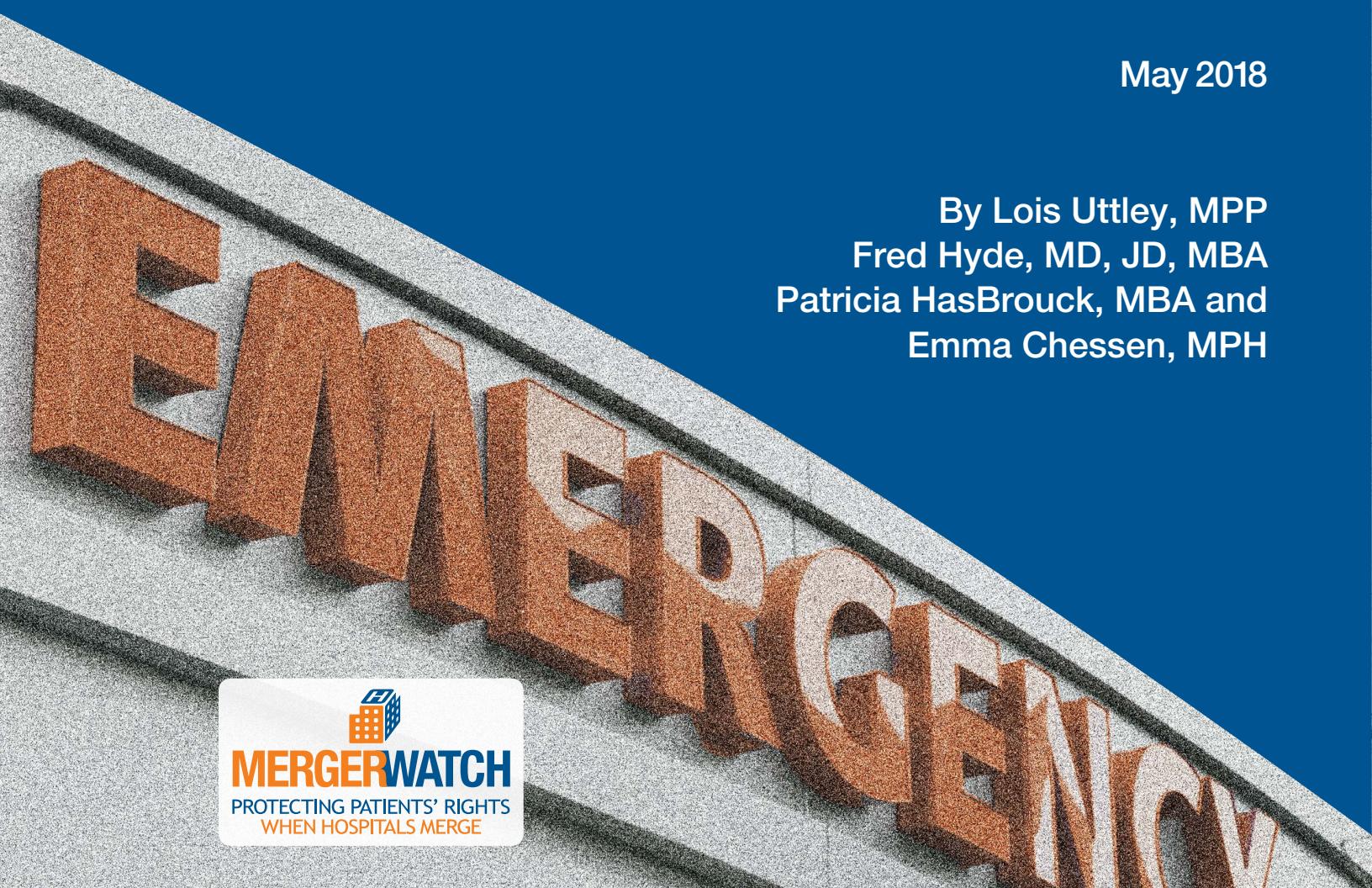


EMPOWERING NEW YORK CONSUMERS IN AN ERA OF HOSPITAL CONSOLIDATION



May 2018

By Lois Uttley, MPP
Fred Hyde, MD, JD, MBA
Patricia HasBrouck, MBA and
Emma Chessen, MPH



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Support for this work was provided by the New York State Health Foundation (NYSHealth). The mission of NYSHealth is to expand health insurance coverage, increase access to high-quality health care services, and improve public and community health. The views presented here are those of the authors and not necessarily those of the New York State Health Foundation or its directors, officers, and staff.

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Executive Summary

Over the last 20 years, changes in reimbursement policies and medical advances have altered the hospital landscape nationwide and in New York. Three trends have dominated the hospital industry: 1) downsizing and closing of community hospitals, 2) hospital consolidation and creation of large regional health systems, accompanied by 3) movement of some medical care from hospitals into lower-cost outpatient settings.

The impact of these trends can be seen in the findings from MergerWatch research:

- Forty-one New York hospitals have closed all of their inpatient services over the last 20 years.** Some hospitals have been converted to use as outpatient centers, medical offices, nursing homes or rehabilitation centers, while others have been turned into condominiums or abandoned.
- The number of hospital beds being decertified across New York State jumped from 102 in 2015 to 440 in 2017,** with the largest losses occurring in medical/surgical, psychiatric, maternity and pediatric care, according to New York State Department of Health data.
- A group of large non-profit health systems has been steadily moving to manage or acquire many of the remaining community hospitals in the state.** The 12 largest systems now control half of all the acute care hospitals in New York and 70 percent of the inpatient acute care beds. Four mega-systems – New York-Presbyterian, Northwell Health, NYU Hospitals Center and Mount Sinai Health System – have accumulated multiple hospitals and a combined total of \$14.2 billion in net assets, giving them significant economic power and ability to shape the health system.

With all this change occurring in the hospital landscape, do New Yorkers have a say in hospital closure and consolidation decisions? How are New York’s health consumers being notified of proposed changes to their local hospitals? Are they being afforded the opportunity to comment on how their access to timely, affordable care might be affected? Are state regulators able to ensure that proposed hospital mergers, closings, downsizing and movements

of care to outpatient settings benefit consumers and do not create gaps in access to care? Equally important, how are regulators ensuring that these consolidations do not exacerbate existing health disparities or unnecessarily increase health care prices?

THE CERTIFICATE OF NEED PROCESS PROVIDES AN OPPORTUNITY TO ENGAGE COMMUNITY RESIDENTS IN THESE DECISIONS THAT CAN DRAMATICALLY AFFECT THEIR LIVES.

The state Certificate of Need (CON) process provides an opportunity to engage community residents in these decisions that can dramatically affect their lives. In 1964, New York established the first-in-the nation CON process at a time when new hospitals were being constructed with the aid of the federal Hill-Burton Act. Demand for hospital care was fueled by the growth of third-party private health insurance and by the enactment of Medicare and Medicaid in 1965. Policymakers were concerned that unregulated construction of new hospitals and expansion of existing facilities

would lead to unnecessary construction and duplication of expensive equipment, resulting in higher-than-necessary health care costs. CON was also intended to protect a hospital’s “franchise” from competition that could hurt its ability to repay loans. The CON program has required hospitals and other institutional health providers to seek state approval for construction, expansion, renovation and establishment of new facilities and services.

In the new era of hospital consolidation, is New York’s 54-year-old CON process effective in working to notify the public, meaningfully engage consumers and protect community access to timely, affordable care? A year-long study by MergerWatch, funded by the New York State Health Foundation, set out to find the answer.¹ The study found that New York State Department of Health staff and leaders of the Public Health and Health Planning Council (PHHPC), which reviews the most important CON applications (those designated for full review), have taken some positive steps in recent years to improve CON review. However, the study concluded that the CON process still lacks transparency, consumer engagement and sufficient oversight of health care providers in this rapidly changing landscape.

A 2012 PHHPC report made a number of significant suggestions about ways to reform the CON process. However, some of those suggestions were never acted upon or were implemented in ways other than what the PHHPC had envisioned. Moreover, since that 2012 PHHPC report, the

1. The study was focused on oversight of acute care hospitals and health systems, and did not review the processing of CON transactions involving nursing homes or home care agencies.

pace of change in the hospital sector has quickened. New York's Delivery System Reform Incentive Payment (DSRIP) Medicaid redesign program has put large systems with ample administrative capacity at an advantage and has pushed stand-alone community hospitals to join larger hospital systems. Such marriages of community hospitals and dominant systems come to the CON application process as virtual "done deals," encouraged by state officials and sweetened with state grants.

PHHPC members and DOH staff are engaged in another round of examining how to modernize CON and other state health regulatory oversight processes, with PHHPC Chair Jeffrey Kraut suggesting that the Department of Health "is trying to solve new millennial challenges with a regulatory and CON chassis that is 30-40 years old." At a PHHPC strategic planning retreat in September 2017, Kraut (who is also Executive Vice President of Strategy and Analysis for the Northwell Health system) described a need to "articulate a different vision of a new framework for DOH to fulfill its mission of accountability and oversight, to have transparency and public engagement."²

This MergerWatch study is intended to offer valuable suggestions on how to ensure that CON reform enhances transparency and consumer engagement, and that it protects access to affordable care for vulnerable health consumers. The study concludes that the CON program as currently operated in New York State does not adequately inform or engage health consumers about hospital consolidation, downsizing or closing that could affect their access to timely, affordable care.

THE CON PROGRAM DOES NOT ADEQUATELY INFORM OR ENGAGE HEALTH CONSUMERS ABOUT HOSPITAL CONSOLIDATION, DOWNSIZING OR CLOSING THAT COULD AFFECT THEIR ACCESS TO TIMELY, AFFORDABLE CARE.

Key Findings

- **No state-mandated system exists to notify and engage affected consumers in advance when their community hospitals will be closing, downsizing, transforming into outpatient settings and/or joining a large health system that will assume decision-making over the local facility.** Public hearings are not required *in the affected communities or at convenient times for consumers* in advance of a hospital closing, downsizing or other transaction with a major impact on the facility and community.

2. Jeffrey Kraut, "The Role of the PHHPC in Public Health and Health Planning; Looking Back and Looking Forward," September 6, 2017, <http://www.totalwebcasting.com/view/index.php?func=VIEW&id=nysdoh&date=2017-09-06&seq=1>

- **Hospital closings and some types of downsizing (such as eliminating the emergency department or maternity services) are not subject to “full review” by the PHHPC in a public meeting.** Instead, many are being handled through “limited review” CON applications that are decided by state DOH staff.
- **Increasing numbers of CON applications are being decided out of public view through “administrative review” and “limited review” or through simple “notice” to the state.** State processing of CON applications has been streamlined and shortened at the urging of hospitals, making it more difficult for affected consumers to learn about and comment on proposals.
- **User-friendly information is difficult to find on the NYS DOH website concerning individual CON applications, the CON review process or how to submit comments on pending applications.**
- **PHHPC meetings and their agendas are not widely publicized.** The meetings are held only on weekdays in Albany or New York City, creating hurdles for consumers who would have to take time off from work and travel to present comments. There frequently is no response when the committee chair asks, “Are there any comments from the public?”
- **The public’s voice is not well represented on the PHHPC itself, with only a single seat being designated for a consumer representative (and that seat having been vacant since mid-2016).** This is in stark contrast to public representation in some other states, where health care *provider* representation is severely limited on CON-decision making bodies and the chair must be a consumer.
- **Since the demise of all but one local Health System Agency (HSA), no replacement process has been devised to seek and consider the views of local health officials and affected communities on pending CON applications.**
- **Until now, CON decision-making has not included consideration of whether proposed hospital transaction would advance identified local or state health planning goals, such as those articulated in the Prevention Agenda.** In June of 2018, the “full review” CON applications for general hospitals will begin to ask applicants about how the proposed project advances local Prevention Agenda priorities, which will represent an important step in the right direction.

