool. Third, the State and the Medicaid payers it regulates must change the reimbursement weighting system that underpays the costs of treating psychiatric and substance abuse disorders and fails to financially acknowledge the critical contribution of social services.

3. City actions to push private hospitals to do/or pay for their share

The City and State should consider whether tax benefits, permitting, and zoning exceptions awarded to private, nonprofit hospitals ought to be based on a demonstrated contribution to caring for the sick, regardless of ability to pay—and in the absence of such contribution, the collection of special taxes to help offset the costs of services currently borne by NYCH+H. Property tax and commercial income tax exemptions are awarded to charitable enterprises. Are all of NYC's private healthcare networks entitled to these exemptions? A Morristown,

New Jersy, judge, for example, recently revoked a local hospital's nonprofit status—finding that the hospital behaved not like a charity, but like a business.[47] Perhaps the City of New York should apply similar criteria for awarding property tax exemptions and granting zoning and construction permits.

The City might consider a program like one implemented by San Francisco. The Charity Care Ordinance of 2001 tied local approval of construction permits to demonstrated provision of charity care. As related by Elizabeth Rosenthal in her book, *American Sickness*, Sutter's California Pacific Medical Center had to promise $1.1 billion in concessions before the city would issue the required permits. Among the items the hospital promised were a freeze on prices charged city employees insurance, operation of a nearby safety net hospital, some affordable housing investments and upgrades of transit and sidewalks.[48] New York City might want to broaden the scope of such a program to include property tax forgiveness.

4. City leadership on creating a New York City health system for the 21st century

A transformation plan that focuses only on the NYCH+H hospital system's finances, without considering the role that it plays in the broader healthcare system, is doomed to failure. NYCH+H cannot become self-sustaining because it absorbs the losses that the private providers are unwilling to shoulder.

The NYCH+H system thus has a symbiotic relationship with the private providers, absorbing costs and assuming obligations for services that the City needs but that the other hospitals can avoid because of the existence and role of the public system.

Given this dynamic, any restructuring of NYCH+H or path toward sustainability must include maintenance of effort to support NYCH+H's quality of care. The alternative is a vicious downward cycle of cuts that affect quality, causing loss of market share and more revenue losses that in turn cause further losses and more cuts in service.

The City working with the State must also take on a more assertive role in shaping the structure of the entire public and private hospital care system. The goal of any restructuring cannot be merely to fix the finances of NYCH+H but to create an integrated city-wide healthcare system in which the private and public provider systems work together to provide health services to the people of New York.

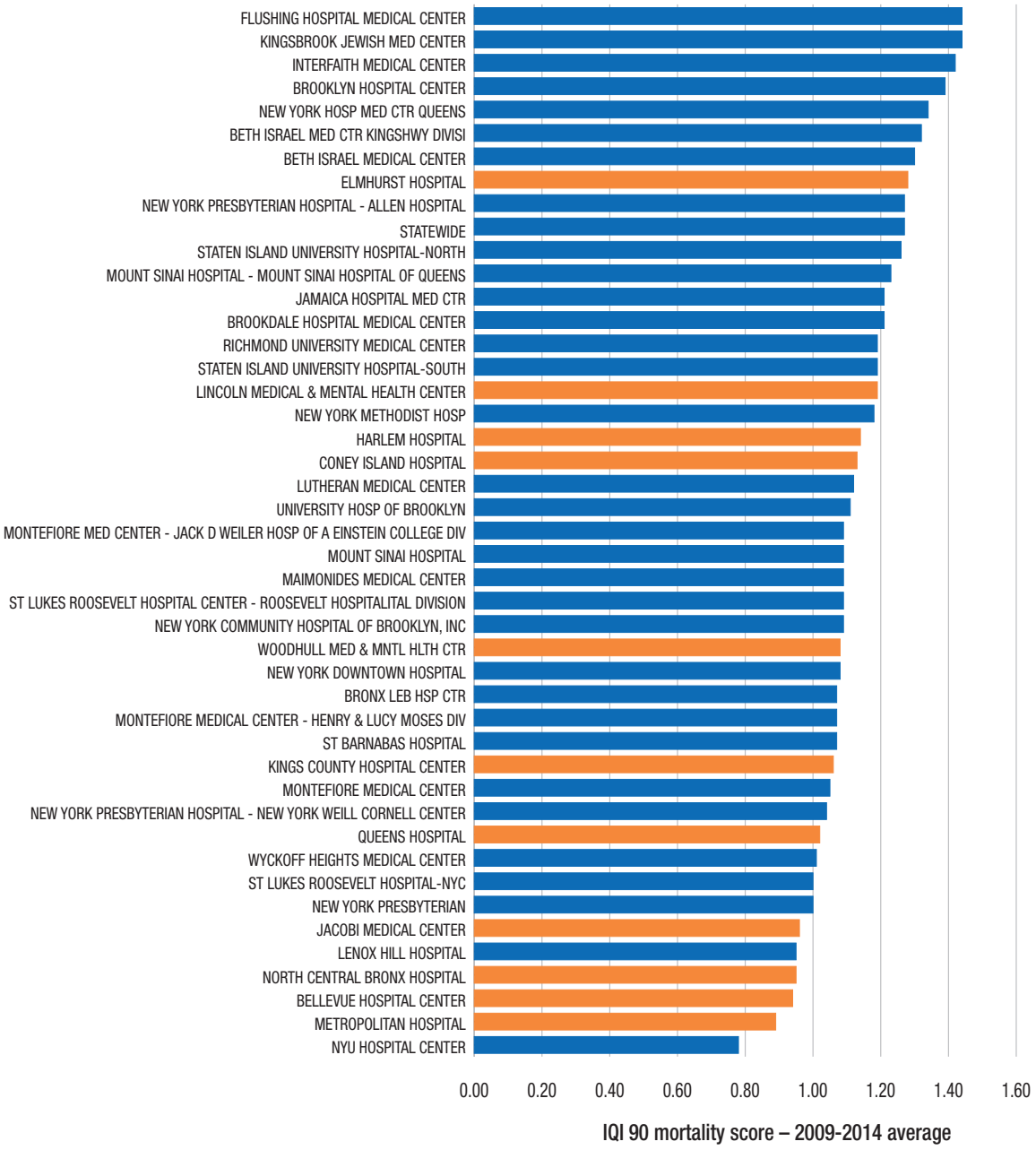
47 A recent judgment against New Jersey's Morristown Medical Center nonprofit status was based on two factors, according to *Modern Healthcare.* http://www.modernhealthcare.com/article/20150708/NEWS/150709925) Frist, the hospital had relationships with for-profit subsidiaries and owned a number of MD practices. Second, the Medical Center paid its executives high salaries. "If it is true that all nonprofit hospitals operate like the Hospital in this case," the judge observed, "then for purposes of the property-tax exemption, modern nonprofit hospitals are essentially legal fictions."

