The Challenge of Financially Distressed Hospitals in New York

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Introduction

Perhaps the dominant economic theme of the 21st century has been the disruption of entire industries by technological innovation and related changes in producer and consumer behavior. For example, e-commerce platforms like Amazon have transformed retail, reducing foot traffic in brick-and-mortar stores and leading to the closure of thousands of shopping malls. The rise of streaming platforms such as Netflix disrupted traditional television networks, cable television, and movie theaters. Ride-sharing platforms such as Uber and Lyft have upended traditional taxi services, while electric vehicles are disrupting the traditional auto industry.

Technology and medical progress are similarly disrupting the hospital industry, enabling more procedures to be performed outside of the hospital, leading to profound changes in providers' business models and healthcare consumers' preferences. These changes have led to a long-term decline in inpatient hospital admissions and a dramatic shift in market share to outpatient settings such as ambulatory surgery centers and specialty centers, most of which are not owned by hospitals. Because of their business model, physician-owned outpatient specialty practices can deliver services at a lower cost than their hospital competitors while better serving the economic interests of physician providers and patients' desire for convenience. These trends that shifted care away from hospital-based care settings accelerated sharply during the COVID-19 pandemic and continue unabated.

Although the hospital industry is being disrupted as surely as the industries described above, it is more problematic for society and government to allow market forces to entirely reshape the hospital sector than it is to watch shopping malls close, for example. This is the case both because of the vital role hospitals play from a clinical and community health perspective and because of the economic impact and sense of identity that hospitals represent to their local communities. Hospitals are often the largest employer and the most important institution in their communities, and as such, they command a disproportionate share of attention from stakeholders, elected officials, and policymakers.

The word "hospitals" in the context that is used in policy discussions is something of a misnomer in 2023. Even many standalone hospitals own some outpatient facilities and a large and growing number of hospitals organized into "health systems," in some of which outpatient revenue is almost as large as inpatient revenue. Nevertheless, the inpatient hospital is still the hub of the wheel for even the largest health systems and are by far the largest part of the operations of financially distressed hospitals.

The primary policy response of the State over the last decade to the growing number of financially distressed hospitals in New York was, first, the introduction, and then the steady expansion, of financial operating subsidies sufficient to enable financially distressed hospitals to continue operations. The State intended for these subsidies to serve as a bridge to a restructuring or "transformation" that would improve the financial sustainability of the hospitals receiving them. Unfortunately, the actual experience has not lived up to that vision.

At best, these operating subsidies have been cushioning the transition to meaningful restructuring by giving financially distressed hospitals time to achieve incremental progress – albeit more slowly than was envisioned before the pandemic – toward a restructured system that advances the related goals of access, equity, quality, and financial sustainability. At worst, these subsidies have proven to be just enough to keep the doors open, but not enough to enable substantial progress towards a transformation that maintains access to the quality services communities need but at a more financially sustainable cost

in terms of State operating support. In the latter cases, operating subsidies have simply preserved an unsustainable status quo without serving as a bridge to a financially sustainable future.

State operating support for financially distressed hospitals is not a screaming financial crisis: the State share of hospital operating subsidies is barely more than 10% of what the State spends on home care and personal care in the Medicaid program. But after years of thinking hard about this problem, it is clear to me that the existing business model of most safety net hospitals and community hospitals that comprise the universe of financially distressed hospitals will likely continue to deteriorate in the years ahead. As the saying goes, something that is unsustainable ultimately cannot be sustained. Sooner or later, the State's approach to managing the issue of financially distressed hospitals needs to change.

The Policy Brief is longer than usual, but barely scratches the surface of this complicated issue. We think it's important to understand the background of the increasing numbers of financially distressed hospitals in New York and the growing depth of their operating deficits. We then attempt a diagnosis of a number of the underlying causes of this financial distress. The paper concludes with what I would call working hypotheses for a policy prescription the State should pursue.

I would be the first to say that the prescription to address this problem is not obvious. It is difficult to reconcile the sometimes-competing goals of access, equity, quality, and financial sustainability. Considerably more work is necessary to convert the vision of the prescription section of this paper into an actionable plan. Nevertheless, the recommendations of this paper suggest some important options the State should consider to meet the challenges of financially distressed hospitals.

Governor Hochul recently announced a New York State Commission on the Future of Health Care with a mandate to develop recommendations for the healthcare delivery system in New York over a 5-10 year time horizon. The Commission can make an important contribution by thinking about the long-term role of hospitals in the healthcare delivery system and suggesting ways to facilitate a lasting transition. Improving the future of the healthcare delivery system in New York goes well beyond hospitals, of course, including strengthening public health and the whole continuum of clinical care from primary care to long-term care. But it's hard to see that effort being successful without significant reforms affecting hospitals. This paper concludes with ten recommendations that would, if adopted, begin to address the structural disadvantages of financially distressed hospitals and generate the substantial operating and capital resources that likely will be needed to make viable a long-term vision suggested by the Commission.

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A Note on Data

Data discussions concerning financially distressed hospitals in New York can easily get confusing. Many data points in this paper refer to State fiscal years, which end on March 31. For example, FY 23 ended on March 31, 2023, so FY 23 is most closely related to calendar year 2022. FY 20, which ended on March 31, 2020, is most closely related to calendar year 2019. Because 2019 was the last full year before the pandemic, and 2022 was the first full year in which treatment of COVID-19 was not a material part of a hospital's admissions, comparisons between these two time periods are particularly instructive.

Much of the data regarding revenue, expense, and operating gain/(loss) in the paper are derived from the publicly available calendar year Institutional Cost Reports (ICR) that hospitals file with the NYS

Department of Health (DOH). The ICRs are based on the calendar year and generally accepted accounting principles (GAAP) but have slightly different rules than audited financial statements for reporting revenue and expense. For example, in the ICRs, the professional service fees paid in connection with services provided by physicians by the hospital are excluded from revenue, and their salaries are excluded from reported expense. As a result, there are minor differences between the ICRs and the audited financial statements of hospitals.

Unless otherwise noted, "operating gain/(loss)," as used in this paper, is based on the operating gain or loss before the receipt of State operating subsidies. The paper uses the operating gain /(loss) data reported by a hospital in its ICR report, adjusted to back out from revenue any State operating subsidies the hospital received during the year and to back out from operating expense any depreciation or amortization expense the hospital incurred during the year.

Spending on State operating subsidies is reported based on New York State's fiscal year (April 1st through March 31st). For FY 23, individual hospital subsidies are based on a response to a legislative RFI produced in connection with the FY 24 Budget. Accordingly, when we are comparing fiscal year operating subsidy levels to calendar year operating revenue and operating gain/(loss), we are comparing slightly different time periods. These numbers are close enough, however, that the comparison is still valid. The State generally does not make the subsidy levels to specific hospitals publicly available, so this paper uses aggregated or de-identified data when discussing operating subsidy levels and trends.

Part I: Background

The Decline of Hospital Profitability

According to the Department of Health (DOH) website, 222 facilities are licensed by the DOH as "general hospitals." Many of these facilities are part of health systems, whether large health systems with an academic medical center such as New York Presbyterian or small health systems with just a few facilities, such as Medisys in Queens, which operates Flushing Hospital Medical Center and Jamaica Hospital Medical Center. Health systems large and small now have significant ambulatory care services as part of their corporate structure. Indeed, in many large health systems, ambulatory or "outpatient" revenue is close to or even greater than hospital inpatient revenue.

Stagnant revenue and rising expenses have led to a significant decline in hospital profitability nationally and in New York. Although this trend has been ongoing for close to a decade, excluding temporary COVID-19 pandemic-related Federal subsidies, the decline accelerated significantly during the pandemic.

As described in the report by the PwC Health Research Institute – Medical Cost Trend: Behind the Numbers 2024:

> The pandemic revolutionized the dynamics of the US healthcare system by rapidly shifting the site of care from more expensive inpatient hospitals to less expensive outpatient. While this trend started before the pandemic with cataracts and cosmetic surgery in the 2000s, it accelerated toward the end of the pandemic when employment in ambulatory care settings recovered the fastest. As a result, lower-cost freestanding and non-acute sites were able to absorb a large portion of the demand for these healthcare services that were previously only available through inpatient settings. With the increased demand for outpatient surgeries, home-based services, and virtual care, the healthcare delivery system has reached a new phase.

A Report by the health consulting firm Kaufman Hall, based on a nationwide survey of all hospitals' financial performance, reflected this sharp decline in financial performance since the last full year prior to the pandemic. Patient discharges in 2022 were 9% lower than in 2019, while expenses were 20% higher over the same period. Increased reimbursement rates partially offset the decline in unit volume, resulting in average operating margins of 0.2% for hospitals nationwide in 2022. Approximately half of all U.S. hospitals ended 2022 with a negative operating margin, as growth in expenses (especially labor expenses) outpaced growth in revenue.

New York hospitals experienced a similar decline in financial performance and operating metrics between 2019 and 2022. According to a joint hospital association survey:

- From 2019 to 2022, inpatient admissions dropped statewide by 8.3%;
- 64% of New York's hospitals and health systems report[ed] negative operating margins; and
- The number of New York hospitals and health systems reporting negative or unsustainable operating margins increased by 23% from 2019 to 2022.

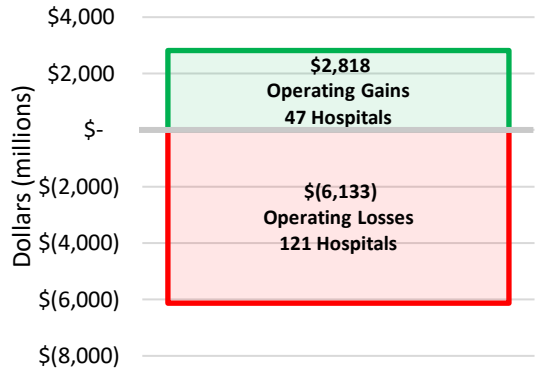
The survey report added, "[P]atients are staying at the hospital longer because their needs are more complex and/ or a diminishing number of post-acute and other appropriate settings are preventing hospitals from discharging patients. Hospitals are serving as nursing homes with payment that fails to keep pace with the cost of caring for these patients…."

There are indications that nationally, some hospitals are seeing improvements in 2023, although that does not appear to be the experience of most financially distressed hospitals in New York.

The total reported revenue (excluding State operating subsidies) of the 168 hospitals that submitted 2022 ICRs to DOH was $100.8 billion dollars. In aggregate, the total *net* operating gain/(loss) of these 168 hospitals in 2022, excluding the benefit of State operating subsidies but including depreciation and amortization, was a loss of approximately $3.3 billion. This loss is comprised of hospitals that lost approximately $6.1 billion in aggregate, offset by an aggregate profit pool of approximately $2.8 billion. Only 47 hospitals had a positive operating gain in 2022. Two large health systems (NYU and New York Presbyterian) accounted for roughly 35% of the approximately $2.8 billion profit pool in 2022.