NO PROCESS HAS BEEN DEVISED TO SEEK AND CONSIDER THE VIEWS OF LOCAL HEALTH OFFICIALS AND AFFECTED COMMUNITIES ON PENDING CON APPLICATIONS.

- Publically-available summaries of CON applications often do not explain how the project would meet the needs of medically-underserved people, such as those who are low income, racial and ethnic minorities, women or people with disabilities.³
- Also unaddressed in CON decision-making is whether a proposed consolidation could increase the price of health care in affected communities.
- No CON review or public notification is required when health systems initiate takeovers of local hospitals by using an unregulated “passive parent” mechanism found in no other state. When systems do submit CON applications to assume “active parent” governance of hospitals (which gives them direct authority over the hospital’s budget and management), applicants are not required to explain how local residents would be given a continuing voice in hospital decision-making (such as through seats on the board).

“WE HAVE NOT HAD A DISCUSSION ABOUT THE IMPLICATIONS OF CONSOLIDATION.”
– DR. JOHN RUGGE

“We look with a microscope at individual applications with criteria that are decades old, and have not had a discussion here about the implications of consolidation and should there be expectations of consolidation,” said Dr. John Rugge, who is Chair of the PHHPC’s Planning Committee and Founder, Executive Chairman of the Hudson Headwaters Health Network.⁴ “For example,” he asked, “should there be expectations about local governance?”

Summary of Recommendations

How can New York’s CON process be made more transparent and engaging of consumers in the new era of hospital consolidation? The study produced four categories of recommendations about how to make the process more transparent, drawing on practices found in other states and in a few cases on recommendations from the 2012 PHHPC report that were not acted upon:

1. **Ensure that consumers affected by hospital closures or elimination of key hospital services are notified and engaged.** We propose (a) requiring 90 days advance notice and provision of a proposed closure plan, as well as (b) a public hearing in the affected community at least 60 days in advance and (c) full review of these transactions in public meetings by the Public Health and Health Planning Council (PHHPC), with special attention to the potential effect on health consumers who are low-income, racial and ethnic minorities, women, people with disabilities, the elderly, and members of other underserved groups.⁵

3. As spelled out in Section 709.1, determination of need pursuant to section 2802 of the Public Health Law, accessed at <https://regs.health.ny.gov/book/export/html/45945>

4. Dr. John Rugge, in comments to the Public Health and Health Planning Council on December 7, 2017, as reported in the minutes of the meeting.

5. Section 709.1 - Determination of public need pursuant to section 2802 of the Public Health Law

WE URGE FULL DISCLOSURE BY HEALTH SYSTEMS OF PLANS TO DOWNSIZE OR TRANSFORM HOSPITALS THEY ARE ACQUIRING.

2. Improve transparency, consumer engagement and accountability when health systems propose takeovers of community hospitals.

We urge full disclosure by systems of plans to downsize or transform hospitals they are acquiring, followed by post-transaction reporting and monitoring to ensure accountability to affected consumers.

We urge a requirement for public hearings in affected communities to ensure consumer engagement, especially for consumers who are medically underserved or could become so as a result of the transaction. We propose eliminating health systems' use of an unregulated mechanism (called "passive parent") to begin takeovers of local hospitals without transparency or accountability to affected consumers.

3. Increase consumer representation on the PHHPC and improve the overall transparency and consumer engagement of the current NYS CON process.

We urge the addition of more consumer representatives to the PHHPC to better ensure consumer views are heard and considered, and to counterbalance the presence of health system representatives. We recommend improvements to the NYS DOH website to make it easier for consumers to find hospital CON applications and to submit comments on them. We recommend requiring CON applicants to submit Letters of Intent 30 days prior to the filing of a CON, and posting those LOIs promptly on the DOH website.

4. Ensure CON-approved projects protect access to timely, affordable care and advance identified local and state health planning goals.

We recommend that CON applicants be required to state how their projects would address identified state and local health planning goals, such as the Prevention Agenda, and advance health equity by improving access to care for medically-underserved health consumers. We also suggest that applications for large-scale transactions, especially hospital consolidations, be required to project the impact of the transactions on the price of health care services.



The Changing Hospital Landscape

Across the nation, the pace of hospital consolidation is quickening and health care delivery is transforming. Historically independent community hospitals are joining regional and national health systems. The number of hospital mergers and acquisitions nearly doubled between 2010 and 2015.⁶ In 2017, there were 115 hospital mergers and acquisitions, the highest number in recent history.⁷ Some financially stressed community hospitals are downsizing, converting into urgent care centers or freestanding emergency departments, or closing. Especially hard hit are rural hospitals, more than 119 of which have closed since 2005.⁸ Some urban hospitals, particularly those that are publicly owned and disproportionately serve uninsured and Medicaid patients, are also struggling.

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6. "Hospital Merger and Acquisition Activity Up Sharply in 2015, According to Kaufman Hall Analysis," KaufmanHall, Skokie, Ill., January 20, 2016, accessed at <https://www.kaufmanhall.com/news/hospital-merger-and-acquisition-activity-sharply-2015-according-kaufman-hall-analysis>
 7. "2017 in Review: The Year M&A Shook the Healthcare Landscape" (Kaufman Hall, 2018), <https://www.kaufmanhall.com/resources/2017-review-year-ma-shook-healthcare-landscape>
 8. Data from North Carolina Rural Health Research Program, cited in Mincer, J., "More hospital closings in rural America add risk for pregnant women," Reuters, July 18, 2017, accessed at <https://www.reuters.com/article/us-usa-healthcare-rural/more-hospital-closings-in-rural-america-add-risk-for-pregnant-women-idUSKBN1A30C5>

Many externalities are driving these trends, including clinical advances that make it possible to safely move treatment from inpatient hospitals to ambulatory sites. Other factors include payer demand (from private insurers, employers and government payers) for “value-based” care that necessitates capital investment in expensive technology (such as electronic medical records) to support collaboration among health care providers along the continuum of care, as well as administrative capacity to negotiate and manage value-based contracts. These requirements have proved challenging for smaller hospitals with limited administrative capacity and access to capital. Health systems have also acquired hospitals to increase market share, thereby gaining

negotiating leverage with health insurers, as well as a larger patient base to feed larger tertiary care hospitals within each system. For rural and some urban hospitals, challenges may be precipitated by prohibitive costs to renovate aging hospital buildings, lack of access to capital and high percentages of patients who are uninsured or who are insured by (lower paying) Medicaid.

PAYER DEMANDS FOR “VALUE-BASED CARE” HAVE PROVED CHALLENGING FOR SMALLER HOSPITALS WITH LIMITED ADMINISTRATIVE CAPACITY.

What has been happening in New York State? A total of 41 hospitals have closed general inpatient services over the last 20 years, MergerWatch research has found. Sixteen of those hospital campuses have been converted to non-medical uses – such as condominiums, assisted living facilities, office space and schools – or are abandoned. The remaining 25 former hospital sites continue

to be used for a range of medical services, such as clinics, labs, ambulatory surgery centers, urgent care centers, psychiatric treatment facilities, nursing homes, and drug or alcohol rehabilitation centers. (See the list of closed hospitals on page 12.)

More than half of these closings (23 hospitals or 56 percent) have occurred since 2007. Some were recommended in 2006 by a state hospital “rightsizing” initiative called the Commission on Health Care Facilities in the 21st Century (known the Berger Commission, after its Chairman, Stephen Berger). The commission estimated that the state had excess capacity of more than 10,000 hospital beds, which it said was enormously costly. The Commission targeted five hospitals in New York City for closure: St. Vincent’s Midtown Hospital and Cabrini Medical Center in Manhattan, Victory Memorial in Brooklyn, New York Westchester Square Medical Center in the Bronx and Parkway Hospital in Queens. Four upstate hospitals were targeted for closure: Millard Fillmore Gates Circle in Buffalo, St. Joseph’s in Cheektowaga, Bellevue Women’s Hospital in Niskayuna and Community Hospital in Dobbs Ferry. Nearly all of the recommended closings occurred within a year or two of the Commission’s report. The Commission also recommended that 48 other hospitals reconfigure, either by merging with nearby facilities or by converting hospital beds to other uses. Many of these reconfigurations have taken place, or are in process.

TABLE 1

New York hospitals closed for inpatient services since 1997

| HOSPITAL NAME | LOCATION | YEAR OF CLOSING | CURRENT USE OF FORMER HOSPITAL FACILITY/CAMPUS |
|--|----------------------------------|-----------------|--|
| NON-MEDICAL USE OF FORMER HOSPITAL CAMPUS | | | |
| Beth Israel Medical Center- Herbert and Nell Singer Division | Manhattan | 2004 | Demolished and luxury condos built in place |
| Cabrini Medical Center | Manhattan | 2008 | Converted to residential units (2013) |
| Catholic Med CTR of Brooklyn/Queens- Mary Immaculate Hospital | Queens (Jamaica) | 2009 | Residential units planned |
| Catholic Med CTR of Brooklyn/Queens- St. John's Queens Hospital | Queens (Elmhurst) | 2009 | In process of conversion to residential |
| Genesee Hospital | Rochester | 2001 | Demolished and office complex built in place |
| Kaleida Health Adult Hospital- Millard Filmore Gates | Buffalo | 2012 | Demolished and senior assisted living complex built in place |
| Mary McClellan Hospital | Washington County (Cambridge) | 2003 | Abandoned |
| New York United Hospital | Port Chester | 2005 | Abandoned, plans for mixed use development |
| Orange Regional Medical Center- Middletown Campus | Middletown | 2011 | Repurposed as campus for Touro College, osteopathic medical school |
| Parkway Hospital | Queens (Forest Hills) | 2008 | Abandoned for several years, purchased and undergoing DEC review |
| Salamanca Hospital District Authority | Salamanca | 1998 | Demolished (2011) |
| Sheehan Memorial Hospital | Buffalo | 2012 | Office space (2013) |
| Staten Island University Hospital-Concord Division | Staten Island | 2009 | Public School |
| St. Agnes Hospital | White Plains | 2003 | Luxury assisted living residence (2013) |
| St. Vincent's Midtown Hospital | Manhattan | 2007 | Partly abandoned, partly residential (2014) |
| St. Vincent's Hospital and Medical Center of New York | Manhattan | 2011 | Demolished and luxury condos built in place |

| SOME TYPE OF MEDICAL SERVICES ON FORMER HOSPITAL CAMPUS | | | |
|--|-----------------------|------|---|
| Albert Lidley Lee Memorial Hospital | Fulton | 2009 | Urgent care center |
| Amsterdam Memorial Hospital | Amsterdam | 2014 | 10 rehab beds, ambulatory services |
| Bayley Seton Hospital | Staten Island | 2004 | Small portion of property used for chemical dependency treatment |
| Brunswick Hospital Center | Amityville | 2003 | Inpatient Psychiatric Hospital |
| Our Lady of Victory Hospital of Lackawanna | Lackawanna | 2002 | Nursing home |
| Faxton- St. Lukes Healthcare- Faxton Division | Utica | 2003 | Ambulatory surgery, urgent care, other ambulatory care services |
| Inter-community Memorial Hospital at Newfane | Newfane | 2014 | Ambulatory care services |
| Lakeside Memorial Hospital | Brockport | 2013 | Free-standing Emergency Department and ambulatory care services |
| Long Beach Medical Center | Long Beach | 2013 | Free-standing Emergency Department |
| Long Island College Hospital | Brooklyn | 2014 | Free-standing Emergency Department run by NYU Langone |
| Manhattan Eye Ear & Throat Hospital | New York | 2007 | Ambulatory surgery and other ambulatory services |
| Massapequa General Hospital | Seaford | 2000 | Medical offices and school |
| Myers Community Hospital | Sodus | 2003 | Medical offices |
| New York Westchester Square Medical Center | Bronx | 2013 | Free-standing Emergency Department run by Montefiore |
| North General Hospital | New York | 2010 | Ambulatory care services and medical residency program |
| North Shore University Hospital at Syosset | Westbury | 1997 | Ambulatory surgery |
| Peninsula Hospital Center | Queens (Far Rockaway) | 2012 | Nursing and Rehabilitation Center (2014) |
| St. Clares Hospital- McClellan Division | Schenectady | 2011 | Ambulatory care services |
| St. John's Riverside Hospital- Park Care Pavilion | Yonkers | 2001 | Inpatient chemical dependence rehab and detox |
| St. Luke's Cornwall Hospital- Cornwall Campus | Cornwall | 2017 | Medical offices |
| St. Mary's Hospital of Brooklyn | Brooklyn | 2005 | Transitioning to nursing home |
| Tri-Town Regional Hospital | Sidney | 2005 | Free-standing Emergency Department |
| Union Hospital of the Bronx | Bronx | 1998 | Ambulatory care services, dental, mental health, urgent care, PT/OT |
| United Memorial Medical Center- Bank Street Campus AKA St. Jerome | Batavia | 2000 | Ambulatory care services |
| Victory Memorial Hospital | Brooklyn | 2008 | Urgent care center |

The number of hospital beds in New York has been steadily decreasing as facilities are downsized and transformed. NYS DOH data on hospital bed changes from 2015-2017 reveal a sharp jump in the number of beds lost, from 102 in 2015 up to 474 in 2017. The greatest reductions have been in the number of traditional medical/surgical beds, which decreased by 402 beds over the three-year period. The next largest reduction was in psychiatric care, which decreased by 202 beds, followed by maternity care (down 88 beds) and pediatrics (down 80 beds).

