STATEMENT OF COMMISSION ON THE PUBLIC'S HEALTH SYSTEM

Medicaid Redesign Team Brooklyn Workgroup Public Hearing
July 28, 2011

My name is Judy Wessler, and I am Director of the Commission on the Public's Health System (CPHS), a member of the Save Our Safety Net-Campaign.

In the measly two minutes that I am given on the critically important issue before you today, I will just give some highlights of what we believe needs to be said:

- First, I grew up in Brooklyn, but I don't believe that that fact qualifies me to sit on this committee which has the power to help or devastate communities.
- Second, the map that I have with me was prepared for what we fondly refer to as Berger I. It needs to be updated because since 2006 when this map was prepared, more hospitals have closed in medically underserved communities, identified as the red areas on the map. Certainly Mary Immaculate would need to go on in Queens, and possibly St. John's. All of the five hospitals at stake today would fit in the Brooklyn red area, as would Peninsula in Rockaway.
- Third, the Medicaid Redesign Team and the Governor's office continue to disrespect people who were willing to come out and testify at the first round of hearings, or to submit testimony. Despite a public statement by James Introne at an MRT meeting that the inaccuracy would be corrected, it has not been. The attachment on the MRT web site for Recommendation #67 continues to incorrectly identify people as supporters of this resolution, but for which they spoke against. Those people are: Grace Otto, RN; Anne Bove, RN; Ed Davila, Harlem Hospital Community Advisory Board; Joann Casado, The Bronx Health Link; DC 37. If this was a good path to take why the need to use people's names and reputations in such an outrageous way.
- Fourth, a CPHS Board member, Honorable Karen Smith, documented some of the important special services provided by each of the five vulnerable Brooklyn hospitals, services that are needed and not easily replaceable. These include: 123 psychiatric beds at Interfaith, OB/GYN services at Brookdale and Brooklyn Hospitals; designated stroke center and center for advanced wound healing at Wyckoff; primary care centers at Brookdale; dental services at Brookdale, Brooklyn, and Kingsbrook Jewish. To name a few important services.
- Fifth, what if any consideration is being given to designating hospitals and health centers as needed safety net health care providers? What if any consideration is being given to working on proposals to adjust the dollar flow and reimbursement going to these health care providers so that they don't get into financial trouble and can remain open? CPHS made some important proposals dealing with these issues that have never gotten a "fair hearing."

- Finally, does it bother anyone on this panel as much as it does others of us, that medically underserved, low-income, immigrant and communities of color continue to be stripped of services while the major academic medical centers continue to spend money as if it is going out of style. What does this say about our morals, about our beliefs?

Safety Net Hospitals in New York City

Identifying safety-net hospitals in New York City based on the 2008 Institutional Cost Reports (ICR). This table was prepared by the Commission on the Public's Health System based on data prepared by the Committee of Interns & Residents (CIR).

To be considered part of the safety net, for this table, a hospital must have a minimum of 50% Medicaid and Uninsured patients in all services. The hospital must also have a minimum of 70% Medicaid and Uninsured for outpatient services.

Hospital	**Total % Medicaid and Uninsured – all services**			**Total % Medicaid and Uninsured – clinic services**		
Bronx	Uninsured	Medicaid	Total	Uninsured	Medicaid	Total
Jacobi	8.2%	62.6%	70.8%	15.2%	58.0%	73.2%
Lincoln	16.4%	58.6%	75.0%	26.3%	48.9%	75.2%
North Central	8.4%	70.2%	78.6%	15.6%	65.5%	81.1%
St. Barnabas	9.7%	60.5%	70.2%	12.5%	67.9%	80.7%
Brooklyn						
Brooklyn	7.1%	53.1%	60.2%	8.3%	74.1%	82.5%
Coney Island	15.8%	46.2%	62.0%	27.2%	43.1%	70.3%
Interfaith	7.3%	64.5%	71.8%	7.0%	65.6%	72.7%
Kings County	20.9%	54.1%	75.0%	7.0%	65.6%	72.7%
Lutheran	11.0%	49.2%	60.2%	17.5%	57.2%	74.7%
Maimonides	6.3%	48.2%	54.5%	20.4%	63.0%	83.4%
Woodhull	19.5%	58.6%	78.1%	34.4%	47.4%	81.1%
Wyckoff	7.3%	55.4%	62.7%	2.4%	71.1%	74.2%
Manhattan						
Bellevue	20.5%	51.8%	72.3%	31.7%	44.0%	75.6%
Harlem	16.6%	58.2%	74.8%	31.6%	46.4%	78.0%
Metropolitan	17.6%	60.3%	77.9%	28.5%	48.6%	77.1%

There are other hospitals named below that met the safety net criteria for one of these tests, but not for both.