Figure 1: 2022 Operating Gains and Losses

Based on 2022 ICRs

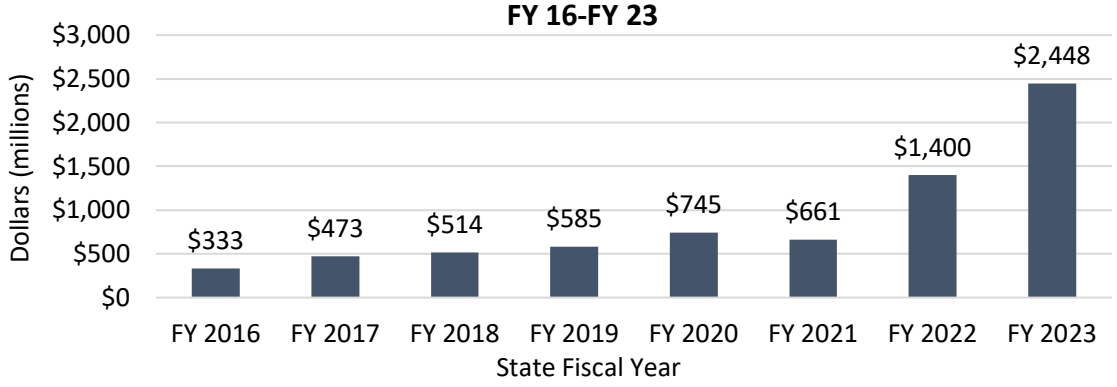


The accelerated pace of the disruption of the hospital industry brought about by the COVID-19 pandemic is changing the landscape of the hospital sector in New York. It used to be the case that you could divide New York hospitals into three categories: wealthy health systems with an academic medical center at their core; the "struggling middle class" of community hospitals; and financially distressed safety net hospitals. If current trends persist, New York's hospital system will mostly be divided between a small number of Haves and a much larger number of Have Nots.

The Growth and Changing Nature of State Operating Subsidies

One measure of the growing financial distress of hospitals in New York is the dramatic increase in State operating subsidies over time. Between FY 16 and FY 20, gross State operating subsidies grew from $333 million split among 26 hospitals to $745 million split among 22 hospitals. By FY 23, gross State operating subsidies had grown to approximately $2.5 billion going to more than 50 hospitals. It is expected that the total amount of State operating subsidies for financially distressed hospitals and the number of hospitals receiving subsidies will increase (at least somewhat) in the State fiscal year ending March 31, 2024.

Figure 2: State Operating Subsidies (Gross)
FY 16-FY 23



The State only began to provide significant operating subsidies to hospitals in 2014, when it became clear that several safety net hospitals in New York City would close unless they were supported by operating subsidies from the State. Beginning in FY 16, the State relied on a program called the Value-Based Payments-Quality Improvement Program (VBP-QIP) to provide operating subsidies to hospitals that had 15 days cash on hand or less, in which case they could not continue operations without these subsidies. The operating subsidy was distributed in fixed monthly installments based on administrative decisions by the DOH at the beginning of each fiscal year.

The State implemented an important strategic change in 2021 when it shifted the basis of most State operating subsidies from fixed monthly payments to a program of enhanced rates for Medicaid clinical services provided to specific patients over the course of the fiscal year. This “volume-based” subsidy program is known as the Directed Payment Template (DPT) program. CMS has clear guidelines for the DPT program. Eligibility for the DPT program is based on CMS requirements, which require a single, objective standard for eligibility (such as the percentage of inpatient discharges and outpatient visits represented by Medicaid). In addition, except for modest differences for volume-weighted adjustments, all participants in the DPT program receive the same supplemental DPT payment for each category of service (i.e., acute care, inpatient psychiatry, emergency, ambulatory surgery, and outpatient clinic).

As described below, the State has two different DPT programs: the Safety Net DPT program and the Critical Access Hospital/Sole Community Hospital (CAH/SCH) program.

Different Categories of Financially Distressed Hospitals

The State has found it useful to categorize different types of financially distressed hospitals that receive State operating subsidies. Although there is a great deal of commonality in terms of the challenges all

these hospitals face, the specific situational diagnosis and the policy prescription for sole community and rural hospitals, for example, may be somewhat different from the prescription for financially distressed hospitals in urban areas.

Categories of Financially Distressed Hospitals:

- Safety Net Direct Payment Template (DPT) Hospitals: this category includes 18 voluntary[1] safety net hospitals, nine of which are located in New York City. The threshold for eligibility is a minimum of 36% of both inpatient discharges and outpatient visits being attributable to Medicaid patients.
- SUNY Hospitals: of the three SUNY hospitals in New York, Stony Brook Medical Center, Upstate Medical Center, and Downstate Medical Center, SUNY Downstate was the only SUNY hospital that was a recipient of State operating subsidies in FY 23.
- Public Benefit Corporation Hospitals: the three public benefit corporations that were formerly County hospitals – Erie County Medical Center (ECMC), Nassau University Medical Center (NUMC), and Westchester Medical Center (WMC) – received State operating subsidies in FY 23, although WMC transferred the subsidy it received to one of its subsidiaries, Health Alliance.
- CAH/SCH DPT program: this includes all 18 Critical Access Hospitals (CAH) and 20 Sole Community Hospitals (SCH) in New York. The enhanced DPT rate for CAH/SCH hospitals is significantly lower than for hospitals in the Safety Net DPT program. While enhanced rates in the Safety Net DPT program increase Medicaid reimbursement rates for acute care services by slightly more than 100%, the rate enhancement under the CAH/SCH DPT program is approximately 10-15% of the base Medicaid reimbursement rate.
- Other Upstate Financially Distressed Hospitals: 18 voluntary Upstate FDHs received State-only operating subsidies in FY 23. Five of these hospitals also received subsidies under the CAH/SCH DPT program.

Figure 3 below shows the amount of State operating subsidies to these categories of hospitals in FY 23.

Figure 3: FY 23 State Operating Subsidies (Gross) by FDH Category (in millions)

Financially Distressed Hospital Category	Number of Hospitals	Total Gross Subsidy for FY23	Total Revenue before Subsidies	Gross Subsidy as % of Total Revenue before Subsidies
Safety Net DPT Program	18	$1,911	$10,488	18.2%
SUNY Hospitals	1	$63	$430	14.5%
PBC Hospitals	3	$98	$2,905	3.4%
Upstate FDH	18	$248	$3,213	7.7%
CAH and SCH DPT Program*	33	$129	$3,376	3.8%
Total	**73**	**$2,448**	**$20,412**	**12%**

***Note:** The five CAH/SCH hospitals that also received subsidies outside of the DPT program are only included in the Upstate FDH Hospitals row to avoid double-counting.

[1] Not-for-profit hospitals that are not public hospitals are referred to as "voluntary" hospitals.

Severely Financially Distressed Hospitals

Of the approximately $2.5 billion in gross State operating subsidies provided in FY 23, more than 85% went to 14 severely financially distressed hospitals. Three of these hospitals are public hospitals, and the rest are voluntary hospitals that participate in the Safety Net DPT program. Eleven of these 14 hospitals are located in New York City, and all of them are located in communities where health disparities are most pronounced. For the purposes of this paper, we are defining these 14 hospitals as the "Severely Financially Distressed Hospitals," because they account for the vast majority of State operating subsidies. It should be noted that there are other, smaller hospitals upstate whose viability is more at risk without State operating subsidies, and the amount of State operating subsidy for a few of the Severely Financially Distressed Hospitals (most notably Montefiore), while large absolute terms is a relatively small percentage of total revenue. These hospitals are named in Figure 4 below.

Figure 4: New York's Severely Financially Distressed Hospitals

Type	S-FDH Hospitals	Borough or County
Voluntary Hospitals	One Brooklyn Health (Brookdale and Interfaith)	Brooklyn
	Montefiore	Bronx
	Medisys (Jamaica and Flushing)	Queens
	Maimonides Medical Center	Brooklyn
	St. John's Episcopal	Queens
	Wyckoff Heights Medical Center	Brooklyn
	St. Barnabas Health	Bronx
	Brooklyn Hospital Center	Brooklyn
	St. John's Riverside	Westchester
Public Hospitals	Nassau University Medical Center (NUMC)	Nassau
	SUNY Downstate	Brooklyn
	Erie County Medical Center (ECMC)	Erie

Medicaid is the payer for at least 36% of inpatient discharges and outpatient visits at all the voluntary Severely Financially Distressed Hospitals, making those hospitals eligible for the Safety Net DPT program. The three public hospitals in this group also have very high Medicaid and Medicare ("government pay") patient shares.

While a high government pay patient mix is a common denominator among these hospitals, the Severely Financially Distressed Hospitals differ in other important ways. They range from small standalone hospitals such as St. John's Episcopal in the Rockaways and St. John's Riverside Hospital in Yonkers – that resemble community hospitals in terms of their service offerings— to Montefiore Medical Center in the Bronx, which is both a safety net hospital and an academic medical center with services as comprehensive any health system in the state. Financially, State operating subsidies represent a high percentage of total revenue among the smaller Severely Financially Distressed Hospitals, but a much lower percentage of total revenue among the Severely Financially Distressed Hospitals with a large revenue base.

Nevertheless, the deficit trends of all the Severely Financially Distressed Hospitals reflect a dramatic deterioration in financial performance since 2019, the year before the pandemic began. Three large hospitals, Montefiore Medical Center in the Bronx, Maimonides Medical Center in Brooklyn, and the

ECMC in Buffalo, swung from an operating gain in 2019 to an operating loss in 2022 – requiring State operating subsidies for the first time. In the case of nearly all the Severely Financially Distressed Hospitals that already had a loss in 2019, the operating loss generally roughly doubled between 2019 and 2022. Although information for 2023 year-to-date performance is not publicly available, our understanding is that the operating losses at most of the Severely Financially Distressed Hospitals have generally grown in 2023.

What Constitutes a "State Operating Subsidy?"

It is important to define what constitutes a "State operating subsidy" because many policy decisions affecting reimbursement and supplemental pools have the effect of creating winners and losers among institutions. The State generally defines "operating subsidies" as being limited to "supplemental payments" to a hospital under three programs: enhanced Medicaid rates under the Directed Payment Template (DPT) program, Federally-matched Vital Access Program (VAP) payments, and State-only[2] Vital Access Provider Assurance Program (VAPAP) payments.

An example of policy decisions that affect particular institutions but are generally not considered State operating subsidies is the different treatment between public hospitals and voluntary hospitals when it comes to the allocation of Disproportionate Share Hospital (DSH) payments from the Indigent Care Pool (ICP) and Intergovernmental Transfer (IGT) programs. Public hospitals generally receive 100% of their "facility-specific DSH caps," while voluntary hospitals typically receive about 30% of their facility-specific DSH caps. To make an apples-to-apples comparison of the economics of private, not-for-profit voluntary hospitals and public hospitals, you would need to account for the higher level of DSH payments that public hospitals receive.

Another important concept in understanding State operating subsidies is the difference between the "gross" amount the hospital receives (which includes the Federal share of the subsidy, if any) and the "State share" amount. The State share includes only the amount of the State contribution in the case of payments with a Federal match. Nevertheless, the convention is to refer to State operating subsidies as including both the State share and the Federal share when a match is available. If a Federal match is unavailable, then the gross amount is equal to the State share amount.

Technical provisions of Federal law limit the circumstances under which a Federal share is available. State-only funding, when used, greatly increases the State's burden of operating subsidies because the Federal share typically represents between 50% and 60% of the overall payment. One of the State's objectives with respect to financially distressed hospitals is to obtain a Federal match for as much of the subsidy payment as possible.