TABLE 2
New York hospital beds changes by category 2015-17
(with largest categories of bed losses highlighted)

| HOSPITALS | 2015 | 2016 | 2017 | Total |
|---|-------------|-------------|-------------|-------------|
| BED CATEGORY | | | | |
| AIDS | N/A | N/A | -13 | -13 |
| Bone Marrow Transplant | 0 | 0 | 2 | 2 |
| Chemical Dependency, Detox | -31 | 0 | -12 | -43 |
| Chemical Dependency, Rehab | 0 | -30 | 37 | 7 |
| Coma Recovery | -4 | 0 | -5 | -9 |
| Coronary Care | 0 | -7 | -10 | -17 |
| Intensive Care | 25 | 33 | -2 | 56 |
| Maternity Beds | 0 | -4 | -84 | -88 |
| Medical/Surgical | -89 | -131 | -182 | -402 |
| Neonatal Intensive Care | 55 | 16 | 6 | 77 |
| Neonatal Intermediate Care | -19 | 16 | -14 | -17 |
| Neonatal Continuing Care | 0 | -2 | -3 | -5 |
| Pediatric | -7 | -36 | -37 | -80 |
| Pediatric ICU | 8 | 0 | -5 | 3 |
| Physical Medicine & Rehabilitation | 19 | -32 | -58 | -71 |
| Prisoner | N/A | N/A | -8 | -8 |
| Psychiatric | -43 | -89 | -70 | -202 |
| Traumatic Brain Injury | -16 | 0 | -16 | -32 |
| Transitional Care | 0 | 78 | N/A | 78 |
| NEW YORK STATE TOTAL | -102 | -188 | -474 | -764 |

Data sources: NYS Department of Health

A snapshot of 2017 bed changes by type of care and region of the state is shown in Table 3 on page 14. Most of the 2017 reduction was in beds classified as medical/surgical, maternity, psychiatric, or physical medicine & rehabilitation. Regions experiencing the greatest losses in beds included New York City, the Northeast region (Capital District and north) and Long Island.

When Charles Abel, Deputy Director of the NYS DOH's Center for Health Facility Planning, addressed this reduction in beds at the February 8, 2018, PHHPC meeting, he said that "these are beds that have proven not to be needed." He added, "Some of those have come out as a result of hospital construction projects where the hospital does not see the need to construct a new wing or a new addition with the same number of beds."

TABLE 3

Changes in number of hospital beds by region 2017

(with largest areas of bed decertifications highlighted)

| REGION | Western | Finger Lakes | Central | NY-Penn | North East | Hudson Valley | NYC | Long Island | Total |
|---|------------|--------------|-----------|----------|-------------|---------------|-------------|-------------|-------------|
| BED CATEGORY | | | | | | | | | |
| AIDS | 0 | 0 | 0 | 0 | 0 | 0 | -13 | 0 | -13 |
| Bone Marrow Transplant | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Chemical Dependency, Detox | 0 | 0 | 0 | 0 | 0 | 0 | -12 | 0 | -12 |
| Chemical Dependency, Rehab | 42 | 0 | 0 | 0 | 0 | -5 | 0 | 0 | 37 |
| Coma Recovery | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -5 | -5 |
| Coronary Care | -4 | 0 | 0 | 0 | -6 | 0 | 0 | 0 | -10 |
| Intensive Care | -5 | 0 | 0 | 0 | -6 | 0 | 4 | 5 | -2 |
| Maternity Beds | -27 | 0 | 0 | 0 | -8 | 0 | -38 | -11 | -84 |
| Medical/Surgical | -17 | 40 | 0 | 0 | -143 | -44 | -13 | -5 | -182 |
| Neonatal Intensive Care | 0 | 0 | 0 | 0 | 0 | 8 | -2 | 0 | 6 |
| Neonatal Intermediate Care | 0 | 0 | 0 | 0 | 0 | 0 | -13 | -1 | -14 |
| Neonatal Continuing Care | 0 | 0 | 0 | 0 | 0 | 0 | -3 | 0 | -3 |
| Pediatric | 0 | 0 | 0 | 0 | -15 | 0 | -22 | 0 | -37 |
| Pediatric ICU | -5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -5 |
| Physical Medicine & Rehabilitation | 0 | 0 | -15 | 0 | 0 | 0 | -19 | -24 | -58 |
| Prisoner | 0 | 0 | 0 | 0 | 0 | -8 | 0 | 0 | -8 |
| Psychiatric | 0 | 0 | 8 | 0 | -6 | 0 | -51 | -21 | -70 |
| Traumatic Brain Injury | 0 | 0 | 0 | 0 | 0 | 0 | 0 | -16 | -16 |
| NEW YORK STATE TOTAL | -14 | 40 | -7 | 0 | -184 | -49 | -182 | -78 | -474 |

Data sources: NYS Department of Health

The trend of hospital consolidation, downsizing and transformation into outpatient facilities or freestanding emergency departments is likely to continue in New York. More than 30 hospitals are financially endangered and would have closed or significantly reduced services within the past four years, absent extraordinary state support, according to recent presentations by New York State Department of Health (NYS DOH) staff.⁹

“We have been working very closely with approximately 25-30 facilities, depending on the year, that are all hospitals that are seriously at risk of closure, of not being able to make payroll, because of substantive, often structural, financial issues,” explained DOH’s Charles Abel at the February 8, 2018,

9. NYS DOH presentation, “Priority Next Steps for Transformation of Health Care Delivery System: Beyond the Walls of the “H,” Rethinking CON and the Regulatory Framework,” given at the Public Health and Health Planning Council Strategic Retreat, Tarrytown, NY, Sept. 7, 2017.

meeting of the PHHPC.¹⁰ In some cases, he explained, “We’ve been able to fund operating losses to facilitate a transformation turnaround plan and be able to move these facilities forward – often through affiliation efforts, through active parent or merger applications. We provide stabilization and a financial runway to be able to have stronger health care systems come, step up to the plate, assume responsibility for facilities that are fragile and, through economies of scale and some strategic initiatives, these facilities have been able to improve themselves, stabilize, and actually have come off of those state subsidies.”

“WE PROVIDE A FINANCIAL RUNWAY TO HAVE STRONGER HEALTH CARE SYSTEMS STEP UP TO THE PLATE AND ASSUME RESPONSIBILITY FOR FACILITIES THAT ARE FRAGILE.”

– CHARLES ABEL, NYS DOH

Since 2014, 35 financially-distressed hospitals have received \$2.05 billion in funding from New York State through the Interim Access Assurance Fund, the Vital Access Provider Assistance Program and the Value Based Payment Quality Improvement programs, according to a recent report by the Community Service Society.¹¹ The report listed New York’s top safety-net hospitals, including 26 where more than 50 percent of all discharges were either insured by Medicaid or self-pay (uninsured).

One particular focus of the DOH and the Governor’s office has been an effort to rescue three struggling Brooklyn hospitals and the patients who depend on them. More than \$700 million in capital development funds have been awarded to One Brooklyn Health, a new unified health care system that brings together Brookdale University Medical Center, Interfaith Medical Center and Kingsbrook Jewish Medical Center.¹² The funds will “strengthen local health care facilities to close current gaps and increase services, develop a 32-site ambulatory care network that will include partnerships with existing community-based providers, and transform the health care system by increasing access to quality services and preventive care,” according to an announcement from the Governor’s office in January of 2018.¹³ With aid of the funding, Kingsbrook Jewish Hospital will “evolve into a Medical Village with new and expanded primary and specialty care, emergency services and post-acute care,” while Brookdale will undergo renovations to maintain its role as a regional trauma center and Interfaith will expand its emergency department and add a Comprehensive Psychiatric Emergency Program. One Brooklyn Health was proposed following a state DOH-funded study by Northwell Health consultants about how to restructure the health system in Central and Eastern Brooklyn.

10. Charles Abel, Deputy Director, NYS DOH Center for Health Facility Planning, in comments to the Public Health and Health Planning Council on February 8, 2018, as reported in the minutes of the meeting.

11. “Unintended Consequences: How New York State Patients and Safety-Net Hospitals are Shortchanged,” Community Service Society, January 2018.

12. Dr. Howard Zucker, NYS Commissioner of Health, in a report to the Public Health and Health Planning Council on February 8, 2018, as reported in minutes of the meeting.

13. “Governor Cuomo Announces Transformation of the Health System in Brooklyn,” announcement from the Governor’s Office, posted on January 24, 2018, at <https://www.governor.ny.gov/news/governor-cuomo-announces-transformation-health-care-system-brooklyn>

MergerWatch research found that the 12 largest systems in New York control more than half of the short-term acute care hospitals, 70 percent of inpatient beds, and account for more than 71 percent of all inpatient discharges.

As individual New York hospitals change, merge and close, the health systems that began to take shape 20 years ago are growing in size, geographic reach and power, and strategically affiliating with or acquiring struggling community hospitals. Between January 2011 and September 2017, a total of 78 mergers or acquisitions were approved or pending, according to the Department of Health.¹⁴ Through such transactions, a small group of non-profit hospital systems have grown steadily larger in recent years. These systems now own or manage multiple hospitals, ambulatory surgery centers, urgent care centers and physician practices stretching over several counties.

