Nassau – Suffolk Hospital Council
Representing the not-for-profit and public hospitals serving the residents of Long Island
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Testimony

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Before the

Regional Advisory Committee, Long Island Region of the Commission on Health Care Facilities in the 21st Century

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Good afternoon and thank you, for the opportunity today to comment on the restructuring efforts that will be carried out by the commission in the months and years to come. I am especially grateful that the commission decided to include regional advisory committees as part of their fact gathering process, because it is only on this very local level that we will be able to understand the magnitude and minutiae of local health care needs in our communities.

The Nassau-Suffolk Hospital Council is the collective voice of 23 not-for-profit and public hospitals on Long Island. In Suffolk, we represent 11 hospitals, ranging from multi-hospital systems to independent facilities and one public hospital. This mix includes one Level 1 Trauma Center and ten other acute care/community hospitals. According to the most recent U.S. Census Bureau count, Suffolk's population hovers at 1.4 million. Larger in square miles than its cousin county (Nassau), Suffolk's thousands of companies, including hundreds of mom and pop enterprises, are spread out, creating

different access challenges than those faced in Nassau. All these people, at some point in their lives, will seek the services of their local hospital, either for themselves or a loved one. These individuals have a right to remain on Long Island for hospital care they need and are entitled to, and we as policy makers must ensure that these individuals always have appropriate access to and availability of hospital-based care and services. This is an important consideration to include in your deliberations, particularly concerning access on the eastern end of both forks.

Let me begin my testimony by asking the committee members and those in attendance at this public hearing to think about where health care/hospital policy stood about nine years ago. It was at that time that our legislature moved to de-regulate the hospital industry and allow the market to settle itself. But did it settle? I would argue, and I think many of my hospital colleagues would conclude, that nine years later we are not really completely regulatory free. What we envisioned a free hospital market to be, and what it is today, are two different pictures. It is truly a schizophrenic situation and is at the heart of many of the problems hospitals face today.

About 50% of a hospital's revenue comes from government reimbursements. Yet, Medicare and Medicaid reimbursements are continually cut in state and federal budgets. Take the Medicaid Emergency Room rate for example. This reimbursement has been frozen at $95 since 1991. The average cost of an Emergency Room visit is $400.

Additionally, hospitals' ability to negotiate fair and reasonable rates with commercial insurers has been eroded to the point where facilities here on Long Island are receiving lower than average reimbursements from these insurers, when compared to surrounding states. This "quasi" market environment has led to self- adjustment among facilities on Long Island. In just the past five years, these closings occurred:

- Brunswick Hospital (Amityville)
- Massapequa General Hospital (Massapequa)
- Island Medical Center (Hempstead)
- Maternity Units (Franklin and New Island Hospitals)
- Inpatient Pediatric Unit (Mercy Medical Center)
- Satellite Rehab Center in Valley Stream (Mercy Medical Center)
- Cardiac/Pulmonary Rehab Unit (Huntington Hospital)

"Rightsizing" – it appears, has already begun.

Long Island's population is as diverse as its landscape. In Suffok County, 2003 U.S. Census Bureau data indicate that about 23% of Long Island's residents are aged 55 years and over. As the more junior members of this senior group age in the next decade, they will join their frail elderly counterparts and our hospitals must be ready to care for thousands of people who will be in their prime "health needs" era. Not only will hospitals be called to help in the management of long-term chronic age-related illnesses like diabetes and heart disease, but they will also face a rise in complications from those illnesses resulting in acute care hospitalizations.

Add to this, the explosion in the undocumented population in Nassau and Suffolk counties and the situation worsens. According to the Long Island Association, our region's economy is fifth in the nation in terms of its growth and sustainability. This prosperity will continue to draw immigrants from Central and South American countries, as well as from Slavic European countries and other depressed areas from around the world. The southern to central portions of Suffolk county are currently experiencing a surge in immigrant growth populations. Hospital ERs are usually the first and only access such immigrants have to care. We ask the commission to please keep this trend in mind, especially because the undocumented are just that – not counted and unknown in true number.

Our hospitals struggle each day to operate efficiently and ensure capacity at all times. The ever looming threat of a terrorist attack or that category 4 hurricane that is sure to hit the Island in the not too distant future are realities that hospital administrators keep in mind always. A huge storm surge could wipe out our coastal hospitals. Ever present too is the possibility of flu outbreak. In February, *Newsday's* front page reported that flu season finally peaked on Long Island, a few weeks behind the normal seasonal surge. Hospital planners must keep all these variables in mind in order to strike the right capacity balance.

Further, we believe the notion to triage and house patients, resulting from a surge event, in nearby hotels, school auditoriums, and other public buildings undermines public

health and safety protocols. Additionally, the logistical planning for staff, supplies, and medical equipment inherent in such a maneuver poses its own disaster. Please keep in mind, we do not mean a hospital should exist just because there is a potential threat for a natural or manmade disaster, but we do mean members of your commission and the committee cannot overlook these disaster scenarios when making your recommendations. Careful and calculated planning is essential.

As of December 2005, the Hospital Council's utilization statistics reported 3,231 certified hospital beds (excluding newborn bassinets) in hospitals in Suffolk County, which in 1.3% fewer beds than in 2003. Yet, we are aware that hospitals usually staff a lesser number. This means that right now there is adequate capacity on hand to accommodate any large-scale emergency events and daily fluctuations in demand for services. Surge capacity is required by the federal government as part of our nation's homeland security plans. Hospitals must show the government that they have the capability within three hours to house and treat a surge of 500 patients for every one million people in their service areas. That translates to 9,600 beds statewide and 750 beds in Suffolk County with a population of 1.4 million.