Part II: Diagnosis

Disruptive Innovation and Hospital Business Models

Technological innovation that enables new business models to offer a product of equivalent or better quality than the incumbent at significantly lower prices is known as "disruptive innovation." The father of the business theory of disruptive innovation, the late Harvard Business School Professor Clayton Christensen, considered hospitals to be ripe for disruption, although he saw the pace of the process of

[2] "State-only" means there is no Federal match for the payment, in contrast to the DPT and VAP programs.

disruption as being impeded by regulatory friction. He said: "The bottom line is that in the absence of philanthropy and constraints on trade, almost all hospitals would collapse."

Christensen said that the core problem hospitals faced was being in the business of solving any problem with which a patient might present, which resulted in unsustainable overhead to support the many processes such a capability requires. He drew an analogy with the disruption of another industry with high fixed costs, the manufacturing of axles. In that case, disruption was brought about by a firm that offered fewer options but was able to reduce fixed overhead cost by two-thirds through specialization. In most industries, the disruptive insurgents significantly reduce operating costs through specialization that reduces the number of potential processes the firms are performing. This enables them to offer a narrower range of products of at least equivalent quality but at a much lower cost than their incumbent competitors. Christensen envisioned a hospital market in which a few hospitals could thrive as general "solutions providers" capable of solving almost any problem on a fee-for-service basis, while the bulk of the market would transition to becoming more specialized "process" providers.

Christensen's lecture on *Disruptive Innovations and Hospital Business Models*, delivered in 2012, foresaw the evolution of hospitals and the rise of outpatient specialty practices that have occurred over the last decade. Notwithstanding a restrictive regulatory environment and a culture of medicine that was built on "solving any problem a patient presents," the inexorable progress of technology and the overwhelming economic advantages of delivering services in specialized settings outside of the hospital, have brought about the disruption that Christiansen prophesied.

One of the themes of Christensen's influential book, *The Innovator's Dilemma: When New Technologies Cause Great Firms to Fail*, published in 1997, was how difficult it is for incumbent firms to avoid being disrupted by smaller, more nimble competitors. Many legacy firms are unable to adapt to a changed environment, and they shrink considerably or simply disappear, not as a result of poor management but simply because of economic dynamics. Larger health systems that have the resources to recruit staff and make investments have responded to the challenge of disruption to hospitals from for-profit ambulatory surgery centers and multispecialty providers by developing their own ambulatory care networks. It is much more difficult for standalone hospitals or small health systems to be able to adapt in this manner.

As this trend of economic disruption continues, an increasing percentage of inpatient utilization will be accounted for by patients requiring services (such as emergency services, behavioral health – especially inpatient psychiatry, and labor and delivery) that have relatively low reimbursement rates both because of the nature of the service and the payer mix of patients requiring the services. These low reimbursement rate services are not profitable enough, or face too many regulatory restrictions to be displaced by for-profit outpatient businesses.

The difficulty of legacy firms in other industries to survive disruptive innovation is a cautionary tale. As the State develops policy prescriptions designed to achieve a new equilibrium for hospitals within the broader healthcare delivery system, it needs to distinguish between those interventions that have a reasonable chance of success from those interventions that are doomed to failure because they are swimming against the tide of inexorable economic forces.

Technological Advances Have Led to Declining Hospital Admissions

It is probably fair to say that disruptive innovation is the most significant factor contributing to the long-term decline in hospital admissions.[3] New technologies – including telehealth, robotic surgery, and improved imaging, among many others – have made it possible for procedures that previously could only be performed on an inpatient basis to be delivered in outpatient settings such as ambulatory surgery centers or other specialized office-based practices, which in turn led to new disruptive business models. This has already led to ambulatory surgery centers in such specialties as orthopedics and cardiac procedures to rapidly gain market share from hospitals.

More recent innovations in technology enabling new models of care will further erode the demand for hospital-based services. For example, the growing Hospital at Home model relies on remote patient monitoring and periodic home visits that can both prevent certain inpatient admissions – freeing up inpatient capacity— and also shorten the length of stay following procedures performed in hospitals. Hospitals across the country are implementing the Hospital at Home model, which has been supported by CMS regulatory flexibility (i.e., "Acute Hospital Care at Home" (AHCaH)). Although these new delivery models promise to benefit patients and reduce the total cost of care, hospitals, with their large, fixed-cost base, have difficulty replacing the inpatient volume "lost" to such alternative service delivery models.

New business models supported by technological innovation have the advantage of combining access to lower-cost capital and the entrepreneurial energy of these new for-profit competitors. These for-profit investors and entrepreneurs include the physician providers themselves, but increasingly, these independent operations have been acquired by private equity firms, vertically integrated insurers like Optum (a subsidiary of United Healthcare), and other for-profit corporations. The competitive advantage of these specialty and multispecialty practices over hospitals is sufficiently large that for-profit acquirers of physician-owned practices frequently find it possible to increase the existing price for services and still offer the service or procedure at a lower price than it would cost on an inpatient basis.

Another factor driving patient volume away from inpatient services – and indeed, in some cases, hospital-owned ambulatory services – are governmental policies and managed care plan practices that promote "efficient" healthcare delivery, which often involve denying reimbursement for inpatient procedures for procedures and hospital-based settings that could be performed in a lower cost setting. Although these policies reduce the total cost of care, they still exacerbate the financial pressure on traditional hospitals.

Both the popular press and academic literature suggest we are on the cusp of dramatic technological and medical advances that will prevent disease and significantly enhance the ability to manage chronic illnesses, both of which will further reduce the demand for inpatient hospital services. Indeed, an antidote for our increasingly pessimistic time is to learn more about the extraordinary progress being made in medicine and life sciences. You can get a sense of the scope of these impending changes by reading *Ground Truths* by Eric Topol, MD, and *The Medical Futurist* by Bertalan Meskó, PhD.

[3] It should also be acknowledged that the long-term loss of population is an important factor in many upstate and rural communities, but this phenomenon has happening for decades. The demographic shift affects the overall demand for hospital services but does not as directly affect the traditional hospital business model as most of the other factors described in this diagnosis.

Nevertheless, as positive as these developments are for humanity, they seem likely to further disrupt the business model of traditional, full-service hospitals.

Loss of Market Share to Larger Health Systems

Except in the case of acute emergencies, patients and healthcare consumers can vote with their feet. Over time, financially distressed hospitals tend to lose market share to better-resourced hospitals or specialty ambulatory care facilities. This is especially true if a specialist a patient has been seeing at a financially distressed hospital is hired by a better-resourced, competing hospital or private specialty practice with a modern ambulatory care facility. Although empirical data on this point is hard to come by, it is not unreasonable to think that as communities gentrify, more affluent new residents who have non-government insurance coverage, are more likely to seek care from better-resourced providers in the area than to go to a local financially distressed hospital.

Higher Labor Costs Driven by Workforce Shortages and Regulatory Requirements

Notwithstanding patient volume being flat to down since 2019, hospitals in New York are experiencing growth in operating expenses that is much higher than both growth in revenue and the level of general inflation. According to the Kaiser Family Foundation, hospital-adjusted expenses per inpatient day in New York grew by 17.5% between 2019 and 2021.

The single largest factor accounting for expense growth has been the increased wage costs for various clinical staff titles, especially nursing staff. During the COVID-19 pandemic, there was a massive increase in expenses associated with hiring temporary agency nurses, who were much more expensive than full-time staff. Although there has been some improvement in this area, hospitals have not been able to fully reverse the agency staffing phenomenon.

The cost of nurse staffing also increased in many hospitals because of legislation enacted in New York in 2022 that mandated hospital-based management-labor staffing committees to establish minimum nurse staffing ratios, which led to an increase in nurse staffing levels. One major hospital system in upstate New York reported a 66% increase in nursing costs in a single year, which it attributed roughly equally to higher wages for temporary agency staff and increased staffing levels because of the new staffing requirements.

Most New York hospitals have now baked into their cost structure expense increases well in excess of inflation for the next several years. In 2022, most of the voluntary hospitals in the downstate region (and some upstate hospitals) entered into collective bargaining agreements with the New York State Nurses Association (NYSNA), which provided for wage increases of 18% over three years.

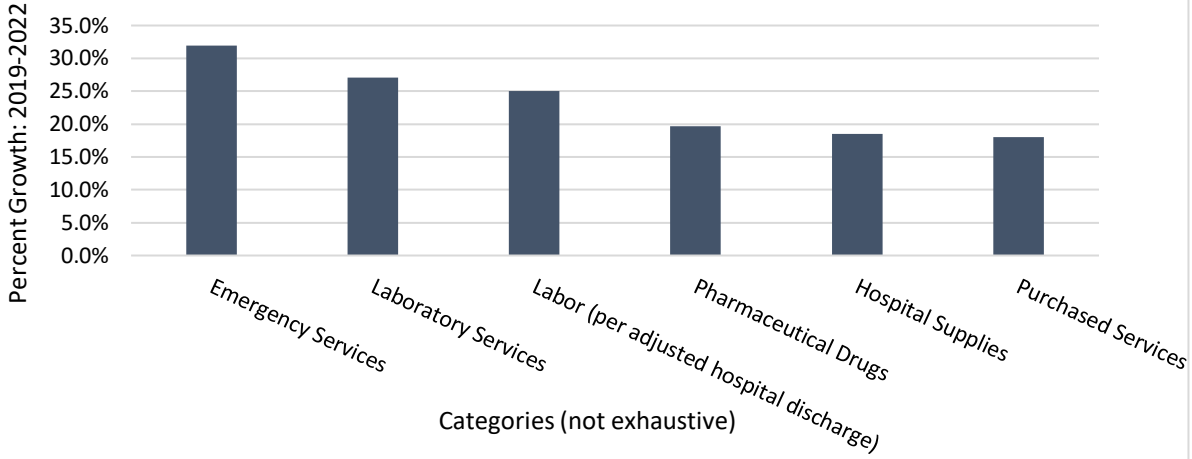
The NYSNA contract established a pattern not only for nurses represented by other unions, but for other hospital employees as well. A few months after the NYSNA contract was ratified, hospitals offered identical terms to the large number of their support staff represented by 1199SEIU. This, in turn, led to salary compression with non-unionized workers, many of whom received similar percentage increases as a result. Given that labor typically represents approximately 70% of New York hospitals' total expense, these wage increases *alone* will increase total hospital costs by approximately 12.5% annually by the final year of these contracts.

The lack of differentiation among hospitals in contract terms with organized labor puts further pressure on financially distressed hospitals. The wealthiest academic medical centers and the poorest voluntary safety net hospitals adopt contract terms negotiated by the League of Voluntary Hospitals, a group dominated by larger downstate health systems that are better able to support cost increases.

The challenge of rising wage rates and the inability of financially distressed hospitals to negotiate better terms are not problems that are easily solved. These wage increases were the result of the very competitive labor market (especially for nurses and other clinical titles) following the pandemic. It may also be the case that increased staffing levels improve patient satisfaction and patient outcomes. The long-standing practice of undifferentiated labor contracts among all voluntary hospitals, combined with the unusually tight labor market, certainly hampers the ability of financially distressed hospitals to hold out for better contract terms. Nevertheless, these labor cost increases are unlikely to be matched by increased revenue and will exacerbate the financial distress of many hospitals in New York.