TABLE 4

Dozen largest hospital systems operating in New York State

Rankings based on total staffed beds at short-term acute care general hospitals, and critical access, orthopedic and women's hospitals (hospital counts exclude psychiatric and rehabilitation hospitals)

APRIL 2018

| Rank | System | Counties Served | Short-Term Acute Care General Hospitals | Inpatient Discharges | Staffed Beds | % of All NYS Acute Care Hospitals | % of All NYS Acute Care Discharges | % of All NYS Acute Care Beds |
|--|---|---|---|----------------------|---------------|-----------------------------------|------------------------------------|------------------------------|
| 1 | Northwell Health | Queens, Nassau, Suffolk, Kings, Richmond, Westchester, New York, Onondaga | 20 | 340,031 | 6,611 | 10.3% | 16.1% | 14.0% |
| 2 | New York - Presbyterian | New York, Westchester, Kings, Queens | 9 | 192,209 | 5,140 | 4.6% | 9.1% | 10.9% |
| 3 | Mount Sinai Health System | New York, Queens, Kings, Richmond | 9 | 151,444 | 3,902 | 4.6% | 7.2% | 8.3% |
| 4 | NYC Health and Hospitals | Kings, Queens, Richmond, New York, Bronx | 11 | 149,246 | 3,172 | 5.6% | 7.1% | 6.7% |
| 5 | Montefiore Health System | Bronx, Westchester, Rockland, Orange | 8 | 133,437 | 3,107 | 4.1% | 6.3% | 6.6% |
| 6 | Trinity Health* | Erie, Niagara, Onondaga, Albany, Rensselaer, Schenectady | 9 | 108,905 | 2,289 | 4.6% | 5.2% | 4.9% |
| 7 | NYU Langone Health | New York, Kings, Nassau | 4 | 111,601 | 1,936 | 2.1% | 5.3% | 4.1% |
| 8 | Catholic Health Services of Long Island | Nassau, Suffolk | 6 | 74,818 | 1,724 | 3.1% | 3.6% | 3.7% |
| 9 | Westchester Medical Center Health Network | Rockland, Orange, Westchester, Ulster, Delaware, Dutchess | 8 | 58,325 | 1,546 | 4.1% | 2.8% | 3.3% |
| 10 | Great Lakes Health System of Western New York** | Erie, Niagara, Cattaraugus, Chautauqua | 8 | 71,901 | 1,476 | 4.1% | 3.4% | 3.1% |
| 11 | SUNY Health Sciences Centers | Kings, Onondaga | 3 | 40,064 | 1,252 | 1.5% | 1.9% | 2.7% |
| 12 | University of Rochester Medical Center | Monroe, Ontario, Allegany, Livingston | 5 | 62,866 | 1,207 | 2.6% | 3.0% | 2.6% |
| TOP 12 SYSTEMS TOTAL | | | 100 | 1,494,847 | 33,362 | 51.3% | 71.0% | 70.7% |
| Grand Total - All Hospitals in Data Set | | | 195 | 2,106,667 | 47,172 | | | |

Data sources: NYS DOH hospital listings, Definitive Healthcare data from Medicare cost reports, hospital websites

*Trinity Health includes Catholic Health (Buffalo), St. Peter's Health Partners and Trinity Health.

** Great Lakes Health System of Western New York includes Kaleida Health, TLC Health Network, and Great Lakes Health System of Western New York. Hospital counts for each system include member hospitals and affiliated hospitals.

14. NYS DOH presentation, "Priority Next Steps for Transformation of Health Care Delivery System: Beyond the Walls of 'H': Rethinking CON and the Regulatory Framework," Sept. 7, 2017.

These trends have not gone unnoticed by members of the PHHPC. At the Council's retreat in September, Dr. Howard Berliner, a PHHPC member who is Chair of the Department of Health Policy and Management at SUNY Downstate's School of Public Health, noted that, "The creation of health care oligopolies has been accompanied by the demise of small stand-alone general hospitals. We in PHHPC deal with this every other month because we're either merging small hospitals into larger systems or we're watching small hospitals close."¹⁵

The largest non-profit health systems operating in New York City have ample assets and operating income, and are expanding.¹⁶ Audited financial statements for 2016, depicted in Table 5, show that New York Presbyterian's net assets exceeded \$6.6 billion, making it the financial powerhouse of New York's health systems. Northwell¹⁷ had net assets of \$3.6 billion followed by NYU Hospital Center with \$2 billion and the Mount Sinai system, with \$1.9 billion.

Together, these four systems had 98 percent of the total net assets of the top dozen health systems in New York, or 72 percent of the assets of those top systems with a positive net worth.¹⁸

“THE CREATION OF HEALTH CARE OLIGOPOLIES HAS BEEN ACCOMPANIED BY THE DEMISE OF SMALL STAND-ALONE GENERAL HOSPITALS.”

– DR. HOWARD BERLINER, PHHPC MEMBER

By contrast, one of the oldest, largest and most visible systems in the state, NYC Health and Hospitals (NYC H + H), faces significantly greater financial and operational challenges than do the other systems. H + H is a public hospital system that provides a disproportionate share of care to uninsured people and people with Medicaid insurance in New York City. While accounting for 20 percent of all inpatient discharges from hospitals in New York City, H + H has 48 percent of all *uninsured* inpatient discharges, 53 percent of *uninsured* ER visits and 80 percent of *uninsured* hospital clinic visits in the city. H + H accounts for half of all Medicaid inpatient discharges in the city and relies on Medicaid for two thirds of all patient services revenues.¹⁹ Projections for 2019 estimate an operating deficit of \$1.9 billion and the system's balance sheet shows a negative net worth of more than \$5 billion.²⁰ While other systems are strategically growing, H + H is struggling to fulfill its mission serving the people of New York City.

15. Howard Berliner, "Changing Nature of the Organization and Delivery of Health Care," September 7, 2017, <http://www.totalwebcasting.com/view/index.php?func=VIEW&id=nysdoh&date=2017-09-06&seq=1>

16. New York State Public Health Law currently prohibits for-profit hospitals, so all hospitals in the state are either private non-profit or public hospitals.

17. Northwell's operating income fell 69.4%, to 34.1 million, in the first three quarters of 2017, compared to the same period in 2016, according to a report in Crain's Health Pulse on December 1, 2017. Losses at Northwell's health insurance plan were blamed.

18. Removing NYC Health +Hospitals and Westchester Medical Center and its network from the calculations, as both have negative net assets.

19. Caress, Barbara, and James Parrott. *On Restructuring the NYC Health + Hospitals Corporation*. New York City: New York State Nurses Association, 2017.

20. Audited financial statements, fiscal year 2016.

TABLE 5

Largest hospital systems in New York ranked by net assets

NOVEMBER 2017

| Hospital or Health System* | Total Net Assets, FYE 2016 | Total Operating Revenue, FYE 2016 | Operating Income, FYE 2016 | Hospitals Included in "Hospital or Health System Financial Results" [Multiple non-hospital entities may also be included in financial results] |
|---|----------------------------|-----------------------------------|----------------------------|---|
| New York-Presbyterian | \$6,604,721,000 | \$7,424,831,000 | \$324,613,000 | NYPH, NYP/Lawrence Hospital, NYP/Hudson Valley Hospital, NYP/Queens, NYP/Brooklyn Methodist. |
| Northwell Health | \$3,602,526,000 | \$9,938,268,000 | \$95,867,000 | North Shore (including Syosset Hospital), Long Island Jewish Medical Center (including LIJH, LIJ Forest Hills, LIJ Valley Stream, Cohen Children's Medical Center, Zucker Hillside Hospital), Staten Island University Hospital, Lenox Hill Hospital, Southside Hospital, Glen Cove Hospital, Huntington Hospital, Plainview Hospital, South Oaks Hospital, Phelps Hospital, Northern Westchester Hospital, Peconic Bay Medical Center. |
| NYU Hospitals Center | \$2,054,865,000 | \$3,698,208,000 | \$280,544,000 | Tisch Hospital, NYU Hospital for Joint Diseases, NYU Lutheran Medical Center. |
| Mount Sinai Health System | \$1,942,123,000 | \$4,686,225,000 | \$39,085,000 | Mount Sinai Hospital, combined with separate statements filed for Beth Israel Medical Center, St.-Luke's Roosevelt and New York Eye and Ear Infirmary. |
| Catholic Health Services of Long Island | \$1,315,492,000 | \$2,523,431,000 | \$109,953,000 | Good Samaritan Hospital Medical Center, Mercy Medical Center, St. Catherine of Siena Medical Center, St. Charles Hospital, St. Francis Hospital, St. Joseph Hospital. |
| Montefiore Health System | \$1,188,138,000 | \$5,261,809,000 | \$49,804,000 | Montefiore Health System, Nyack Hospital, White Plains Hospital, Burke Rehabilitation Hospital, St. Luke's Cornwall Hospital. |
| Trinity Health (figures shown only for NYS hospitals; Trinity has 93 hospitals in 22 states) | \$1,110,684,000 | \$2,716,032,000 | (-\$26,952,000) | Figures shown are a sum for those from Catholic Health (Mercy, Sisters, Kenmore Mercy, Mount St. Mary's), St. Peter's (Albany Memorial, Samaritan, Seton Health, St. Peter's) and St. Joseph. |
| University of Rochester Medical Center | \$885,590,508 | \$2,164,177,545 | \$94,484,212 | Strong Memorial Hospital, Highland Hospital, F.F. Thompson Hospital, Jones Memorial Hospital, Noyes Health all audited separately but results combined here. |
| Great Lakes Health System of Western New York | \$509,448,000 | \$2,113,191,000 | \$60,464,000 | Kaleida Health (Buffalo General Medical Center, Women and Children's Hospital of Buffalo, Millard Fillmore Suburban Hospital, DeGraff Memorial Hospital); Erie County Medical Center, the latter audited separately but results combined here. |
| Rochester Regional Health System | \$465,040,000 | \$1,944,284,000 | \$45,008,000 | Rochester General Hospital, Clifton Springs Hospital, Newark-Wayne Community Hospital, Unity Hospital, United Memorial Medical Center. |
| WMC Health, Westchester Medical Center Health Network | (-\$221,426,000) | \$2,008,889,000 | \$1,336,000 | Westchester Medical Center, HealthAlliance; also includes Bon Secours Charity Health System, audited separately but results combined here. |
| NYC Health + Hospitals | (-\$5,107,554,000) | \$7,682,559,000 | \$40,145,000 | Bellevue, Coney Island, Elmhurst, Harlem, Jacobi, Kings County, Lincoln, Metropolitan, North Central Bronx, Queens, Woodhull. |
| | \$14,349,647,508 | \$52,161,904,545 | \$1,114,351,212 | |

Data sources: audited financial statements of hospitals, FYE 12-31-2016, except NYC H+HC 6-30-2016, NYU 8-31-2016

*Only hospitals that were financially integrated in 2016 (not clinically integrated, collaborative, management contract, etc.) are included in entries, except as noted

Some stakeholders and policymakers see the large non-profit hospital systems as the likely saviors of New York's failing hospitals. In 2016, Greater New York Hospital Association chief executive Kenneth Raske suggested at a state budget hearing that the state pay \$2.5 billion over five years to the big hospital systems to "adopt and adapt these facilities to the new world."²¹ In fact, state Health Care Facility Transformation Program grants and payments through the DRSRIP program have been helping struggling community hospitals to merge with nearby facilities or join large systems.

21. LaMantia, J., "N.Y. hospitals call for \$2.5 billion bailout for struggling facilities," Modern Healthcare, February 1, 2016. <http://www.modernhealthcare.com/article/20160201/NEWS/301279997>

In the FY 2019 State Budget, \$500 million has been allocated to ensure viability of financially-distressed safety net hospitals. In addition, the budget includes \$425 million²² for capital investment for health care facilities to transition those providers into financially sustainable systems.

Since 2015, DSRIP has directed funding to 25 Performing Provider Systems (PPS) around the state to develop integrated systems of care capable of assuming financial risk. Nearly all of the PPS networks are led by hospitals, and several are the same large systems highlighted in our research – such as New York Presbyterian, Mount Sinai, NYU Langone, Montefiore and Westchester Medical Center²³ – which have enlisted smaller hospitals into their DSRIP PPS networks.²⁴

The Bronx-based Montefiore Health System, for example, was given approval at the December 7, 2017, PHHPC meeting to become the “active parent” of both Nyack Hospital and St. Luke’s Cornwall Hospital in Orange County, after more than a year of being their “passive parent.”

“WE DO NOT BELIEVE THAT ABSENT THE ONGOING STATE SUPPORT THAT MONTEFIORE WOULD HAVE PARTNERED WITH ST. LUKE’S CORNWALL HOSPITAL.”