48 Elizabeth Rosenthal, *An American Sickness*, Penguin Press 2017 p. 52

APPENDIX 1

CHART 17

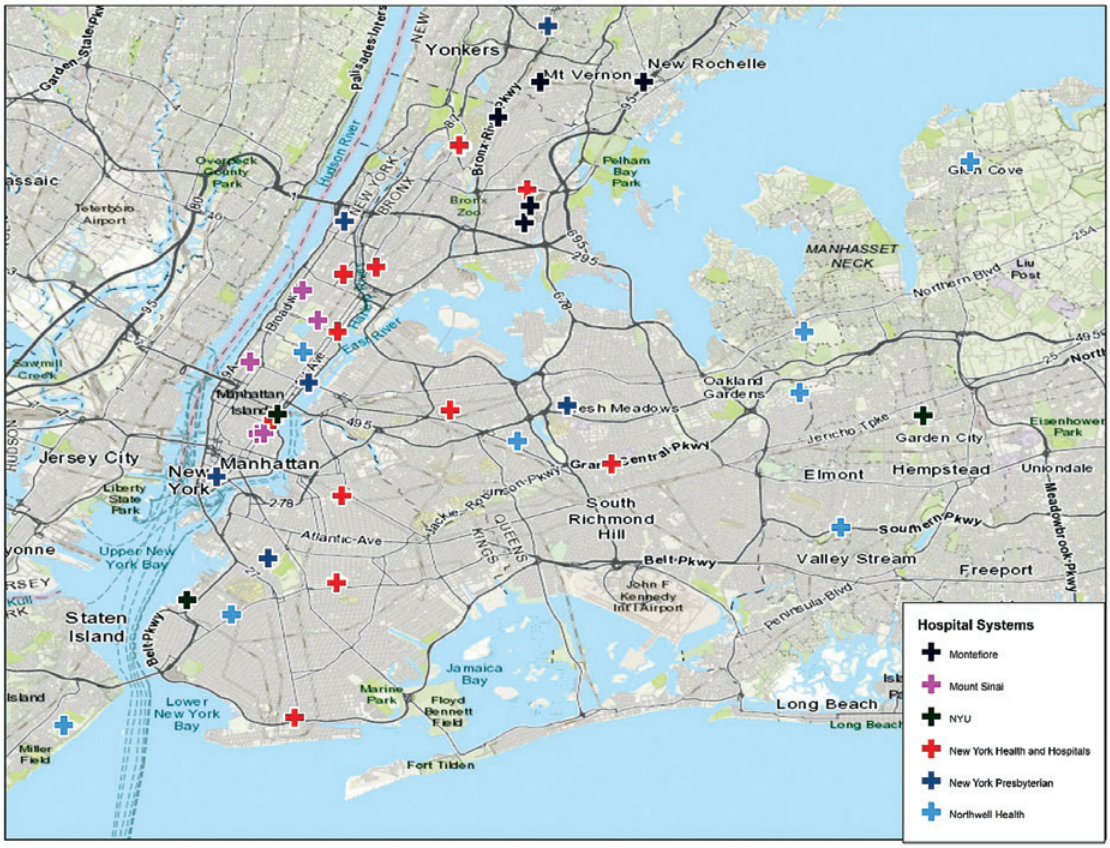
Quality Indicator—observed to expected mortality ratios, average 2009-14



Source: NYS Department of Health All Payer Inpatient Quality Indicators (IQI) by Hospital (SPARCS): 2009-14 . The average of the observed-to-expected weighted average mortality ratios: IQI 91—Acute Myocardial Infarction (AMI) • Heart Failure • Acute Stroke • Gastrointestinal Hemorrhage • Hip Fracture • Pneumonia

APPENDIX 2

NYC and environs hospital networks



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