Although labor costs are the most significant source of expense growth increases, other hospital expense categories have also grown rapidly in recent years. From 2019 to 2022, New York hospitals reported drug costs were up 42%, supply and equipment costs were up 20%, and energy costs were up 21%. These increases were generally consistent with national trends.[4]

Figure 5: National Rates of Hospital Expense Increase, per Patient, by Category: 2019 to 2022



Source: https://www.aha.org/costsofcaring

Long-standing Structural Inefficiencies of Financially Distressed Hospitals

The trends described above affect almost all hospitals. In addition to these challenges, however, financially distressed hospitals also face a multitude of structural inefficiencies that weaken their financial performance. The State's strategy for financially distressed hospitals has rested in part on the

[4] The reported increase in prescription drug costs by New York hospitals is roughly twice the national average. It is not clear what accounts for that difference.

belief that a partnership with a larger health system could mitigate the disadvantages financially distressed hospitals face due to their lack of economies of scale and struggling operating infrastructure.

Lack of Economies of Scale

The limitations stemming from a lack of economies of scale ripple through all aspects of a financially distressed hospital's operations. These include:

- Higher Direct Clinical Unit Costs: Without economies of scale, financially distressed hospitals often have higher unit costs for delivering services. In part, this stems from the condition of financially distressed hospitals to be able to perform a comprehensive range of "tertiary" (i.e., medium acuity) diagnoses and procedures. Their relatively low volume for many of these procedures leads to inefficient staffing patterns, including the use of "locum tenens" or temporary physician staff, including specialists.
- Higher Overhead Costs: Financially distressed hospitals have higher fixed overhead expenses as a percentage of revenue and total expense than larger health systems. A part of this fixed expense is the "standby" cost of maintaining operational capacity to provide services, which is not fully utilized. Another part is maintaining a full administrative staff (e.g., CEO, CFO, COO), the cost of which must be spread over a smaller revenue base.
- Financial Constraints: Although small hospitals can take advantage of the buying power of large group purchasing organizations, their precarious financial position often leads them to extend accounts payable beyond normal payment terms, leading to unfavorable terms with many vendors. Moreover, the lack of financial resources constrains infrastructure improvements that could increase revenue or reduce costs.
- Inadequate IT infrastructure: Many financially distressed hospitals lack the capital to acquire IT infrastructure – electronic health records and other clinical technology as well as back-office productivity software – that could more efficiently deliver services or perform tasks. They also lack the resources to hire IT network specialists, cybersecurity specialists, and data scientists.
- Inability to Support Risk Arrangements: The absence of a strong IT infrastructure, as well as the limits of management capacity, make it difficult for most small systems (Medisys is an exception to this rule) to effectively engage in population health management in a way that would enable them to benefit from risk-bearing arrangements with payers.
- Lack of Market Power: As discussed in more detail below, a lack of market power results in unfavorable reimbursement rates and payment terms from managed care plans in both Medicaid and commercial markets.
- Insufficient Marketing and Customer Service Make It Difficult to Expand the Patient Base: Small systems and standalone hospitals generally lack resources for marketing and a robust customer service infrastructure that would enable them to expand their patient base to include healthcare consumers (especially those with commercial insurance) who have more options about where to receive services.

Aging Physical Plant and Inefficient Infrastructure

Financially distressed hospitals typically operate with an aging physical plant and inefficient infrastructure. Routine capital maintenance becomes a luxury when hospitals are struggling to meet operating expenses. The deferred maintenance costs alone of many distressed hospitals are enormous.

An aging physical plant and obsolete mechanical systems are inefficient to operate and contribute to patients who have a choice seeking their care elsewhere.

Lack of Market Power with Payers

Managed care plans, including Medicaid managed care organizations, Medicare Advantage plans, commercial insurance plans, and third-party administrators (on behalf of self-insured entities), have largely displaced fee-for-service as the payment vehicle for hospitals and other providers. The market for both government and commercial plans in New York is increasingly dominated by four large national, for-profit health insurance companies. The profitability and market capitalization of these companies have soared in recent years, while the profitability of hospitals has plummeted.

Financially Distressed Hospitals' lack of market power with managed care plans harms them in two ways. First, in the case of commercial insurance, with the exception of the few larger health systems that have their own power in the marketplace, hospitals generally have been unable to offset volume declines and increasing operating expenses with higher reimbursement rates. Moreover, as discussed further below, Medicaid and Medicare rates have increased much less than the rate of hospitals' growth in expenses.

The second challenge financially distressed hospitals face due to the lack of market power is the inability to negotiate terms that limit certain business practices of managed care plans. Managed care plans pursue strategies that are designed to reduce costs for the plan and the ultimate payer, whether a governmental payer or commercial policyholders. Nevertheless, these business practices often reduce hospital revenue in a zero-sum game dynamic. Among the policies and practices that create this tension between the interests of the plan (and policyholders) and hospitals are the following:

- Increasingly aggressive use of medical necessity denials to limit payment for inpatient hospital admissions.
- Limitations on ED reimbursement based on tighter medical necessity standards;
- Changes in site of service eligibility to push services for routine, non-urgent outpatient screenings and surgical procedures, such as colonoscopies and other endoscopies, from hospital-owned outpatient facilities to less expensive freestanding ambulatory surgery centers and office-based care sites; and
- Plans pursuing vertical integration by acquiring specialty physician practices, which puts the plan in direct competition with hospitals.

These business practices are not the primary cause of the decline in hospitals' profitability, but they increase the financial pressure on small systems and standalone hospitals that lack the market power to push back on these practices in network contract negotiations.

Limited Management and Governance Capacity

In my experience, the leadership teams of financially distressed hospitals work tirelessly in service of their mission of providing quality care to patients and competing with better-resourced providers. That said, because small systems and standalone hospitals need to spread the cost of their administrative staff over a smaller revenue base, they tend to be thinly staffed in many management functions. This lack of management capacity, combined with a weak IT and decision-support infrastructure, results in an inability to address operating inefficiencies and missed opportunities to capture increased revenue.

The governance challenge of standalone hospitals and small systems is more structural. As I learned when I served as a member of the Board of Trustees of Interfaith Medical Center in 2014-15, the trustees of these hospitals are always conscious that their fiduciary duty is to the institution on whose board they serve, not to broader State budgetary concerns or even the overall health of the larger community. This attitude, born of the best of intentions, makes it difficult for boards of financially distressed hospitals to envision restructuring their institution in a way that might reduce services that currently are being offered – even when a patient's needs could be equally or better served in a different part of the healthcare delivery system.

The Impact of Negative Operating Leverage

Many of the Severely Financially Distressed Hospitals face a phenomenon in which their operating expenses are much more than their operating revenue, a gap which has been filled by State operating subsidies. Moreover, most operating expenses are subject to significant inflationary increases every year. As a result, unless revenue is growing at a much greater rate than expense growth, the hospital's operating loss will increase every year.

This effect is compounded when expenses grow at a rate that is even slightly higher than revenue growth, which tends to be the case with financially distressed hospitals. The figure below illustrates how the compounded effect of negative operating leverage dramatically increases the operating deficit over five years for a hypothetical financially distressed hospital, even when revenue is growing at almost the same rate as expense growth.

Figure 6: Illustration of the Effects of Negative Operating Leverage

Impact on loss for a hypothetical hospital with revenue of $500 million growing at 4% per annum and expenses of $800 million growing at 7% per annum.

	Y0	Y1	Y2	Y3	Y4	Y5
Revenue	$500	$520	$541	$562	$585	$608
Expenses	$800	$856	$916	$980	$1,049	$1,122
Loss	($300)	($336)	($375)	($418)	($464)	($514)
Increase in Loss	N/A	($36)	($39)	($42)	($46)	($50)
Total $ Increase in Loss over Five Years	**$214M**					
Total % Increase in Loss over Five Years	**71%**					

The Question of Rate Adequacy

Many hospital stakeholders, including the leadership of most financially distressed hospitals in New York, believe that inadequacy of reimbursement rates is a more significant cause of hospitals' financial distress than all of the other factors described above. A thorough diagnosis of the causes of financial distress among New York hospitals must include a deeper analysis of both the level of reimbursement rates and the existing reimbursement rate methodology in New York. An examination of the issue of "rate adequacy" should begin with an understanding of the evolution of commercial, Medicare, and Medicaid reimbursement rates, as well as the relationship between inpatient rates for acute medical-surgical care and rates for outpatient services.

Most hospitals and health systems operate hospital-owned (technically called hospital-based) clinics and other ambulatory facilities. Historically, reimbursement rates for hospital-based outpatient services have recovered a smaller share of total cost than rates for inpatient services, on the theory that outpatient services provide a referral feeder system of higher-margin inpatient services that offset losses on outpatient services. In 2007, as part of an early reform effort to incentivize community-based care, the Spitzer administration shifted a meaningful portion of funding from inpatient rates to increase outpatient rates.

Prior to this change in 2007, reimbursement rates for Medicaid, Medicare, and commercial plans were closely clustered. The story of the last 16 years, however, is the substantial increase in commercial rates while Medicaid rates have been mostly stagnant. Until the Affordable Care Act (ACA), Medicare rates were above Medicaid rates and closer to commercial rates. Since the ACA, however, Medicare rate increases have not kept pace and are now closer to Medicaid rates than to most commercial rates.

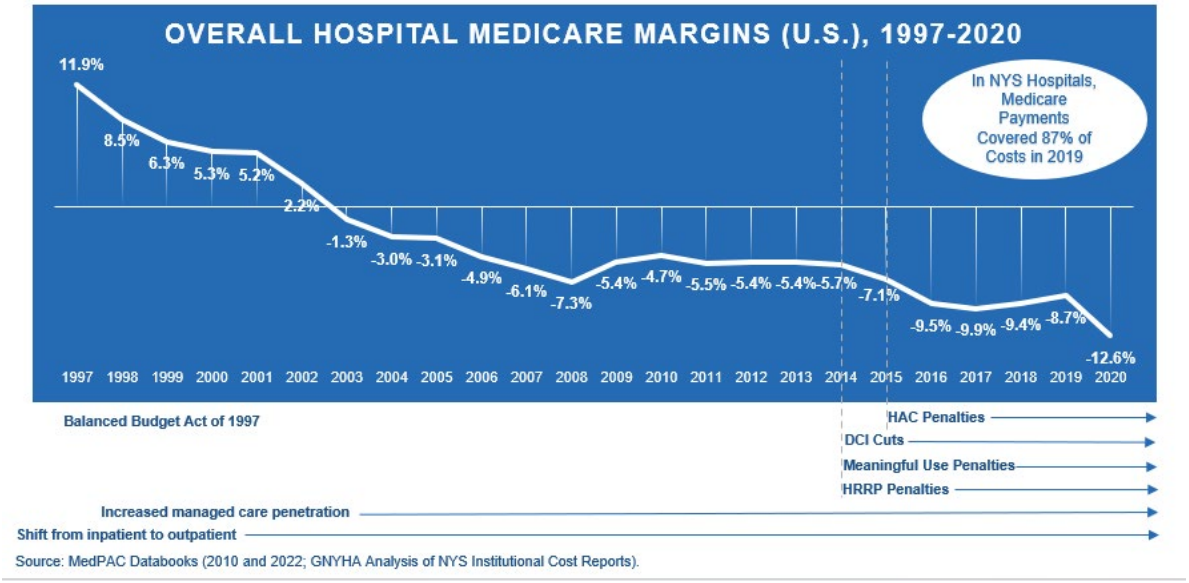
As commercial rates became so much higher than Medicaid and Medicare rates, cross-subsidization of government rates by commercial business became an indispensable feature of the business model of larger health systems and academic medical centers. This cross-subsidization strategy is not available to financially distressed hospitals for two basic reasons: first, few financially distressed hospitals have the market power to be able to command premium commercial rates; and second, most financially distressed hospitals have so little commercial volume that higher rates would not make much of a difference.