– DANIEL SHEPPARD, NYS DOH DEPUTY COMMISSIONER

As a “passive parent,” the system was able to exercise considerable behind-the-scenes control over the facilities through appointments to their boards and other means, but was not financially responsible for the hospitals. Parent organizations may only apply for “active parent” status when they wish to have the power to make budgetary decisions for the affiliated hospital, which also means assuming financial responsibility for the facility.

Montefiore’s adoption of Nyack Hospital and St. Luke’s Cornwall Hospital was encouraged by state DOH officials and made possible with state funds from the DSRIP program and a capital grant program to improve

efficiency at the SLCH Newburgh facility’s emergency department, explained DOH Deputy Commissioner Daniel Sheppard. “We do not believe that absent the ongoing state support that Montefiore would have partnered with St. Luke’s Cornwall Hospital,” he said, adding, “Absent that partnership, St. Luke’s Cornwall would not be in a position to be sustainable.”

Sheppard explained the Department of Health’s thinking in encouraging Montefiore to bring the community hospital into its system: “They are leaders in a payment model that has become a Department strategy for how to have sustainable health care – value-based payments. They are

22. Of that amount, \$60 million will be directed to community-based providers, such as clinics, and \$45 million to residential health care facilities, two categories that do not appear to include hospitals.

23. Northwell does not have its own PPS, but is a member organization of Advocate Community Partners, which is technically led by AW Medical, a physician practice. However, Northwell names 50% of the Board of Directors of Advocate Community Partners, giving it significant decision-making power.

24. In 2015, the Federal Trade Commission (FTC) issued a letter expressing concern about the potential anti-competitive effect of the DSRIP approach in fostering creation of these networks and immunizing them from anti-trust claims. See https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-center-health-care-policy-resource-development-office-primary-care-health-systems/150422newyorkhealth.pdf

responsible for over 200,000 lives. They have expertise they have built up over a number of years and we view them as an excellent partner with community hospitals.”

Hospitals merging with other hospitals or joining large systems can potentially achieve greater financial stability and better access to the capital needed to upgrade needed infrastructure and technology. But, in some cases newly-acquired hospitals are quickly converted to deliver other health care services (such as outpatient care or substance abuse treatment) or closed. (See the case study of Cornwall Hospital in Appendix A for an example.) Patients needing inpatient care are referred to larger hospitals within the system, sometimes referred to as “regional hubs” or “centers of excellence.”

“COMMUNITY HOSPITALS ...ARE THEY A THING OF THE PAST?”

– HARVEY LAWRENCE,
PPHPC MEMBER

“Community hospitals...are they a thing of the past? And if they are, from the state’s perspective, what does that mean?” asked PPHPC member Harvey Lawrence, President and CEO of the Brownsville Multi-Service Family Health Center, at the Council’s December 7 meeting. “What are the implications of consolidation? Will that result in greater access to care? Will that result in lower cost? What are the implications if we continue to see consolidation and community hospitals disappear?”

With encouragement from policymakers and payers, hospital systems are moving care to outpatient settings, such as urgent care centers and physician practices, while downsizing existing hospital facilities. One large-scale example is the ongoing transformation of Mount Sinai Beth Israel from an aging 800-bed inpatient facility to a new 70-bed hospital and multiple outpatient settings scattered across lower Manhattan.

As the existing facility is being downsized in preparation for closing, patients are being sent to other Mount Sinai facilities in uptown Manhattan or Brooklyn for maternity care, cardiac surgery and other services formerly provided at Beth Israel. (See case study in Appendix B.)

Another emerging trend is the replacement of full-service acute care hospitals with freestanding emergency departments.²⁵ The first in New York was opened by

**HOSPITAL SYSTEMS
ARE MOVING CARE
TO OUTPATIENT
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DOWNSIZING EXISTING
HOSPITAL FACILITIES.**

25. The future of freestanding emergency departments is uncertain, particularly with new draft recommendations from the April 2018 meeting of the Medicare Payment Advisory Committee (Medpac). The recommendations suggest a reduction in Type A emergency department payment rates by 30 percent for freestanding EDs that are within six miles of an on-campus hospital emergency department. This would reduce Medicare payment rates for approximately 75% of freestanding EDs across the country.

Montefiore Medical Center in 2013 at the former Westchester Square Medical Center in the Bronx. Another was opened in Manhattan by Northwell Health, near the shuttered St. Vincent's Hospital, parts of which became luxury condos. NYU Langone opened a third in Cobble Hill Brooklyn, where Long Island College Hospital had closed after much community uproar. Upstate, Adirondack Medical Center operates an emergency department and outpatient services at the former site of Placid Memorial Hospital in Lake Placid and Strong Memorial Hospital (Monroe County) is doing the same at the site where Lakeside Hospital closed.

**HEALTH SYSTEM
CONSOLIDATION AND
THE MOVEMENT OF CARE
INTO NEW SITES MAY HAVE
FINANCIAL BENEFITS,
BUT IT CAN ALSO POSE
RISKS TO PATIENT
SAFETY IF NOT
CAREFULLY MANAGED.**

– DR. ATUL GAWANDE

Health system consolidation and the movement of care into new sites may have financial benefits, but it can also pose risks to patient safety if not carefully managed, warned Dr. Atul Gawande and colleagues at the Harvard School of Public Health and Brigham and Women's Hospital in a recent JAMA article.²⁶ In such situations, the authors point out, clinicians frequently must travel to new practice settings, navigate unfamiliar infrastructure and care processes, and treat different types of patients. Consolidating a system's service line – such as obstetrics, psychiatry or substance use treatment – at one facility could increase the number of patients being seen at that facility and introduce types of patients with whom the clinicians are not familiar, creating cultural and other barriers to good quality care. The authors have developed a patient safety toolkit to guide management of system changes and expansion of practice sites.

26. Haas, S., Gawande, A., Reynolds, M., The Risks to Patient Safety From Health Systems Expansions, JAMA, April, 6th 2018, Accessed at: <https://jamanetwork.com/journals/jama/article-abstract/2678285>



New York's Oversight of Hospital Consolidation Through Certificate of Need

MergerWatch's study of New York's CON program did not attempt to determine whether hospital consolidation is necessary or wise, but rather whether state oversight through CON is transparent to the public, engaging of affected consumers and appropriately protective of community access to timely, affordable care. The study compared New York's CON policies and procedures with those found in other states. Staff interviewed New York State Department of Health (DOH) staff and key organizational stakeholders of the CON process, such as hospital associations. The study included regular attendance at PHHPC meetings and at a PHHPC retreat held in September 2017. MergerWatch staff also conducted two case studies of ongoing or just-completed hospital closings, Mount Sinai Beth Israel and Cornwall Hospital, including interviewing affected consumers and their representatives in local and state government. (Those case studies can be found in Appendices A and B.)

The "Report of the Public Health and Health Planning Council on Redesigning Certificate of Need and Health Planning,"²⁷ issued on December 6, 2012, included a number of suggestions for updating New York's CON process. Since the issuance of that report, DOH staff and PHHPC leaders have taken some positive steps to improve transparency of the CON process.

27. Accessed at https://www.health.ny.gov/facilities/public_health_and_health_planning_council/docs/con_redesign_report.pdf

For example, webcasting of PHHPC meetings is now routine. Also, DOH created a New York State Electronic Certificate of Need (NYSE-CON) system that, in theory, makes information about CON applications more available to the general public. In practice, however, the NYSE-CON system is difficult for consumers to find and navigate, and appears designed to streamline submission and processing of applications.

Meanwhile, efforts in recent years to streamline the processing of CON applications have led to nearly 90 percent of CON applications being considered and decided out of public view

EFFORTS TO STREAMLINE THE PROCESSING OF CON APPLICATIONS HAVE LED TO NEARLY 90 PERCENT BEING DECIDED OUT OF PUBLIC VIEW.

through “limited” and “administrative” review by DOH staff or by simple “notice” to the DOH, instead of through “full review” by PHHPC members in public meetings. The criteria for which CON applications qualify for which types of review are primarily financial ones, tied to the cost of the proposed project. In 2017, the PHHPC approved DOH-proposed changes to increase the cost thresholds of each type of application. Hospitals had argued that the thresholds should be increased to reflect the rising cost of construction. Under the new thresholds, full review is required if a proposed project will cost more than \$30 million for general hospitals and \$15 million for other facilities. Administrative review

is for projects costing \$15 million to \$30 million for general hospitals and \$6 million to \$15 million for other facilities. Limited review CONs can be used for projects under \$15 million for general hospitals and \$6 million for other facilities.

MergerWatch applauded the DOH’s decision to exempt from these increased dollar thresholds any applications that propose the decertification of services or conversion of beds to other purposes. However, the practical impact of that exemption may be minimal, since our study found that the stated cost of closing service units or decertifying beds typically is well below the \$6 million ceiling of costs under which limited review can be sought for decertification proposals. In fact, recent limited review CONs that allowed Mount Sinai to close units at Beth Israel stated that each project would cost just \$500, which is the CON application filing fee. So, transactions with such low stated costs would never qualify for full review in a public PHHPC meeting, even when the project would remove services from a hospital.

A fourth category of submissions, “notice,” was instituted in 2012 for non-clinical projects meeting certain criteria. Notice review requires simply the provider’s submission of written notice to the DOH. Over the past few years, according to DOH annual report statistics shown in Table 6, the number of projects being carried out with only written notice has climbed from 232 in 2012 to 449 in 2017. The number of projects receiving administrative review has fluctuated, but had an overall increase between 2012 and 2017. By contrast, the number of projects receiving full reviews by the PHHPC at public meetings has declined from a high of 195 in 2013 to 120 in 2017.

TABLE 6

Number, value and type of CON applications 2015-17

| Number of Submissions | | | | | | Value of Submissions (in thousands of \$) | | | | | Average Value (in thousands of \$) | | | |
|-----------------------|-------|------|-----|--------|-------|--|-----------|---------|-----------|-----------|---------------------------------------|--------|-------|--------|
| Year | Admin | Full | Ltd | Notice | Total | Admin | Full | Ltd | Notice | Total | Admin | Full | Ltd | Notice |
| 2012 | 182 | 139 | 352 | 232 | 905 | 475,513 | 2,879,596 | 347,124 | 274,346 | 3,976,579 | 2,613 | 20,717 | 986 | 1,183 |
| 2013 | 168 | 195 | 356 | 350 | 1,069 | 666,105 | 3,942,527 | 401,105 | 732,442 | 5,742,179 | 3,965 | 20,218 | 1,127 | 2,093 |
| 2014 | 150 | 124 | 281 | 395 | 950 | 811,405 | 1,703,852 | 356,175 | 343,715 | 3,215,148 | 5,409 | 13,741 | 1,268 | 870 |
| 2015 | 134 | 109 | 254 | 404 | 901 | 505,903 | 1,605,412 | 308,865 | 461,219 | 2,881,400 | 3,775 | 14,729 | 1,216 | 1,142 |
| 2016 | 182 | 122 | 279 | 458 | 1,041 | 956,007 | 1,467,853 | 416,873 | 719,674 | 3,560,407 | 5,253 | 12,032 | 1,494 | 1,571 |
| 2017 | 208 | 120 | 339 | 449 | 1,116 | 1,741,968 | 2,247,043 | 543,861 | 1,939,118 | 6,471,990 | 8,375 | 18,725 | 1,604 | 4,319 |

Data source: NYS Department of Health

NYS DOH data for the last three years of hospital CON applications show that limited review applications account for most of the overall increase in applications. The number of full review applications has stayed relatively constant and the number of administrative review applications increased slightly, but the number of limited review applications for hospitals increased dramatically from 180 in 2015 to 232 in 2017.