We believe that the bed capacity at hospitals in Suffolk County, taking into account surge capacity needs, is currently at its proper level. I defer to the alternative methodology for calculating estimated excess bed capacity developed by our state hospital association. Committee members have already received a copy of this white paper. That alternative methodology takes into consideration a series of realities in the day-to-day operation of hospitals. Namely, it considers variations in census counting taken at different times of the day. Ideally, the more accurate census occurs at around noontime – when the hospital is busiest. When we apply this methodology in our region there do not appear to be any excess capacity.

The most recent statistical data collected routinely by the Council shows that in 2005 hospital admissions continued to grow almost 4% over 2003. For 2005, average length of stay remained steady compared to 2003, at 5.85 days. Occupancy rates increased 6.5% over 2003 to 74.2%. Emergency room volume remained steady compared to 2003 with 443,845 visits in 2005.

The statement that hospitals in this county are full and busy 24 hours a day, seven days a week and the fact that Long Islanders highly value the expertise, proximity, and community benefits of their hospitals is much more than just rhetoric. A voter poll commissioned by the Healthcare Association of New York State, and conducted in February, found that 57% of respondents believe hospitals are extremely important to their communities, followed by their schools. Health care (at 18%) is the second most important issue on Long Island after taxes (at 23%). Currently, 63% believe there is just the right amount of hospitals in their communities and 20% feel there should be more hospitals.

In terms of our aging population, the poll found that 42% of respondents in Nassau/Suffolk feel that right now there are not enough elderly care services or facilities available. A large majority (79%) believe there is likely to be a shortage of elder care facilities in the future, as the baby boom generation ages.

The Nassau-Suffolk Hospital Council has taken its own informal poll of voter opinions and concerns during the past year through "Healthy Conversations" – town hall type meetings that are sponsored by our hospitals at local public libraries, civic, and community centers. The intent of these conversations is to elicit from the attendees their understanding of hospitals and health care, what they feel works and doesn't work in the system, and what changes they would like to see. At the top of the list, no matter the type audience addressed, is the good accessibility to hospital care that now exists in the county. That is followed by advanced technology, research, and innovation. We feel these observations are extremely indicative of the pulse of Long Island's hospital patients, because the conversations take place in relaxed, real-time situations. Additionally, diverse age and economic groups express these similar opinions. We invite members of this committee to take part in one of our upcoming "Healthy Conversations."

Community health services and initiatives are at the heart of each of our hospital's mission. Every day, physicians, nurses, and other professional staff from our hospitals serve the community through free health fairs and screenings, educational meetings, and other outreach activities. Our hospitals provide free and sliding scale pediatric and adult primary care at hospital-based clinics and in clinics located throughout the community. Mobile mammography vans and traveling flu clinics bring these and other preventative

services to the elderly and other populations who would otherwise forego such cost-saving care.

Any consolidation and re-structuring of services and access must consider these un-reimbursed benefits provided by hospitals throughout the region. If the community hospital is no longer there to provide well and sick pediatric care to a local immigrant population, for example, will private physician offices be willing to pick up the slack? How would such closures affect the local county health department that is already overstressed? These and similar consequences must be viewed very carefully.

We ask the committee to also look closely at emergency department needs in this county. According to U.S. Census Bureau data, Suffolk County has about 152,000 uninsured, which is 10.6% of its population. Historically, the uninsured have turned to hospital emergency departments as their first line of care. And with more and more employers dropping health insurance coverage because of its expense, the uninsured situation will worsen.

The hospital-based emergency department also plays an important role, because it is there 24 hours a day, seven days a week for anyone regardless of insurance status. In the middle of the night, hospital EDs are the only places open for care. Medicaid patients who use the ER for routine care further burden hospital EDs. There are two compounding factors inherent in this practice. On the one hand, physicians in the community are not required to see Medicaid patients, so they often direct patients toward hospital-based ER care. Hospital planning policy needs to address this imbalance. On the other hand, the absurd $95 Medicaid ER reimbursement rate further strains the hospital. Again, this is an issue policy planners, like you, must address.

An often-overlooked fact concerning hospitals is their positive economic presence in a community. The 11 hospitals in Suffolk County contributed about $4.3 billion to their local economies. This includes direct and indirect spending by hospitals and their employees. These figures were prepared by the Healthcare Association for New York State for the Hospital Council and reflect an earlier study (2003) that the Hospital Council conducted on its own through the Long Island Association. There is no question that hospitals are a vital force driving Long Island's economy. Hospitals' economic

impact on their communities must be taken into consideration during the commission's deliberations.

The Nassau-Suffolk Hospital Council agrees that some industry "rightsizing" needs to take place. The commission will cause "rightsizing" to occur, if it looks at the systemic problems that hospitals encounter daily. To properly prepare health care facilities for the 21st century we ask the commission to consider these forces currently pressing down upon our region's hospitals:

- Unreasonably low reimbursements rates from government payers for services such as the $95 frozen Medicaid ER rate
- Unfair bargaining position imposed upon hospitals by the commercial insurers
- Competition from physician-owned health care facilities who circumvent their social mission to the communities they serve and siphon professional talent from hospitals
- Regulatory-like practices of balancing state and federal budgets by reducing hospital reimbursements
- Further regulatory obstacles that prevent health care facilities from rationalizing services on their own (e.g. anti-trust protections)