Historically, healthcare advocacy in New York has been focused on increasing Medicaid rates. According to the Greater New York Hospital Association (GNYHA), *base* Medicaid rates, on average, cover only about 70% of a hospital's total cost. Even without being able to validate the specific percentage, we can stipulate that *base* Medicaid rates certainly do not cover fully allocated costs of hospitals and, in some cases, may not even cover all of the marginal cost of providing the service.

Nevertheless, Medicaid rate adequacy is not the sole or even primary cause of the State's challenge with financially distressed hospitals for two main reasons. First, in the case of hospitals in the Safety Net DPT program, which account for 78% of total State operating subsidies, the DPT-enhanced Medicaid rates are already comfortably above Medicare rates. Moreover, although CMS regulations have required that DPT-enhanced rates must be below the *average* commercial rates for all hospitals participating in the Safety Net DPT program, for all but a few of the hospitals in the Safety Net DPT program, the DPT-enhanced Medicaid rate is the *highest* reimbursement rate they receive from any payer.

Second, Medicaid represents a materially smaller portion of payer mix for financially distressed hospitals in the upstate region than is the case in the downstate region. For financially distressed hospitals upstate, the relative decline of Medicare rates as a percentage of Medicaid and commercial rates has been a bigger problem than stagnant Medicaid rates.

The decline over time in hospital margins resulting from providing Medicare services is reflected in the chart below from the Greater New York Hospital Association:



Two broad factors account for this relative decline in Medicare reimbursement rates. First, statutory and regulatory changes have reduced the overall size of Medicare reimbursement payments. Second, there has been a significant redistribution in the Medicare rate formula away from New York and in favor of other, typically more rural, states. The expansion of managed Medicare Advantage plans, which have a particularly high and growing rate of penetration in New York, has also depressed the amount hospitals realize from Medicare programs because of their aggressive denial policies on the basis of medical necessity.[5]

A recent comprehensive study of the literature from the Kaiser Family Foundation found that commercial reimbursement rates nationally were, on average, 189% of Medicare rates for inpatient hospital services and 264% of Medicare rates for outpatient hospital services, with significant variation among hospitals and plans. Medicare rates in New York are also far below average commercial rates and are closer to Medicaid rates. Based on 2022 New York data, average commercial reimbursement rates were approximately 210% of Medicare FFS rates for inpatient acute care services and approximately 250% higher for outpatient services. By contrast, Medicaid acute care reimbursement rates on a CMI-adjusted basis are generally in the neighborhood of 75% of CMI-adjusted Medicare rates.

After long advocacy by Senator Schumer, the Federal government acknowledged the inadequacy of Medicare rates for upstate hospitals earlier this year when it amended the Medicare Wage Index to include approximately $967 million in increased Federal funding for hospitals across upstate New York. Although the net effect— after taking into account other changes in the funding formula— was reduced to approximately $600 million, this provided tremendous financial relief to any upstate hospitals.

[5] See, e.g., the letter from the American Hospital Association to Acting Assistant Attorney General Brian Boynton, dated May 19, 2022, citing HHS-OIG, found that 13% of prior authorization denials and 18% of payment denials actually met Medicare coverage rules and should have been granted.

However, downstate hospitals were unaffected by this change and generally continue to receive Medicare funding below the total cost of providing the service.

Commercial rates negotiated with standalone hospitals and health systems vary widely depending on the market power of the health system in network contract negotiations. We have written about the much greater level of transparency of health data and information in Massachusetts compared to New York. Massachusetts publishes Relative Price and Provider Price Variation information that makes it easier to compare the level of commercial rates across hospitals of all types. Although this data is not readily available in New York, the Rand Corporation has published a number of analyses that show the wide variation of commercial rates among hospitals in New York.

Medicaid Rate Reimbursement Methodology Disadvantages Financially Distressed Hospitals

A less-recognized factor than the overall level of reimbursement rates in explaining the relatively low revenue per discharge of financially distressed hospitals is that the Medicaid reimbursement rate methodology is weighted against the types of services provided by safety net hospitals and community hospitals, which contributes to their becoming financially distressed.

The Medicaid rate methodology is a complex formula that includes many adjustments that reflect such factors as the actual wage level at a particular hospital and the complexity of the services it delivers. For example, the Institution Specific Adjustment Factor (ISAF) is an adjustment to the Statewide Base Price (Base Price) before adjustments and add-ons, and is primarily based on the substantial wage expense differences between upstate and downstate New York hospitals. The case mix index (CMI) multiplies the Base Price (adjusted by the ISAF) by an index. If the CMI index is greater than 1.0, it *increases* the Adjusted Base Price for the "acuity" of the procedure; if the CMI index is lower than 1.0, it *decreases* the Adjusted Base Price that is paid.[6]

The Medicaid rate reimbursement methodology also includes numerous "add-ons" for other factors that reflect hospital expense. These include reimbursement based on the number of residency slots that are reimbursed by supplemental Graduate Medical Education (GME) payments and reimbursement of the Medicaid portion of capital expenditures (which favors hospitals with a history of significant capital expenditures).

Figure 7 illustrates how the major components of the Medicaid reimbursement rate methodology affect three representative hospitals – a downstate academic medical center, a downstate safety net DPT provider with an average CMI, and an upstate community hospital that does not receive State operating subsidies.

[6] The CMI is based on a statutory provision that specifies that the Service Intensity Weights (SIWs) and average length of stay (LOS) for each All-Patient Refined (APR) diagnosis-related group (DRG) patient classification category is assigned in a manner that reflects the relative cost variance of that APR/DRG classification from the average cost of all inpatients in all APR/DRGs. Such SIWs are developed using three years of Medicaid fee-for-service cost data, Medicaid managed care data, and other third-party payer data as reported to the Statewide Planning and Research Cooperative System (SPARCS). However, the Department of Health still utilizes the 2013 calendar to determine the SIWs and statewide average LOS.

Figure 7: Medicaid Reimbursement Rate Methodology at Three Representative New York Hospitals

Rate Components	Representative Downstate Academic Medical Center	Representative Downstate Safety Net DPT Hospital	Representative Upstate Community Hospital with no State Operating Subsidies
Statewide Price Adjusted for Budget Neutrality	$6,741	$6,741	$6,741
Institutional Specific Adjustment Factor (ISAF)	1.08	1.10	0.83
SP Adjusted by ISAF	$7,250	$7,406	$5,604
Case Mix Index	1.89	1.42	1.13
Revenue Before Add-Ons	$13,702	$10,517	$6,332
GME and IME Add-ons	$7,426	$3,639	$0
Capital per Discharge	$928	$287	$190
Total Base Medicaid Revenue per Acute Discharge	**$22,055**	**$14,442**	**$6,522**
Safety Net DPT Revenue Enhancement	N/A	$10,832	N/A
Total Medicaid Revenue per Acute Discharge After Safety Net DPT	**$22,055**	**$25,274**	**$6,522**

This Medicaid rate methodology generates less base revenue per acute discharge for the representative downstate Safety Net DPT hospital than for the representative downstate academic medical center for the following reasons: the financially distressed hospital has lower overall wages, reducing the ISAF adjustment; primarily provides services in categories with a low CMI; has fewer GME residency slots; and has spent less on capital expenditures, which reduces the capital and so on. These same factors also affect the representative upstate community hospital.

The services with a lower CMI include emergency department (ED) services, labor and delivery, inpatient behavioral health services, and low-acuity medical-surgical services that have a CMI of less than 1.0 – in other words, the main services provided by financially distressed hospitals. Lower CMI services cover a smaller proportion of fixed overhead expenses than high CMI services. Moreover, emergency visits and inpatient psychiatry stays are reimbursed at a level that covers a smaller percentage of a hospital's actual cost than is the case for medical-surgical services. Medicaid rates are periodically rebased within categories of service for changes in cost on a revenue-neutral basis (meaning rates are redistributed among different DRGs rather than increased). A rebasing that crosses categories (e.g., inpatient psychiatry and medical-surgical services) would reduce some of these rate inequities, but there is little political appetite to create more winners and losers than is the case when each category is rebased separately.

Importantly, the Medicaid reimbursement rate methodology does not reflect the standby costs and social value of maintaining services that currently generate low Medicaid reimbursement compared to

more complex procedures. The entire community, not just patients currently receiving services, has an interest in having a place to treat emergencies or individuals with serious behavioral health needs.

Moreover, the Medicaid rate methodology does not reflect the health-related social needs of many of the patients served by financially distressed hospitals. The risk adjustment methodology used in determining capitated payments to managed care plans takes into account these high-cost, high-need patients, but unless the hospital has a sub-capitated risk-based arrangement with a managed care plan, the hospital cannot benefit from an overall plan of care designed to keep these patients out of the hospital.

The Medicare rate methodology is based on a similar methodology to Medicaid, especially as it relates to higher reimbursement rates for higher acuity services. Because commercial reimbursement rates are typically based on a percentage of Medicare or Medicaid rates for the comparable diagnosis-related group (DRG), the value judgments implicit in the Medicaid rate reimbursement methodology flow through to the commercial market.

The Medicaid reimbursement rate methodology was not intentionally gerrymandered to harm safety net hospitals or smaller upstate community hospitals. Rather, the methodology is designed to reflect – as well as possible – the underlying costs of the services being provided. Nevertheless, the rate methodology over time has a self-reinforcing effect. Thoracic surgery costs more than a cesarean delivery in part because thoracic surgeons make more money than obstetricians – which, to some extent, is a function of the fact that reimbursement rates are higher for thoracic surgery than for cesarean deliveries.

Some of the anomalies in the Medicaid reimbursement methodology are a function of the fee-for-service system. New York's Delivery System Reform Incentive Payment (DSRIP) initiative, launched in 2013 in connection with a Federal Medicaid Waiver, was intended to reduce preventable hospital readmissions by incentivizing primary care providers with risk-sharing arrangements and compensating hospitals' lost revenue with DSRIP payments. The expectation was that when these payments ended with the expiration of the DSRIP program, managed care plans would pick up the payments because the overall system would have reduced the total cost of care. That generally has not been the case, however. A few financially distressed hospitals, notably Montefiore Medical Center in the Bronx and the Medisys system in Queens, have successfully developed sub-capitated risk-based arrangements covering a large percentage of their patient base. A few Medicaid managed care organizations, most notably the not-for-profit plan Health First, manage risk-based capitated payment programs that incentivize hospitals to engage in population health risk management.