TABLE 7

Hospital CON applications by type and year

| | 2015 | 2016 | 2017 |
|------------------------------|------------|------------|------------|
| Limited Review | 180 | 193 | 232 |
| Administrative Review | 71 | 93 | 92 |
| Full Review | 26 | 34 | 30 |
| Total Applications | 277 | 320 | 354 |

Data source: NYS Department of Health

These statistics do not depict the before-and-after movement of some CON applications from a higher category of review to a lower category by DOH staff, out of public view. As the DOH's Charles Abel explained it, this effort "to try to streamline some of the CON events" has been "mostly in pulling applications out of full review so they could be handled administratively." Some applications, he added, "drop from an administrative review to a limited review."²⁸ The change "obviously doesn't change the complexity of those projects, it just changes the processing," he noted, pointing to increases in 2017 in the median processing time for administrative and limited review CONs, as depicted in Table 7. Such changes also mean that projects bumped down from full review to lower categories are not discussed in public at PHHPC meetings, but rather are handled administratively by DOH staff.

28. Charles Abel, in comments to the Public Health and Health Planning Council on February 8, 2018, as reported in the minutes of the meeting. He also stated that 197 submissions were "not approvable and the facility or the Department deemed them withdrawn."

Despite the increases from 2016 to 2017 to which Abel referred, the time frame in which most CON applications are being acted upon has been shortened significantly since 2012. Health providers have urged streamlining of the process so they can begin projects more quickly. However, such a significant decrease in the number of days spent processing an application most likely means a decrease in transparency, as well. The pace of processing applications is so fast in some instances that there is little or no time to inform affected communities about potential changes to their local facilities, and to seek public comment.

TABLE 8

Median days of CON processing time

| Year | Admin | Full | Ltd |
|------|-------|------|-----|
| 2012 | 123 | 166 | 61 |
| 2013 | 63 | 196 | 28 |
| 2014 | 69 | 143 | 19 |
| 2015 | 56 | 142 | 24 |
| 2016 | 55 | 129 | 20 |
| 2017 | 77 | 131 | 32 |

**From acknowledgement to approval*

Data source: NYS Department of Health

THE PACE OF PROCESSING APPLICATIONS IS SO FAST IN SOME INSTANCES THAT THERE IS LITTLE TIME TO INFORM AFFECTED COMMUNITIES.

For example, the establishment of Montefiore Health System as the “active parent” of St. Luke’s Cornwall Hospital was placed on the November 16, 2017, agenda of the PHHPC Establishment Committee, barely two weeks after a summary of the CON application was posted on the NYSE-CON system on November 2. No details of the proposal were provided to PHHPC members or subscribers to the PHHPC meeting listserv until one week prior to the committee meeting. No members of the public provided comments at the Establishment Committee meeting in Albany when the application was approved.²⁹ When the full PHHPC took up the application at a December 7 meeting in Manhattan, there again were no members representing the community present, but the Council did have a robust discussion about the transaction prompted by a letter sent in by Assemblymember James Skoufis, who represents Cornwall and surrounding areas.

Since the issuance of the PHHPC’s 2012 report, two other key health reform initiatives have been implemented in New York affecting hospitals and consumers. One is the Medicaid redesign program known as DSRIP, an \$8 billion initiative that has encouraged the creation of networks of hospitals and other types of providers. The other is the hospital community benefit program established under the Affordable Care Act that is requiring hospitals to undertake Community Health Needs Assessments. A recent report from the New York Academy of Medicine suggested

29. Assemblymember James Skoufis, who represents the affected area, said he was unaware that the transaction was on the Establishment Committee’s agenda until MergerWatch contacted him to ask his views of the proposal. When Skoufis tried to submit written comments in advance of the committee meeting, since he was unable to travel to Albany for the meeting on short notice, he says he was told he had missed the deadline for submitting comments 72 hours in advance of the meeting.

that these two initiatives are not sufficiently aligned with the New York State Prevention Agenda.³⁰ The MergerWatch study suggests a need for more transparent alignment of the CON process with the Prevention Agenda, DSRIIP and the hospital community benefit program, all of which affect hospitals and communities that rely on them.

Overall, the MergerWatch study concluded that the current CON system in New York is not transparent to the public and that it fails to notify and engage consumers affected by hospital consolidation. The study had 10 key findings.

**THE CURRENT
CON SYSTEM
FAILS TO NOTIFY
AND ENGAGE
CONSUMERS
AFFECTED
BY HOSPITAL
CONSOLIDATION.**

Key Findings

- 1. Hospitals are being closed, downsized, merged into large health systems and/or transformed into outpatient care facilities without adequate public notice or engagement of affected consumers.** While state officials may encourage hospitals to hold community meetings, there is no state requirement for public hearings in the local community on proposed closure plans *in advance* of a planned hospital closing.
- 2. Hospital closings and most downsizing efforts (such as eliminating the emergency department or maternity services) are reviewed only by the NYS DOH staff and state Health Commissioner under “limited review” procedures.** These transactions are not subject to “full review” by the state’s Public Health and Health Planning Council (PHHPC) in public meetings at which consumers could be informed and provide comments.
- 3. Unique to New York, hospital systems are allowed to begin the process of community hospital acquisition through “passive parent” relationships that are not subject to CON review.** These “passive parent” relationships are also not transparent to local health consumers – that is, their meaning for local health services availability and cost are unclear and often unexplored. CON review is required only when the parent system decides to apply for “active parent” status, often several years after the initiation of the “passive parent” relationship. By that time, acquisition of the community hospital has become viewed by hospital management (future employees of the merged system) as all but inevitable.

30. Libman, K., Ukeje, C, and Griffin, K, Alignment across Hospital Investments toward Building a Culture of Health in New York State, NY Academy of Medicine, Nov. 17, 2017, accessed at: https://nyam.org/media/filer_public/6d/62/6d629d09-5345-48a6-bf37-13484c101632/community_benefit-r4.pdf

- 4. Even when proposed transactions are subject to full review by the PHHPC, obstacles in the process frustrate potential consumer participation.** Meetings are not widely publicized and the agendas and voluminous exhibits are sent out electronically just one week in advance, to a list of people who must know to sign up to receive them. PHHPC meetings are held only in Albany or New York City, and only on weekdays. The lack of adequate advance notice that a particular transaction will appear on a PHHPC agenda makes it even less likely that affected consumers will be able to participate.
- 5. It is difficult to find user-friendly information on the NYS DOH website about CON applications, the CON review process or how to submit written comments on pending applications.** Copies of CON applications are not available on the website, leaving consumers in the dark about exactly what facilities are proposing to do. The NYSE-CON electronic system created by the NYS DOH is difficult for consumers to find and navigate.
- 6. The local CON review function once carried out by Health Systems Agencies (HSAs, all but one of which have closed due to funding cuts) has not been replaced with any organized system of soliciting and gathering consumer comments at the local level.** As a result, the place where an HSA recommendation would be included in DOH summaries of proposed transactions typically says “N/A.” A recommendation in the PHHPC’s 2012 report that Regional Health Planning Agencies be created and asked to provide local perspectives on CON applications was not implemented.
- 7. The CON review process has become centralized at the NYS DOH office in Albany, where a small number of staff members are reviewing proposed transactions and have limited time or ability to solicit consumer views on proposed transactions.**

PHHPC MEETINGS ARE NOT WIDELY PUBLICIZED. THE AGENDAS AND VOLUMINOUS EXHIBITS ARE SENT OUT JUST ONE WEEK IN ADVANCE TO THOSE WHO HAVE SIGNED UP.

8. The consumer voice is not well represented on the PHHPC, with only a single seat being designated for a consumer representative, and that seat having been vacant since mid-2016 when Art Levin resigned.

Of Levin's contribution to the PHHPC deliberations, PHHPC Chair Jeff Kraut said "Art was clearly the voice of New York... he was one of the individuals who didn't let us forget that this is the PUBLIC Health Council."³¹

While PHHPC members include many people with valuable expertise about the health system, there is no one from a consumer health advocacy/policy organization who could speak knowledgeably about the likely impact on consumers of CON applications under consideration. Some of the PHHPC members – including its chair and the chair of the important Establishment Committee (which considers all "full review" CON applications and gives recommendations to the full PHHPC) – are executives of health provider organizations that submit CON applications to the DOH (although these members are always careful to recuse themselves on votes concerning their own organizations). As will be noted in our recommendations below, some other states require greater numbers of consumer representatives on CON review boards.

THERE IS NO ONE ON THE PHHPC FROM A CONSUMER HEALTH ADVOCACY/POLICY ORGANIZATION.

9. Consideration of an application's impact on identified local or state health planning goals, such as those articulated in the state Prevention Agenda or in Community Health Improvement Plans, is not explicitly included in CON review and decision-making.

As of June 2018, "full review" CON applications for general hospitals will ask applicants about whether their proposed projects advance local Prevention Agenda priorities, which is an important step forward.

10. Although one of the original purposes of CON programs was to prevent unnecessary health cost increases, current CON review of hospital consolidations fails to consider whether these transactions might cause consumers, employers and insurers to pay higher prices.

This omission appears to be a missed opportunity at a time when studies are showing that hospital consolidation and resulting market concentration can lead to higher prices.³²

31. Jeffrey Kraut, in comments to the Public Health and Health Planning Council on April 14, 2016, as reported in the minutes of the meeting. Accessed at: https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2016-06-09/docs/agenda_full_council_meeting.pdf

32. Weil, A., "Market Concentration" and accompanying article by Fulton, B., "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses," in Health Affairs, September 2017 issue.



Recommendations

The study produced four categories of recommendations about how to make the process more transparent, drawing on practices found in other states and, in some cases, recommendations from the 2012 PHHPC report that were not acted upon. We put forth these recommendations at a time when we are aware that NYS DOH staff are leading regulatory modernization initiatives and members of the PHHPC have been engaging in strategic planning. All of these efforts are prompted by recognition that the CON process and other state regulatory mechanisms need to be updated to better suit the modern era of health care delivery in New York. In letters inviting participation in the DOH's regulatory modernization effort, Deputy Commissioner Daniel B. Sheppard noted that, "The rapid pace of health care innovation and reform has outpaced the ability of New York State's regulatory structure to adapt, resulting in a regulatory landscape that can be out of alignment with the very transformation strategies we are pursuing."³³

The impetus to modernize regulatory oversight of New York's institutional health providers must include consideration of whether potential changes will increase, rather than diminish, transparency of state decision-making. Changes should serve to better engage health consumers and give them a voice in the process in order to truly create a patient-centered health care system. Moreover, the CON process must protect community access to care, especially for vulnerable groups of patients. As PHHPC Chair Jeff Kraut stated at the September 2017 PHHPC

33. Sheppard, D. Letter of invitation to external stakeholders to participate in a workgroup examining the emerging use of off-Campus Emergency Departments in New York, Sept. 26, 2017.

retreat: “We have to be concerned about health equity and disparities among our community and the growing disparity between the haves and have-nots, where markets work differently or don’t work at all.”³⁴

“WE HAVE TO BE CONCERNED ABOUT HEALTH EQUITY AND DISPARITIES.”

**– PHHPC CHAIR
JEFF KRAUT**

The focus of these recommendations is on those CON applications that propose significant changes to hospitals or their services, such as eliminating or downsizing an essential service, closing a hospital or consolidating a hospital into a larger health system. Some of our recommendations could be fulfilled by changes in administrative practices and procedures. Others may require regulatory or legislative action.

1. Ensure that consumers affected by hospital closures or downsizing are notified and engaged

A. Require at least 90-days advance notice to affected communities when a hospital is going to close entirely or eliminate the emergency department, maternity services or other time-sensitive services. At minimum, notices should be posted at the hospital and on the hospital’s website and the NYS DOH website.

Multiple states require advance public notice when a hospital intends to close completely or discontinue essential services. Currently, New York State does not. Instead, New York requires a public hearing to be held by the Department of Health *within 30 days after* hospital closure and the DOH is expected to post information from that hearing within 60 days after that.³⁵ Moving the public notice to a period *before* closure and putting the responsibility on the hospital to help inform the public would greatly increase transparency and allow members of the affected communities to better prepare for impending changes.