Hospital	Total % Medicaid and Uninsured – all services			Total % Medicaid and Uninsured – clinic services		
Queens	Uninsured	Medicaid	Total	Uninsured	Medicaid	Total
Elmhurst	18.5%	57.1%	75.6%	34.3%	47.3%	81.7%
Flushing	8.0%	50.8%	58.8%	10.1%	72.2%	82.3%
Jamaica	7.5%	58.7%	**66.2**%	5.4%	70.9%	76.2%
Queens	19.8%	56.5%	76.3%	32.6%	45.3%	77.8%

Staten Island
None

Hospitals that met one test, but not both

Bronx Lebanon – overall services – uninsured – 10.8%; Medicaid and uninsured – 74.7%
Brookdale – overall services – uninsured – 6.1%; Medicaid and uninsured – 60.0%
Methodist – clinic services – uninsured 6.6% - Medicaid – 65.0% - Medicaid and uninsured – 71.5%
St. Lukes'/Roosevelt – clinic services – uninsured 9.5% - Medicaid – 61.3% - Medicaid and uninsured – 73.6%
St. Vincent's (closed) – clinic services – uninsured 5.0% - Medicaid – 68.6% -- Medicaid and uninsured – 73.6%

Prepared by the Commission on the Public's Health System (CPHS) for the Save Our Safety Net- Campaign
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A New Proposal for Charity Care in New York State

This proposal contains three major recommendations:

Funds from the Charity Care hospital pool would be distributed to hospitals to provide services for the uninsured. 100% of the funding would be allocated to all hospitals on the basis of actually providing care to uninsured patients. By accomplishing this important new allocation method, hospitals would receive payment to meet their obligation of providing care for the uninsured under the Patient Financial Assistance Law (Manny's Law).

A special Upper Payment Limit (UPL) payment would be developed for safety net hospitals, which are defined as hospitals that provide a significant level of their services – 50% -- to Medicaid and uninsured patients.

The Diagnostic and Treatment Center pool would be increased to a level that would match the percent of coverage of payment for services to the uninsured that is provided to the hospitals from their Charity Care pool.

Background

Each year nearly $1 billion dollars is distributed from a hospital Charity Care pool. This is one of the least accountable, least transparent distributions of public funding. Since 1983, New York State has done the right thing in collecting dollars and distributing the dollars to hospitals but this is done under the guise of providing funding for the care of the uninsured and the under-insured. The problem is the method of distribution of the funding. Hospitals have been allowed to use an antiquated accounting methodology to compute how much they are owed from the pool.

In 2008, the State Health Department set up a Task Force to review the pools and ultimately recommend that 100% of the funding be distributed to hospitals based on the care that they provide to uninsured patients. This makes a great deal of sense, particularly in light of the passage of the Patient Financial Assistance Law (Manny's Law) which requires all hospitals to develop and publicize a Charity Care policy for uninsured patients with low

incomes. With this legal requirement, hospitals should be paid for providing uncompensated care for free or on a sliding fee scale.

There are strong, well-funded efforts by hospital associations and their allies to maintain the current unaccountable system. They claim that many hospitals would be hurt if funds that they get, without earning them, were taken from private hospitals, it would hurt many hospitals. This lobbying effort has been very successful with both houses of the state legislature.

The Proposal

There are safety net hospitals in low-income, medically underserved, immigrant and communities of color that provide many services for Medicaid patients and some uninsured patients. A system should be developed for recognizing the service of these hospitals. We would recommend that the State develop a special Upper Payment Limit (UPL) payment for safety net hospitals that can prove that they provide a significant percent of services to Medicaid and uninsured patients. The special UPL payment would only be available for Safety Net hospitals which will be defined based on services to Medicaid and uninsured. This Medicaid rate could include dollars for providing services for low-income patients and proving that they are efficient. There should also be a limit set on the size of the salaries and compensation packages at $1 million for the hospital executives and some other staff. If hospitals spend more on salaries for this staff, the overage should be disallowed in any computation of hospital costs for calculating Medicaid reimbursement.

By developing this special rate, the Charity Care dollars could be freed up and used for their primary purpose – paying for care for the uninsured. One hundred percent of the Charity Care pool dollars should be distributed to hospitals based on their accurate reporting of the numbers of uninsured patients to whom they provide services – emergency, clinic, and inpatient care. The hospitals would have to fully, and appropriately, document that the patient was interviewed for, and approved for, financial assistance. All hospitals, including the public hospitals, would be eligible for full reimbursement for providing this care. (Note: in New York City, the public hospitals provide 66% of all hospital-based clinic care for the uninsured). If private hospitals resist the redistribution of charity care dollars based on providing care for the uninsured, a mechanism must be developed to develop a way of referring uninsured patients to these hospitals, such that they actually provide enough services for the uninsured to earn the charity care dollars they receive.