One of the tangible opportunities available to financially distressed hospitals is to develop the population health management infrastructure necessary to profitably enter risk-based arrangements with more Medicaid managed care plans. However, such an infrastructure is expensive, and managing risk is especially difficult for standalone hospitals or small health systems, because they lose money when their "attributed" patients receive care at unaffiliated hospitals. This is one way in which a partnership with a larger health system with a strong population health management infrastructure could improve the economics of financially distressed hospitals.

The Federal Centers for Medicare and Medicaid Services (CMS) is encouraging states to pursue an analogous population health strategy through what is known as "global budgeting." Global budgeting for

hospitals is a financial management strategy where a fixed amount of funding is allocated for the total operating expenses of a hospital or healthcare system, typically for a year at a time. Because funding is a fixed amount, hospitals do not have an incentive to provide care in the hospital when it could be more efficiently provided in the community. Global budgeting is often tied to an "all-payer" approach that aligns these incentives across all payers under Medicaid, Medicare, and commercial plans.

On September 5, 2023, the Centers for Medicare & Medicaid Services (CMS) announced a new voluntary, state total cost of care model known as the States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD Model) that incorporates the concept of all-payer global budgeting. Hospitals that receive a global budget are paid a prospective, predetermined amount based on the baseline growth trend of their historical Medicare and Medicaid spending. By decoupling revenue received from units of service provided, global budgets may enable hospitals to pursue measures that improve quality and reduce the total cost of care more aggressively, because the hospital will not be at risk for lost inpatient revenue.

New York is expected to seek to participate in the AHEAD Model as part of a broader strategy to reform the healthcare delivery system and improve the sustainability of financially distressed hospitals.

Inability to Fully Implement the State's Financially Distressed Hospital Strategy

In late 2018, the Deputy Commissioner of the Office of Primary Care and Health Systems Management, who was in charge of overseeing financially distressed hospitals at the Department of Health, wrote a comprehensive memo that set forth the State's strategy for financially distressed hospitals, as well as reviewing the state of play of the most financially distressed institutions in the State. This strategy can be summarized as follows:

- Stabilize the financially distressed hospital with temporary State operating assistance;
- Identify a large health system partner for the financially distressed hospital;
- Develop a multi-year transformation plan with a goal of identifying "the most financially sustainable model of care that can meet essential healthcare needs of a community;"
- Get community and labor buy-in to changes in healthcare delivery in their community;
- Deploy state capital grant funds; and
- Execute the plan over 2–5 years or longer.

It is humbling to read the 2018 memo today because so little has changed for the better. There are many reasons why this is the case. First, it is fair to say that a major contributor to the lack of success of the financially distressed hospital strategy is that the pandemic dramatically increased the operating losses of hospitals that already required operating subsidies in 2018, as well as significantly expanding the number of hospitals that could not remain open without substantial State operating subsidies.

That said, the strategy also failed to achieve its intended results because it relied on a number of expectations that simply could not be realized. Perhaps the most important of these failed expectations was that the State could convince large health systems to partner with financially distressed hospitals in a fashion that went beyond traditional consulting services to include some measure of financial and management participation. Partnerships between larger health systems and financially distressed hospitals continue to hold the best prospect for accomplishing the interrelated goals of improving

access, quality, equity, and financial sustainability at financially distressed hospitals. Therefore, it is important to understand the reluctance of large health systems to meaningfully partner with a financially distressed hospital, based on my observations over the years.

The threshold issue is financial. Large health systems recognize that, in most cases, the amount of capital funding necessary to effectively restructure the financially distressed hospital is substantially greater than the State has historically made available (with a few exceptions, such as One Brooklyn Health). Moreover, large health system partners fear that the State, despite its best intentions today, could prove unable to maintain a high level of operating subsidies for the multiyear period necessary to turn around the financial performance of even a well-restructured financially distressed hospital.

Offering assurances to potential large health system partners regarding capital support and operating subsidies is a necessary, but probably not sufficient, condition to attract participation by large health systems. From my observation, the most difficult hurdles to overcome in achieving these partnerships are the concerns large health systems have about becoming embroiled in disputes with the community and labor organizations about service changes at the financially distressed hospital, as well as growing financial pressures in their core business that make larger health systems less willing to take on this type of project, which they see as more a matter of public benefit than in their strategic self-interest. It is worth noting that, at present, only two large health systems in New York City are profitable, and their operating margins lag behind their strongest national competitors.

The State may yet manage to cut the Gordian knot and secure one or more of these partnerships. However, some of the recommendations below offer alternatives that would enable the State to find a vehicle for achieving some of the benefits of these proposed partnerships.

Communities Want Full-Service Hospitals Even When the Economics Do Not Support Them

The diagnosis of, and prescription for, the problem of financially distressed hospitals must take into account the inconvenient truth that nearly all communities want to preserve their full-service hospital even when the economics do not support it. This dynamic can be witnessed in real-time across the State, from Mount Sinai Beth Israel near the East Village to Brooks Memorial Hospital in Dunkirk, New York near the Pennsylvania border. Another important reason that the strategy of restructuring or “transforming” financially distressed hospitals has not found more success is that, with some exceptions, the State has been unable to gain community support and labor buy-in for an alternative vision for delivering essential services to the community.

The most notable exception was One Brooklyn Health (OBH), which worked with the Crown Heights and Central Brooklyn communities to win support for a combination of affordable and supportive housing and significantly expanded ambulatory care facilities as a replacement for the full-service Kingsbrook Jewish Medical Center (Kingsbrook), which was one of three OBH inpatient hospitals. While OBH continues to struggle financially, Kingsbrook is the only large hospital in New York State that has been able to close in nearly a decade.

OBH was able to gain this support because OBH had received a large enough capital grant to convince the community that essential services would still be available from a growing ambulatory care network after Kingsbrook closed. OBH was able to gain buy-in from labor by working hand in glove with 1199SEIU

to ensure that displaced employees (approximately 650 employees were affected) would find alternative employment at OBH or, as a last resort, other 1199SEIU hospitals.

By contrast, other financially distressed hospitals downstate, such as Mount Vernon Hospital in Westchester and St. John's Episcopal in the Rockaways, ran into intense community opposition for even exploring a fundamental restructuring plan, in significant part because no plan for alternative services was presented. This lack of an alternative vision, along with the lack of dedicated funding, meant that there was no alternative vision that could be socialized in depth with community and labor stakeholders.

Part III: Prescription

The Emergence of a New Hospital Prototype

The State may have little choice but to continue to provide substantial – and perhaps growing – operating subsidies as long as financially distressed hospitals continue to operate in their current form. Arguably, the State has created a moral hazard over the last decade by ensuring that virtually no hospitals have been forced to close because of their lack of financial sustainability. It will be difficult to persuade communities that a different type of facility offers the best prospect of ensuring access to the services most needed by the community. But over the next five to ten years, at the latest, a new operating model for a meaningful number of traditional, full-service hospitals will likely need to emerge.

As noted above, both the community and the leadership of financially distressed hospitals almost invariably want to continue to provide "nearly every service a patient might need" for as long as possible. This reflects both cultural and financial reasons. Culturally, full-service hospitals reflect the environments in which physicians were trained. Trustees and leadership feel a fiduciary obligation to their institutions, not to State budgetary concerns. The attitudes of elected officials toward maintaining the status quo reflect the priorities of their communities. Financially, the reason that hospitals seek to preserve almost all services is that fixed costs are so high that, when costs are fully allocated, even highly unprofitable services tend to have a positive contribution margin when only variable costs are considered – so closing discrete services tends to increase operating deficits.

The inability to cover fixed costs is the central fiscal problem that financially distressed hospitals face. It is difficult to materially reduce fixed costs while maintaining the minimum level of clinical assets and capabilities to operate as a licensed full-service hospital in New York. New York's regulatory definition of a "hospital" [7] reflects a full-service hospital.

Full-service hospitals are designed to address most healthcare needs, providing a comprehensive, integrated approach to patient care. Key characteristics of a full-service hospital include:

- Specialized medical departments
- Emergency services
- Surgical facilities
- Imaging and laboratory services
- Inpatient and outpatient care

[7] (5) *Hospital* shall mean an institution with beds for one or more inpatients… which… has, as a minimum, laboratory and radiology services and organized departments of medicine and surgery; 10 CRR-NY 700.2.

- Pharmacy services
- Multidisciplinary teams
- Teaching and research
- Community health services

By contrast, there is an emerging prototype of an alternative model to a traditional full-service hospital. The exact nature of service mix and the characterization of this alternative model are evolving over time and include such designations as “freestanding EDs” or “micro hospitals.” The micro hospital model offers a broader range of services than have typically been provided in freestanding EDs. Beyond emergency services, the model includes some inpatient beds, lab services, imaging, pharmacy services, and sometimes ambulatory surgical and other specialized services not requiring hospital stays. While smaller than traditional hospitals, they have facilities for overnight hospitalization and can manage a broader range of medical conditions, including short-stay hospitalizations.

Micro hospitals have gained traction in recent years, although generally as satellite operations of a larger health system and sited in communities with a high commercial payer mix. The State has supported a few micro hospital restructurings in smaller upstate communities.

Perhaps the best example of this emerging prototype downstate is Northwell Health’s Lenox Hill Greenwich Village facility that replaced St. Vincent’s Hospital in 2014. Lenox Hill Greenwich Village has a small number of beds for observation and short, low-acuity stays. It has a state-of-the-art ED and provides a wide range of specialty services on an outpatient basis. Although the community resisted Lenox Hill Greenwich Village as a replacement for St. Vincent’s Hospital at the time, it has since been embraced by the community for its convenience and high-quality services.

Both the terms “freestanding ED” and “micro hospital” have been seen as pejorative. In early 2021, word leaked that a micro hospital option was in the process of being presented to the board of St. John’s Episcopal in the Rockaways. A firestorm of community and elected official opposition resulted, so the idea was not pursued further at that time. Although “specialty hospital” is a term of art that refers to a hospital that focuses on a single medical condition or target population, for lack of a better name, I would call these scaled-down facilities “specialized hospitals.”

Whatever term is used, this prototype certainly is not a case in which one-size-fits-all. The economics and health needs of every community are different. Some “specialized” hospitals will both need to offer more services for programmatic reasons and be able to economically support a broader range of services than other specialized hospitals. The basic approach, however, of increased specialization in greater integration with community-based providers and a more sophisticated health system should be the common denominator of these specialized hospitals.

Overcoming Resistance to Change

From my observation, the only way the community can be persuaded to embrace a different type of health facility is to present a detailed blueprint for the alternative and to demonstrate that the alternative is fully funded so that it will materialize. It is also critical that organized labor be brought in as a partner in the restructuring. 1199SEIU, in particular, has shown that it can be a good partner when it is included in the planning process. Simply promising the community that alternative services will be available is doomed to failure, but a sustained and transparent campaign to explain how a restructured

facility can both provide better (albeit narrower) services while attaining a level of financial sustainability that will ensure access well into the future, at least has a chance of success.

Another reason that the One Brooklyn Health transformation plan gained support among the community, elected officials, and organized labor is that it was conceptualized as part of a larger effort that integrated and expanded ambulatory care services and, critically, addressed social determinants of health. The Vital Brooklyn transformation plan, as it was known, brought with it more than 7,000 units of affordable and supportive housing in sponsored initiatives in areas ranging from healthy food to violence prevention. Although the amount of housing that could be built within the OBH service area may be unique, opportunities for similar transformation plans to integrate affordable housing and other services designed to improve the non-clinical health of the community exist. The cost of these broader initiatives is considerable, but they promise greater programmatic benefit than simply continuing operating subsidies to hospitals whose business model is unsustainable.