California code requires a facility to provide public notice of a closure or elimination of a service at least 30 days prior to the proposed change. In addition, that notice must be posted at the entrance to the facility and be sent

MULTIPLE STATES REQUIRE ADVANCE PUBLIC NOTICE WHEN A HOSPITAL INTENDS TO CLOSE COMPLETELY OR DISCONTINUE ESSENTIAL SERVICES. NEW YORK DOES NOT.

34. Kraut, “The Role of the PHHPC in Public Health and Health Planning; Looking Back and Looking Forward.”

35. NYS Public Health Law- Article 28, section 2801.G accessed at <http://codes.findlaw.com/ny/public-health-law/pbh-sect-2801-g.html>

to the Department of Health and the county Board of Supervisors. The notice must include all proposed changes being made, list the three nearest facilities where patients could obtain the services being eliminated, and provide the contact information for the facility being closed or downsized, its parent system (if any) and the CEO, to enable affected members of the community to comment on the proposal. West Virginia mandates a public notice from facilities that intend to close at least three weeks before closure via press releases published in all newspapers within the hospital's area.

Notice requirements are already in place in New York State for other non-health oversight processes. For example, under the New York Worker Adjustment and Retraining Notification (WARN) Act, employers with more than 50 full time employees must give 90 days' warning prior to any significant changes in employment. This notification must be given to the affected employees, Department of Labor, employee representatives, and the Local Workforce Investment Board.

WE RECOMMEND THAT NEW YORK STATE REQUIRE HOSPITALS TO PROVIDE PUBLIC NOTICE OF CLOSURE OR ENDING OF TIME-SENSITIVE SERVICES AT LEAST 90 DAYS PRIOR TO THOSE CHANGES BEING MADE.

Since hospitals are large employers, they must already be required to notify their employees well in advance of closures and downsizings. The required practices from the WARN Act could be extended to residents of the communities that would be affected by hospital downsizings or closings, as well as public officials from those communities.

We recommend that New York State make the process more transparent to consumers by requiring hospitals to provide public notice of closure or ending of time-sensitive services at least 90 days prior to those changes being made. In addition, hospitals should be required to post notices at their facilities, and send a press release to all local newspapers and broadcast/on-line media, and to relevant local officials. The Department of Health should also post these announcements on its website. (See Appendix C for our detailed recommendations of how to make the CON section of the NYS DOH website more consumer friendly.) This would simply be another place for community members to obtain the information on the changes being made to their nearby facilities and prepare for those changes.

B. Require hospitals (or their parent systems) to present a closure rationale and plan at least 90 days in advance when closing a hospital or key hospital unit providing time-sensitive services (such as the emergency department or maternity care), indicating where affected consumers will be able to obtain needed care. Require modification of the closure plan based on feedback from affected consumers.

CON APPLICANTS SEEKING TO REDUCE, ELIMINATE OR RELOCATE A SERVICE SHOULD BE REQUIRED TO DESCRIBE THE EFFECT ON UNDERSERVED PEOPLE.

We urge that hospitals be required to give at least 90 days advance notice to affected communities before closure of a hospital or time-sensitive service, such as an emergency department or maternity services. When hospitals or systems give this notice, they should be required to provide a rationale for closure or elimination of services, including, but not limited to the following information: last year's service volume for the hospital or for the services to be eliminated; projected community need for the service within the hospital's service area; and details about where patients will be able to obtain access to the affected care once it is no longer at that facility. As required by existing regulations, but not currently included in the Limited Review Application process, the

CON applicant seeking approval to reduce, eliminate or relocate a service should be required to describe the "effect on the ability of low-income persons, racial and ethnic minorities, handicapped persons and other underserved groups and the elderly to obtain needed health care."³⁶

This closure plan should be submitted to the DOH and disseminated to the general public through local officials, provision to local media and through posting on the NYS DOH website. Provision of this plan would give consumers the opportunity to provide informed comments at the public hearing we urge be required prior to such closure, and would enable NYS DOH officials to work with local health officials to ensure continued access to care, including by requiring modifications to the closure plan and/or assessing the ability of remaining providers to fill the resulting service gap. This process would also give consumers time to understand any changes to their care and ensure they are still able to access the same services in a reasonable way.

C. Require at least one public hearing in the affected community, at night or on a weekend, at least 60 days in advance, when a hospital proposes to close, downsize or close a key service, such as the emergency department or maternity services.

Public hearings are a vital way to engage members of the community, provide them with information on how their local hospitals are proposing to change and elicit consumer comments that could affect closure plans. Vermont, New Jersey and North Carolina are three

36. Section 709.1, pursuant to section 2802 of the Public Health Law.

states that provide potential models of how to use public hearings to engage affected consumers. In Vermont, the Green Mountain Care Board, which evaluates CON applications, holds a public hearing for every application, with few exceptions for expedited review. The hearings are advertised and open to the public, allowing comment from community members and other stakeholders. Members of the public can also submit written comment on an application up to 10 days after the public hearing. Of course, Vermont has many fewer hospitals than New York does.

New Jersey holds public hearings when there is an application for a change in ownership or to close a health facility. North Carolina goes an important step further. Although they do not mandate a public hearing on every application, they require one for projects that are seen as competitive, that spend more than \$5 million, that are determined to be in the public interest by the State Health Planning and Development Agency or for which an “affected party” requests a hearing. In North Carolina, an “affected party” is defined broadly. This can be any person living in the area served by the applicant, anyone who uses health facilities in that area, any provider who practices in the area, a third party payer for facilities in the area, as well as the CON applicant itself. Most significantly, North Carolina holds hearings in the service area that is impacted. The department works with the members of the community to hold the hearing and make it accessible, so that the public may express concerns or comments on their local facility. A system like this could greatly improve consumer engagement around New York State.

**NEW JERSEY HOLDS
PUBLIC HEARINGS
WHEN THERE IS AN
APPLICATION FOR A
CHANGE IN OWNERSHIP
OR TO CLOSE A
HEALTH FACILITY.**

We urge adoption of a requirement for a public hearing in the affected community at least 60 days in advance of a proposed hospital closing, downsizing or closing of a key time-sensitive service, such as the emergency department or maternity services. We recognize that NYS DOH staff members do not have the capacity to organize, publicize or run multiple public hearings around the state each year. We suggest that local Population Health Improvement Program (PHIP) entities or county health departments be asked to take on the responsibility of organizing and publicizing public hearings for facilities in the areas they oversee, in collaboration with the hospital seeking CON permission to close or downsize. This process would give those working on health planning in specific areas a central role and more information about changes occurring in their jurisdiction. We urge that NYS DOH staff who will be reviewing the application, as well as any interested members of the PPHPC (such as those who live or work near the hospital in question) attend the public hearing, and that a summary and transcript be provided to the NYS DOH and PPHPC in a timely manner (no less than 30 days prior to the planned closing).

D. Require full review CONs, with opportunity for public comment, for closing of a hospital or for elimination of any hospital unit or service that could compromise timely and affordable access to those services in the affected community, as well as for converting emergency departments to part time operation.

We urge that “full” CON review by the PHHPC in public meetings be required for hospital closings, elimination of units that provide time-sensitive care, such as emergency departments or maternity services, and for hospital downsizing or transfer of services and/or beds from one facility to another within a given health system, when such transfers could have a potential negative affect on the availability of timely, affordable care in the affected community.

E. For “transformation” of multiple units within a hospital to ambulatory settings, require submission of a full review CON that spells out the hospital’s comprehensive plan and transition timeline for movements of care, along with a plan to inform the community and help patients navigate the new system of care.

Given the trends described earlier in this report – especially the movement of services from hospital inpatient settings to outpatient settings – it is particularly important to improve the transparency of hospital “transformation” initiatives and more fully engage affected consumers in reshaping local health delivery systems.

Currently, hospitals and health systems are being allowed to file a series of multiple, narrowly framed “limited review” CON applications to decertify beds and services over time. Through this process, hospital systems are able to gradually close facilities unit by unit and move services either to their other hospitals or to ambulatory settings without undergoing full CON review at a public meeting. A current example of this use of limited review CONs involves Mount Sinai Beth Israel in Manhattan. From November 2016 to March 2017, Mount Sinai submitted a series of limited review applications to close or decertify beds in multiple units, including maternity care, cardiac surgery and pediatric intensive care. Full CON review by the PHHPC (with opportunity for public comment) will be required only when the system proposes to build a new facility (such as the 70-bed hospital Mount Sinai plans to construct to replace its current much larger facility). By the time the replacement proposal is submitted, substantial sections of the original facility may have been largely deconstructed or moved to other Mount Sinai facilities, enabling the system to argue that the replacement need not include everything previously offered at the original Beth Israel hospital.

IT IS PARTICULARLY IMPORTANT TO IMPROVE THE TRANSPARENCY OF HOSPITAL “TRANSFORMATION” INITIATIVES AND MORE FULLY ENGAGE AFFECTED CONSUMERS IN RESHAPING LOCAL HEALTH DELIVERY SYSTEMS.

We propose a reevaluation of the way the hospitals and health systems seek state approval to transform service delivery, including moving care to outpatient settings and transferring services from one location to another. The goal is to make more transparent to community members what the total “transformation” plan will entail, enabling consumers to provide comments with this full knowledge.

Specifically, we propose that if a hospital (or its parent health system) seeks to close (or transfer elsewhere, such as to an ambulatory setting or a different facility within the system) more than one service within a year, it should be mandated to go through full CON review to do so. Within this full CON review, hospital systems should be required to lay out their plans for how and where health consumers will obtain those services in the future, how patients will be kept informed and what they should expect their new system to look like in the next three to five years. A transformation plan should explain the likely impact of the proposed delivery system changes on consumers who rely on Medicaid or are uninsured, and those for whom travel to other facilities may present an obstacle to obtaining care. This information is necessary for community members to understand how and where they will be accessing the care they need, potentially at new locations, and to provide comments to the PHHPC and DOH to inform CON decision-making.

A TRANSFORMATION PLAN SHOULD EXPLAIN THE LIKELY IMPACT ON CONSUMERS WHO RELY ON MEDICAID OR ARE UNINSURED, AND THOSE FOR WHOM TRAVEL TO OTHER FACILITIES MAY PRESENT AN OBSTACLE TO OBTAINING CARE.

2. Improve transparency, consumer engagement and accountability when hospitals join health systems.

While there can be positive results when community hospitals join large health systems, such as the ability to participate in value-based care reimbursement plans, there can also be downsides, such as loss of local control of a community hospital. Executives of these large systems can and do make decisions to close services at local hospitals (such as emergency departments and maternity care) and direct consumers to other facilities within the system that offer the care. The result could be reduced access to care within a community and longer travel times to obtain care elsewhere. As noted above, a new article by Dr. Atul Gawande and colleagues has flagged potential patient safety issues when system changes send patients or clinicians to new locations.

When system takeovers of local hospitals are proposed, the affected consumers deserve to know the full implications, both positive and negative. One of the obstacles to such transparency is the use in New York State of “passive parent” governance by systems to begin takeover of community hospitals without any CON review. We urge that New York eliminate “passive parent” governance

and allow only an “active parent” relationship that requires full CON approval. In addition, we recommend that mergers, acquisitions, and “active parent” relationships be made subject to post-transaction monitoring to allow for increased oversight of changes to large health systems.

THE “PASSIVE PARENT” DESIGNATION OFFERS AN OPPORTUNITY FOR A SYSTEM TO BEGIN TO EXERCISE AUTHORITY OVER ITS ACQUISITION TARGET, WITHOUT HAVING FINANCIAL RESPONSIBILITY.