A third component of this modest proposal is an increase in the charity care pool dollars for Diagnostic and Treatment Centers. These facilities, many of them public or FQHC's, also treat large number of uninsured patients. Dollars in this pool should be increased so that the clinics receive the same percentage of funding for caring for uninsured patients as hospitals do from the pool. D&TC's already have a transparent, accountable method of reporting and dollars are distributed from this pool strictly on the basis of providing care for the uninsured.

Revised: January 14th, 2011

Medicaid Redesign Team: Health Systems Redesign: Brooklyn Work Group
July 28, 2011 Public Hearing
Mary Li- Commission on the Public's Health System
Testimony

My name is Mary Li and I am the Education and Outreach Coordinator at the Commission on the Public's Health System or CPHS. CPHS also co-coordinates and is a member of the Save Our Safety Net- Campaign.

The Save Our Safety Net- Campaign has recommended, urged, demanded and cried out to the Medicaid Redesign Team since the beginning of Phase 1, that the health needs of NYC's most vulnerable and medically underserved populations must not be ignored. We have repeatedly stressed what we believe is self-evident, that the communities affected by these decisions not merely be heard for two minutes, but be at the table. We feared, since the beginning of Medicaid Redesign, that immediate cuts to Medicaid reimbursement would hurt hospitals that serve a higher percentage of Medicaid and uninsured patients. We urged the State to make definite protections for these essential health care providers and the communities they serve.

So why am I standing here today? Feels like déjà-vu. I'm standing testifying here today, for two minutes again, on behalf of CPHS and the Save Our Safety Net Campaign, because I am disappointed and appalled. Instead of recognizing the need to protect and preserve the safety-net, despite the tricky language of Proposal 67- we are now facing the potential closure of five hospitals in North and Central Brooklyn. 80% of Central Brooklyn's residents are African American and 31% of Central Brooklyn's residents live in poverty. [1] 53% of Bushwick and Williamsburg residents are Latino and 38% of Bushwick and Williamsburg residents live in poverty.[2] Northern and Central Brooklyn residents experience more barriers to health care access than those in New York City, overall. It is arrogant that the MRT has not invited any residents to the decision-making table- so that they can "redesign" their own health system.

No hospitals in these communities should close without first guaranteeing that the necessary healthcare services are in place. If hospitals are closed without establishing accessible healthcare for communities, we take one step closer to becoming a more racially and economically segregated city. For the sake of the neighborhoods of Brooklyn, this work group needs to commit to decreasing the already existing health disparities and they need to make responsible decisions based on thorough community health assessments, from the community. Keep Health Care Local in Brooklyn!

1. Olson EC, Van Wye G, Kerker B, Thorpe L, Frieden TR. Take Care Central Brooklyn. NYC Community Health Profiles, Second Edition; 2006; 10(42):1-16.
2. Olson EC, Van Wye G, Kerker B, Thorpe L, Frieden TR. Take Care Bushwick and Williamsburg. NYC Community Health Profiles, Second Edition; 2006; 18(42):1-16.

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I am Disha Shah, a second year student at the New York College of Osteopathic Medicine and an intern at the Commission on the Public's Health System, which is a member of the Save Our Safety Net - Campaign.

I am here today because I am concerned about the future of healthcare in the North and Central Brooklyn communities. I understand that changes need to be made but taking away healthcare from these medically underserved communities can in no way, be the solution. Proximity to medical care plays a huge role in determining whether a patient will take action against a health problem sooner rather than later. People need to have local access to healthcare. Another issue that I would like to inform you about is that of the unacceptable health disparities in these regions. If you close these hospitals, know that you will be not only be creating, but also encouraging greater health disparities on the basis of race, ethnicity, and income.

I am also concerned about the learning opportunities that will be taken away from students like myself with the closing of safety net hospitals in Brooklyn. Two of the five hospitals, Brookdale and Wyckoff, have affiliations with NYCOM which allow medical students to gain first-hand experience in serving within medically underserved communities. With the recently announced closing of the Peninsula Medical Center, students are already losing one such institution, and we shouldn't have to lose another. Studies have shown that students who are given the opportunity to learn medicine at such hospitals tend to stay and serve within the same communities. By keeping these hospitals, you can help to maintain the presence of physicians in the face of the upcoming shortage of doctors.

I hope that you will take all of these aspects into consideration. The members of the community should be involved every step of the way because they do not deserve to be completely ignored while a panel that does not represent them or their benefits, decides the future of their healthcare.