Investing in Technology

Financially distressed hospitals lack the resources to even invest in technologies that would have a positive return on investment. Supporting such investments is one of the easier-to-implement strategies for assisting financially distressed hospitals, although these decisions cannot be made in isolation from other restructuring decisions. Because a number of these investments involve non-clinical billing and general and administrative functions, it might make sense for the State to make such functionality available on a managed service basis.

While a deep dive into technology investment and how it could improve both operating efficiency and patient satisfaction is beyond the scope of this paper, some of the areas in which technology investments would be accretive include:

Revenue Cycle Management

A hospital revenue cycle is a complex system involving workflows related to patient registration, patient accounting systems, insurance verification/eligibility systems, claims management and clearinghouse systems, revenue cycle analytics, and patient payment systems, among others. Hospitals of all sizes leverage some sort of revenue cycle management (RCM) technology to track their operations and organize the tasks they must complete to get paid for patient care. The more seamless and integrated revenue cycle management systems become, the more a hospital can streamline workflows, enhance data accuracy, improve compliance, produce real-time information, enable seamless data exchange, reduce manual processes to submit clean claims to receive timely reimbursement, and reduce costs for managing multiple, siloed management systems.[8,9]

Compliance and Audit Management

A 2017 finding from the American Hospital Association indicated that an "average 161-bed hospital will spend $7.6 million annually to ensure compliance with Federal regulations and potentially more for hospitals with specialty beds. That equates to roughly $1,200 per patient admitted." There are a variety of domains in which robust compliance and auditing systems can assist hospitals in identifying and

[8] Key Types of Revenue Cycle Technology That Optimize Operations
[9] Tech optimization: Boosting revenue cycle management

managing risk efficiently and consistently. These domains include billing and coding, quality and patient safety, human resources and employment, research, and corporate compliance. Technology enables the automation of manual and repetitive compliance tasks, including generating reports and reminders, tracking deadlines, and managing documentation. Compliance and audit management systems provide a centralized platform to track, monitor, and manage compliance activities.

Appointment Management and Adherence

Missed appointments disrupt the continuity and quality of care for patients, and, for clinicians, missed appointments waste medical and administrative resources and may be associated with adverse patient health outcomes. Additionally, a significant number of missed appointments can equate to millions of dollars in lost revenue in a hospital setting. The causes of missed appointments vary, but reducing the number can improve care and save money.

There are a variety of existing approaches to reducing missed patient appointments. These include phone reminder systems, short messaging systems, and reminder letters. Studies have found that notification systems help reduce missed appointments, in many cases producing a 5-10% decrease in missed appointment rates with no one system outperforming another, and that, looking forward, linking electronic medical records, self-scheduling options, and upcoming appointment notifications will be the most effective approach.

Improved Imaging

Over the past several decades, medical imaging has seen a significant expansion in the variety of imaging procedures. The advent of more sophisticated artificial intelligence, applying machine learning and deep learning, will expand the competitive advantage of hospitals that can afford these investments. Whether it makes more sense for a financially distressed hospital to invest in such technology or rely on partnerships with larger health systems would have to be determined on a case-by-case basis.

Remote Patient Monitoring

Remote patient monitoring (RPM) involves the use of connected electronic tools to record personal health and medical data in one location that is reviewed by a provider at a different location. The data may or may not be viewed as soon as it is transmitted. Increasingly, health systems are leveraging RPM to care for patients being treated for a myriad of conditions, including diabetes, hypertension, and COVID-19. RPM can also be used to track patient recovery once they have been discharged to their homes post-surgery. CMS regulatory changes have bolstered this trend, indicating that RPM is becoming an important part of care delivery.

The cost-effectiveness of providing RPM can vary by types of monitoring, by diseases monitored, and by the setting in which monitoring occurs (such as an integrated delivery network, accountable care organization, or large health system).[13] Prior to the Federal Public Health Emergency, CMS implemented new billing codes and expanded coverage of RPM.

Hospital at Home

Although other states such as Massachusetts appear to be ahead of New York in the adoption of the Hospital at Home model, because of greater progress in addressing reimbursement issues, larger health

systems in New York are setting up hospital-at-home programs that enable treatment for higher acuity conditions at home. These programs can provide a wide array of services, including diagnostics like echocardiograms and X-rays, treatments such as oxygen therapy and intravenous fluids, as well as pharmacy and skilled nursing services. Though hospital-at-home programs involve in-person care, they are supported by continual remote monitoring of biometrics by a care team and telehealth visits.

The consulting firm McKinsey and Company concluded: "By shifting acute care to the home, virtual hospitals could deliver three key benefits over traditional brick-and-mortar models of care: expanded bed capacity, improved patient satisfaction and outcomes, and cost savings. Many patients also prefer to receive care at home rather than in a hospital bed. Three advantages of virtual hospitals – 1) expanded bed capacity available through virtual care, 2) greater patient satisfaction and outcomes, 3) lower costs for providers and patients."

Specific Recommendations

The specific recommendations below are intended to address, to the extent possible, the challenges financially distressed hospitals face as described in the diagnosis above, as well as to begin to implement the three overarching themes in the prescription: the evolution of a new hospital operating model; overcoming resistance to change; and investing in technology.

The prescription and these specific recommendations could all be articulated as "hypotheses" about what will work to achieve the interrelated goals of improving access, equity, quality, and financial sustainability for financially distressed hospitals. While I believe the prescription and specific recommendations are directionally correct, the issues being addressed are complex and difficult to solve. In most cases, further empirical analysis is needed to move these proposals from a vision of the future to becoming a blueprint for change. Government should be humble about its ability to centrally plan changes in the $300 billion healthcare delivery system in New York, of which hospitals are an indispensable part, but also mindful that market forces alone will not produce a system that meets the public's needs.

None of the recommended changes are easy. They require substantial financial resources and create winners and losers among important stakeholders in a way that government generally is loath to do. That said, if we knew in 2018 the extent to which the core businesses of so many traditional hospitals would have deteriorated since the COVID-19 pandemic, I think the State would have been more ambitious in seeking to fundamentally transform hospitals as part of a long-term evolution of the healthcare delivery system. If the State is unable to marshal the resources and the political will to begin these changes now, we could easily look up five years from now and see a hospital system that does not meet the needs of New Yorkers yet requires an ever-larger amount of State operating subsidies to continue the status quo.

Specific recommendations to address the challenges of financially distressed hospitals are as follows:

1. **The State should reform the Medicaid rate reimbursement methodology to reflect the fixed costs and the value of lower acuity "public good" services more fully.**

   Even if the existing Medicaid rate reimbursement methodology accurately reflects service costs (which may not be the case), it doesn't adequately reflect the social value and importance to the healthcare delivery system of "public good" services as the emergency department, inpatient

psychiatry, and other less acute but essential services such as labor and delivery. Rebasing of Medicaid rates, even if it is done on a revenue-neutral basis, should be done across service categories. It is difficult to justify why reimbursement for inpatient psychiatric services should cover a lower percentage of their actual cost than is the case for medical-surgical services.

The definition of "cost" in the Medicaid rate methodology should also be reviewed to ensure that standby costs are appropriately reflected in the methodology. The State should consider whether the methodology should reflect the social value of "public good" services and the increased burden of serving patients with high social needs.

2. **Focus efforts around rate adequacy on hospital-based outpatient services and advocate for Medicare rate methodology reforms.**

   To the extent possible, the State should use market forces to incentivize practices that serve its policy goals. One of those policy goals is to encourage health systems to expand access to high-quality services in hospital-based outpatient settings. The current rate structure under-reimburses for outpatient services compared to inpatient services. In the same vein of aligning reimbursement models with policy goals, the State needs to better understand issues associated with the Medicare rate methodology so it can more effectively advocate for changes that would be consistent with these goals for the Medicaid rate methodology. Senator Schumer's advocacy of changes in the Wage Index calculation in the Medicare rate methodology provided a dramatic benefit to upstate hospitals. The State needs to highlight and seek to reform other anomalies in the Medicare rate methodology.

3. **The State should embrace innovative reimbursement models such as "all payer global budgeting" to align reimbursement practices with its policy goals.**

   The two most important words in "all payer global budgeting" are "all-payer." The State needs partnership from Medicare and commercial payers in creating more financially sustainable hospitals as part of an integrated healthcare delivery system. Implicit in the all-payer concept is that Medicare and perhaps commercial plans will provide the hospital with more funding than it previously would have received in the face of declining patient volume. "Global budgeting" is not a panacea or silver bullet, because it still eventually requires significant changes in the cost structure of the hospital to support greater funding for downstream providers. At the margin, however, global budgeting can help offset revenue losses in the hospital as the health system builds up other parts of the delivery system.

4. **The State should develop financial performance standards and other non-financial criteria to inform the appropriate level of State operating subsidies for financially distressed hospitals, instead of basing subsidies on the amount of financial need to maintain status quo operations.**

   In the absence of other criteria for determining the appropriate level of State operating subsidies to financially distressed hospitals, the State has pursued a de facto policy of providing financially distressed hospitals the minimum amount they need to maintain status quo operations. One of the many drawbacks of this approach is that "financial need" is not a static concept. Instead, "financial need" is significantly influenced by decisions made regarding service offerings, discretionary employee contracts (of both administrators and physicians), and other investments (such as single rooms) that may or may not prove financially accretive.

In the absence of objective standards, the State is forced to make subjective resource allocation decisions on an ad hoc basis, relying mostly on input from management, thus replacing the discipline of the marketplace. Imagine the dilemma of a small number of State employees without experience in hospital operations who are charged with making these resource allocation judgments for dozens of financially distressed hospitals.

One of the great advantages of the State's Safety Net Directed Payment Template (DPT) program is that it creates a common denominator for assessing what could be described as the "efficiency" of financial performance for different types of hospitals. Because the DPT rate enhancement is close to identical for all hospitals in the DPT program (subject to modest volume-based weighting differences), the program facilitates comparison of the financial performance and long-term sustainability among the diverse hospitals in the Safety Net DPT program. Because Safety Net DPT reimbursement rates are higher than Medicare and at or above the commercial rates of most Safety Net DPT hospitals, the Safety Net DPT program serves as a counterweight to the argument that the hospitals' cause of financial distress is largely a function of low Medicaid rates.

The amount of the Safety Net DPT hospitals' operating deficit that can be covered through Safety Net DPT enhanced revenue can be an objective benchmark of sustainable financial performance. It is important to adjust for anomalies (such as nursing home losses not covered by DPT) and account for temporary funding needs that credibly will be covered by transformation initiatives in the process. But with those caveats in mind, the State could state that by a certain date, it will require that a threshold percentage of operating losses (e.g., 75% initially) must be covered by Safety Net DPT enhanced revenue. For hospitals not eligible for the Safety Net DPT program, the State could still perform this calculation on a hypothetical basis to create an objective framework for determining State operating subsidy levels.

Particularly for hospitals that require more funding than this financial performance framework would allow, the State needs to clearly define non-financial "normative" criteria. For example, what is an acceptable travel time to receive particular services at another hospital? What is the forecasted capacity level for providing a service elsewhere if it can no longer be provided in the financially distressed hospital? To an extent, these are questions that are asked as part of the DOH review process for closing bids or facilities. The State would be better served if it could articulate such standards in the abstract.

5. **Develop financial and operating pro forma analyses for prototype operating models for "specialized" hospitals that take advantage of specialization, technology investment, and innovative reimbursement models.**

   It seems likely that at least some of the Severely Financially Distressed Hospitals downstate that account for a large share of total State operating subsidies, and a number of financially distressed hospitals in smaller communities upstate will need to transform from being full-service hospitals to specialized hospitals. This evolution is happening more organically in smaller communities upstate, with active projects for East Niagara Hospital and proposals involving Brooks Hospital in Chautauqua County and affiliates of the Catholic Health System of Western New York in Niagara County. The bigger challenge involves identifying what a prototype operating model would look like in large urban centers, especially, but not exclusively, downstate.

The State should work with large New York health systems that have significant planning capacity, as well as with outside experts with experience in hospital design, to develop detailed pro forma financial and operating models that can accurately predict future financial performance and operational service metrics of various prototype operating models. Such an effort would also reveal the capital cost of such projects and the extent to which a reduction in operating subsidies would at least partially offset that cost over time.

6. **Create a $4-$6 billion Healthcare Transformation Financing Fund as a new public authority financed by inflation-adjusting the Covered Lives Assessment to its 2009 level.**

   Successful implementation of the strategy to facilitate the transition of financially unsustainable full-service hospitals to a new prototype operating model is likely to require significantly more capital than the State has appropriated for hospitals in recent years, with the caveat being that this strategy holds the promise of significantly reducing ongoing operating subsidies for the affected hospitals. Since 2015, when the State appropriated $700 million in capital for a large-scale restructuring of the One Brooklyn Health hospitals and appropriated $300 million to construct a new hospital in Utica, the State's capital grant programs have only been sufficient to make tactical improvements, not to restructure an entire hospital or health system that is on an unsustainable financial trajectory.

   The exact cost of developing these new operating models can only be determined following detailed analysis, as described above. Nevertheless, I expect that to support these new models and provide more tactical capital support to other hospitals for investment in technology and other areas, I expect the State will need to invest at least $4-$6 billion over roughly a five-year period.

   The State should finance this investment with a new Healthcare Transformation Financing Fund that is supported by inflation-adjusting the Covered Lives Assessment (CLA). At one time, the State's CLA assessment for individuals covered by commercial insurance or self-funded plans amounted to approximately 2.0% of such expenditures. Because of inflation, the CLA now amounts to approximately 1.40% of such expenditures. Inflation adjusting the Covered Lives Assessment by restoring it to the 2.0% level would generate approximately $500 million per year. This amount of revenue could support debt service for capital funds as large as $4-$6 billion.

   Ideally, the Healthcare Transformation Financing Fund would reside in a new public authority called the Healthcare Finance Authority, which would be analogous to the State of New York Mortgage Authority, a subsidiary of the State's Housing Finance Authority. Creating a Healthcare Finance Authority with a dedicated funding source would better enable the State to pursue a strategic approach to making these capital awards, which would involve jointly developing transformation plans with eligible hospitals and health systems (the way the State does with affordable housing developers and economic development programs) as opposed to the existing, rigid, application-driven process.

7. **Work to overcome community resistance to change by combining hospital restructuring with affordable housing and other initiatives that address social determinants of health.**

   The most important tools in gaining support for change from communities, elected officials, and organized labor are first, a clearly defined plan for alternative service delivery, and second, sufficient committed funding to ensure that vision becomes a reality. Another lesson of the Vital Brooklyn

experience is that the community will be more likely to accept change when it is accompanied by investments in other areas that address social determinants of health. Advancing an integrated program such as Vital Brooklyn is as much a function of coordinating the agendas of agencies responsible for managing other programmatic areas (which have their own priorities) as it is a matter of increased funding. Done properly, the whole will be greater than the sum of its parts.

8. **The State should create a "virtual public hospital system" ranging from services provided by a managed services organization to a unified governance model in the case of certain severely financially distressed hospitals.**

   As noted above, the best vehicle for financially distressed hospitals to derive the financial and operating benefits of economies of scale is a partnership with a larger health system. Unfortunately, larger health systems in the downstate region have been unwilling to enter such arrangements for financial and non-financial reasons. Unless the stronger health systems' interest in entering meaningful partnerships changes, it is time for the State to seek to capture at least some of the benefits of economies of scale by creating a "virtual public hospital system."

   Converting this idea into an actual plan also requires significant study by outside experts, New York City's Health and Hospitals Corporation, and large health systems that have experience in managing multi-facility operations. Needless to say, converting this idea into an actual plan would also require significant consultation with hospitals that would participate in it, and organized labor whose members would be affected by it.

   Calling this a "virtual" system is intended to convey that the approach would seek to capture as much of the benefits that a "system" can provide while recognizing the art of the possible and the potential drawbacks of scale that does not sufficiently emerge organically. One aspect of this approach would involve creating a management services organization that would provide the general and administrative layer of services, as well as greater clinical integration, to all participating hospitals in an effort to capture at least some of the benefits of economies of scale.

   The greatest potential for efficiency requires a common governance structure, an integrated management chain of command, and a single bottom line. In addition to continuing to explore opportunities for larger health systems to absorb financially distressed hospitals, the State should address whether there are further opportunities for combinations among certain Severely Financially Distressed Hospitals in the downstate region.

9. **The State should seek to level the playing field between financially distressed hospitals and managed care plans.**

   As described above, financially distressed hospitals' lack of market power disadvantages them in contracting with Medicaid and commercial managed care plans. Although administrative simplification efforts sponsored by the Department of Financial Services made some modest progress in recent years, more ambitious efforts in areas such as medical necessity denials have created more heat than light. In the spirit of the season, we can save for another day the deeply entrenched positions of the parties on these issues. Suffice to say, however, that addressing practices that fall disproportionately on financially distressed hospitals should be part of a comprehensive healthcare reform agenda.

In the same vein, we can postpone a discussion of the Hochul administration's efforts to gain greater visibility into acquisitions of physician practices and other small providers by for-profit corporations. Although the anecdotal evidence is strong that at least some of these acquisitions had negative effects on the healthcare delivery system, in the absence of any transparency, we are left to speculate about both the effects of the transactions and what policy adjustments, if any, should be considered in this area.

10. The State should adopt commonsense scope of practice changes and hospitals should seek to optimize staff roles that increase productivity and retention.

Many commonsense arrangements made possible during the COVID-19 pandemic were terminated when the COVID-19 emergency ended. It is important for New York to re-examine many of the limitations on health professionals' scope of practice and examine solutions that have been effective in other states. New York should also implement pilot programs to evaluate changes in scope or the introduction of new health professional titles in New York. For hospitals in the near term though, incorporating LPNs into acute care, maximizing the use and independence of NPs and PAs, and incorporating virtual nursing solutions can increase staff and patient satisfaction and increase staff retention, reducing the costs associated with turnover.

The State could also encourage hospitals to work within existing regulations to optimize staff roles that increase productivity and retention. These practices include:

- Deploying integrated care teams in the acute care hospital setting, which can lead to increased provider and patient satisfaction and increased provider retention. Some of these changes may not even require statutory changes. For example, hospitals are increasingly incorporating licensed practical nurses (LPNs) into the care teams on their general medical and intensive care units as part of a reconceptualized care delivery model. The LPNs are *not* a replacement for registered nurses (RNs) but rather a complement to the RNs and unlicensed assistive personnel (UAPs). This provides the opportunity for each role to focus on the activities that align with the top of their licenses or training.[10] Reducing RN turnover can meaningfully reduce costs.[11]

- Maximizing staff roles through the increased adoption of nurse practitioners (NPs) and physician assistants (PAs) that are employed by the hospital. NPs and PAs are in fairly broad use as employed staff in New York hospitals, and they should be maximized, but the physician supervision requirements for PAs are burdensome and limit the value that PAs can offer. The State should revise this requirement to align with the practice of nurse practitioners.

- Piloting blended care delivery models to include virtual nursing inside the hospital. Per the Patient Safety Network at the Agency for Healthcare Research and Quality, "… virtual nursing is part of a tested model of healthcare," and is particularly suited to complementing on-site nurses

[10] In a pilot on a 24-bed medical-surgical nursing unit with a cardiac sub-specialty at Sentara Leigh Hospital in Virginia, the hospital hired nine LPNs and introduced them into a new care model without changing the RN or UAP assignment ratios. RN satisfaction, workflow and communication improved in all measures and patient HCAHPS scores also improved in all measures.

[11] [In the Virginia pilot], RN turnover decreased from 19.2% in 2021 to 5.0% in 2022. All care team staff (RN, LPN, UAP) turnover decreased from 17.8% in 2021 to 13.5% in 2022.

with patient admissions, education, and discharges. A pilot on two patient care units at Mount Sinai South Nassau Hospital, a Magnet hospital in New York, implemented a blended "traditional and virtual nursing [VRN]" model to "decrease nursing workload." The difference between the pre-implementation and six-month post-implementation outcomes related to the on-site nurses' perceptions of positive impact on nurse satisfaction, patient safety, and nurse retention measures was impressive.[12]

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Conclusion

In his classic book, *Who Shall Live? Health, Economics and Social Choice*, the Stanford economist Victor Fuchs quoted the physician John Knowles, who said: "The hospital has evolved from a House of Despair, avoided by all but the impoverished sick, to a House of Hope to which all roads lead time of crisis – be it somatic, psychic or social in origin." Fuchs traced the evolution of hospitals and noted that: "According to many observers, hospitals should now be putting more emphasis on preventive medicine, health, education, ambulatory care, home, care, rehabilitation services, and responsibility for patients in other institutions…." *Who Shall Live?* was published in 1975. So the question of the future of hospitals and their role in the healthcare delivery system has been with us for some time.

As we noted in the Introduction, despite its length this paper barely scratches the surface of this complicated issue. One of the challenges for policymakers is that discussions about the future of individual hospitals often occur in an atmosphere of crisis. Despite the problems being hidden in plain sight, the political system finds it hard to choose among a series of suboptimal options until institutions are at the brink of failure.

One of the advantages of being out of government is that there is more time to think about the underlying causes of the problems and to think longer term about solutions. Fortunately, there are lots of smart people both in New York and nationally that are thinking about this problem. Our hope is that this paper can contribute to the debate in New York and serve as at least a rough first draft of the comprehensive approach to achieve the "sometimes-competing goals of access, equity, quality and financial sustainability."

[12] [From their poster presentation at the United Hospital Fund's 34th Annual Symposium on Health Care Services in New York: research and practice] outcomes include: 81% improvement in clinical RNs' perception that VRN positively impacts the patient experience (from 48% to 87%); 25% improvement in clinical RNs' perception that VRN will effectively assist with patient admissions (from 80% to 100%); 25% improvement in clinical RNs' perception that VRN will improve patient safety; 36% improvement in clinical RNs' perception that distributing workload between VRN and clinical staff will increase job satisfaction (from 48% to 60%).