A. Eliminate health systems’ ability to enter into non-transparent “passive parent” relationships as the first step in takeovers of local hospitals and require “active parent” designations, which must go through full CON review.

The “passive parent” designation offers an opportunity for a system to begin to exercise authority over its intended acquisition target, without having financial responsibility. This creates an environment that facilitates consolidation while allowing for little oversight of the parent entity, since passive parent relationships do not undergo CON review. A 2012 presentation to the PHHPC by Peter J. Millock (former General Counsel to the NYS DOH) suggested that a health system may employ a “passive parent” relationship with a community

hospital it wants to acquire in order to “arrange governance just to avoid active parent treatment.” The presentation noted that “the free pass given to passive parents may allow them to escape responsibility for the hospitals in their system.”³⁷

No other state allows for the distinction between passive and active parent in system takeovers of local hospitals. The level of transparency and accountability in the arrangement is simply too low. For these reasons, our recommendation is that the distinction between “active” and “passive” parentage in hospital acquisitions be eliminated, so that all of the issues associated with such consolidation can be grappled with in public and with focus.

If eliminating passive parent status is for some reason not feasible, we believe other changes can be made to the process to help increase transparency and accountability. In its 2012 report, the PHHPC put together a set of recommendations to reform the CON process. One part of these recommendations addressed the oversight of “passive parent” relationships. Although these recommendations were not ultimately adopted, they are useful to reconsider now. The Council suggested that prior to the start of a passive parent relationship, facilities would have to notify the

NO OTHER STATE ALLOWS FOR “PASSIVE PARENTS” IN SYSTEM TAKEOVERS OF LOCAL HOSPITALS.

37. Peter J. Millock, “Observations and the Impact of the Public Health Law and Current Health Department Regulations on Healthcare Organization Governance Structures,” presentation to the Health Planning Committee of the Public Health and Health Planning Council, September 19, 2012, accessed at https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2012-09-19/docs/peter_millock_presentation.pdf

Department of Health and include the entities involved and proposed affiliation agreement. The DOH would then have 90 days to recommend if the PHHPC should disapprove of the agreement, for reasons such as concern that the new relationship might have an adverse effect on the availability or price of health care in a community. If the PHHPC did not disapprove, the passive parent relationship would be given three years at which point it would either have to apply for active parent status or for extension of the passive parent relationship.

B. For transactions involving a consolidation, require CON applicants to clearly articulate the public need served by the transaction and provide long-range plans (at least three years) predicting the impact on affected patients' ability to obtain care. Require a public hearing in the affected community to solicit consumer comments. Require a plan for continuing engagement of local health consumers in governance of the hospital.

Health systems have a range of reasons why they enter into "active parent" relationships with community hospitals, but they are not generally required to fully articulate those reasons in CON applications. Sometimes, an underlying but not fully disclosed reason could be to enable a major system headed by an academic medical center to acquire a new source of patients who can be referred to the medical center for complex and highly-reimbursed services. In other cases, the transaction's primary goal may be to increase a system's regional market share. Sometimes, struggling local hospitals are looking to a parent system for financial salvation, with the potential price of loss of local control that can lead to having some of their services consolidated into the system's regional "centers of excellence" at other hospitals.

Recognizing the significant changes that can occur with changes of governance, Connecticut requires the provision of a three-year plan for all transactions that involve a change of ownership. This plan must include a description of how health care services will be provided in the first three years after the change in ownership, including any planned introduction of new services or elimination, consolidation or reduction of existing services.³⁸

We recommend a similar requirement in New York, with some additional features. For all transactions involving consolidation of hospitals, the CON applicant should be required to articulate how the transaction will serve a public need, such as providing services not currently available in the hospital's catchment area, strengthening the quality of care or addressing public health priorities that have been identified by local health departments or health planning partnerships. Even if the transaction is seeking to simply provide better access to capital for the

**CONNECTICUT
REQUIRES THE
PROVISION OF
A THREE-YEAR
PLAN FOR ALL
TRANSACTIONS THAT
INVOLVE A CHANGE
OF OWNERSHIP.**

38. Connecticut Office of Health Care Access, Certificate of Need (CON) Process Statutory Authority, Section 19a-639a.c.1A.

smaller hospital, addressing the issue of public need should help to make the reasons for the active parent status more transparent. The application should also explain how local participation in governance of the hospital will be maintained following the acquisition, merger or establishment of active parent powers, such as through maintaining seats on the hospital board for local representatives.

FOR EACH PLANNED RECONFIGURATION OF SERVICES, THE APPLICANT SHOULD BE REQUIRED TO EXPLAIN HOW PATIENTS WOULD BE ASSISTED IN TRAVELING TO NEW LOCATIONS AND NAVIGATING AN UNFAMILIAR SYSTEM OF CARE.

The applicant should also be asked to describe how the new governance arrangement will affect the current service delivery patterns, such as relocating some services to other facilities, closing units of the hospital or establishing referrals to a system's center of excellence for certain types of complex care. For each planned reconfiguration of services, the applicant should be required to explain how patients would be assisted in traveling to new locations and navigating an unfamiliar system of care. As well, the applicant should predict how current case mix (provision of Medicaid clients vs. commercially-insured clients, those with Medicare and those with no insurance) would potentially change under the new arrangement.

To ensure that affected consumers are notified about the proposed merger or "active parent" establishment and are able to submit comments, we recommend requiring a public hearing in the affected community, after work hours or on a weekend, with a transcript to be provided to the DOH and PHHPC. Other states do hold public hearings on such transactions. For example, the Massachusetts Department of Health scheduled public hearings in December 2017, each beginning at 5 p.m., in two communities that would be affected by the proposed merger of several health systems, including 13 hospitals, on the North Shore and Cape Inn. (See announcement below.)

Comments received from the public and local health planning officials would inform evaluation of the applicant's plan by NYS DOH staff and members of the PHHPC. The PHHPC would have the ability to attach conditions to the approval of any such transaction and require monitoring of the applicant's compliance with the conditions, as described below in our recommendations for post-transaction monitoring and enforcement.

Public hearings set on hospital merger

By Paul Leighton Staff Writer Nov 14, 2017

BEVERLY — The public will get its first chance to speak next month about a proposed merger that would affect several hospitals on the North Shore and Cape Ann.

The Massachusetts Department of Public Health has announced it will hold public hearings on Dec. 5 and 6 regarding the proposed merger of Beth Israel Deaconess Medical Center, New England Baptist Hospital, Mount Auburn Hospital, Lahey Health System, and Seacoast Regional Health Systems.

Lahey Health System includes Beverly Hospital, Lahey Medical Center in Peabody, Addison Gilbert Hospital in Gloucester, and the Lahey Outpatient Center in Danvers. Seacoast Regional is the parent company of Anna Jaques Hospital in Newburyport.

The public hearings are scheduled for Dec. 5 at 5 p.m. at Roxbury Community College and Dec. 6 at 5 p.m. at Gloucester High School.

If the merger is approved, the new system would include 13 hospitals and more than 800 primary care physicians and 3,500 specialists.

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C. For certain large-scale transactions (such as hospital mergers and establishment of “active parent” relationships), consider the use of “limited life” CONs and post-transaction monitoring to assess whether promised benefits to the community and service improvements have been realized.

In recent years, the DOH and PHHPC have been employing “limited life” CONs for ambulatory surgery centers (ASCs), and requiring them to report annually on whether they have met certain conditions, such as achieving targets for the provision of charity care and care to patients

with Medicaid insurance. (Hospitals had expressed concerns that independent ASCs could draw off commercially-insured patients and leave hospitals to serve Medicaid patients and the uninsured.)

As result of the limited life process, the DOH is able to tell the PHHPC whether the targets have been met when limited life CONs come up for review. The consequence of failing to meet such a target can be that an ASC does not get a desired permanent CON, but instead is given an extension on its limited life CON and direction to increase the provision of charity care.

This approach has brought transparency to the ASC CON process, but its effectiveness is open to debate. As of the latest DOH annual report to the PHHPC in February 2018, only five of the 27 limited life ASCs that have been operating for over a year were meeting their charity care targets, which were typically quite low – usually

2 percent or 2.5 percent – although most were meeting or exceeding targets for service to Medicaid enrollees. At a PHHPC meeting on October 11, 2017, Harvey Lawrence, a PHHPC member, noted that most of the limited life ASC projects were underperforming on charity care and asked “is it possible to encourage these institutions to reach out to CHCANY – the Community Health Care Association of New York State, which represents providers of primary care to many low-income New Yorkers – and have some criteria or metrics to show ASCs are making a quantifiable effort to increase charity care?” Howard Berliner, another PHHPC member, asked what the council’s options are when “these places are coming up for their second review and they are not meeting the relatively weak standards we’ve set.” Berliner added that “Looking at the list... I think all the places in New York City are below what I think is a very minimal bottom threshold that we’ve set. It’s unconscionable.”

We do not suggest using limited life for all CON applications, although some states do, such as Massachusetts. We do, however, believe follow-up and more significant oversight is necessary for hospital mergers and when health systems become active parents of community hospitals. Therefore, we recommend a more rigorous and in-depth use of post transaction monitoring.

FOLLOW UP AND MORE SIGNIFICANT OVERSIGHT IS NECESSARY FOR HOSPITAL MERGERS AND WHEN HEALTH SYSTEMS BECOME ACTIVE PARENTS OF COMMUNITY HOSPITALS.

Within a specified time period following approval of a CON for the types of transactions spelled out above, we recommend requiring the CON applicant to provide yearly reports to the DOH and PHHPC. These reports should describe any changes in service configurations or case mix that have occurred since project approval and demonstrate adherence to any conditions that were attached to the CON approval. In addition to the reports provided by the applicant, an “independent monitor” could be hired to act as a compliance reporter for large mergers and acquisitions. Such reporting would increase transparency of the actual effects of the transaction and could lead to an extension of a limited life CON, with increased pressure to comply with terms of the approval in order to win a permanent CON.

Connecticut has a system of post-transfer independent consultants in place to monitor the progress of larger mergers, meet with representatives from the parent organization and its new affiliate, and report back to the state’s Office of Health Care Access. The monitor, often a consulting or public accounting firm, is selected by the applicant and approved by the state agency. The applicant pays for the monitor, which reports to the state on matters involving compliance of the applicant with conditions established in the awarding of the CON. This process allows for more oversight and accountability of new active parent relationships. In addition, more active monitoring would assist the DOH in gathering information about trends in mergers and acquisitions to better understand the current system as a whole.

FOR MERGERS AND SYSTEM TAKEOVERS OF COMMUNITY HOSPITALS, WE RECOMMEND REQUIRING THE CON APPLICANT TO PROVIDE YEARLY REPORTS TO THE DOH AND PHHPC.

CONNECTICUT HAS A SYSTEM TO MONITOR THE PROGRESS OF LARGER MERGERS.

We also recommend consideration of guidelines for financial penalties to be imposed when a CON applicant has failed to comply with stated conditions of CON approval. Many states have penalties, generally financial, imposed for either willful or unintended violation of CON conditions. Actual imposition of penalties appears uncommon, but their existence may inform applicant compliance, and especially the work of law firms, accounting and consulting firms assisting in CON or related work which will have multiple and frequent interaction with state authorities.

3. Improve the overall transparency and consumer engagement of the current NYS CON process

In preparing this set of recommendations, we compared New York’s process to practices we found in other some states, as described below and summarized in the table provided at the end of this section.

A. Increase the number of consumer representatives on the PHHPC.

Currently, only one seat on the 24-member PHHPC is specifically designated for a representative of a health care consumer advocacy organization³⁹, and it has been vacant since mid-2016.

Other states have more CON review board seats earmarked for consumer representatives. For example, New Jersey requires that five of the nine board members who review CON applications are consumer representatives. Maryland’s review board has 15 members, nine of whom are consumer representatives. Delaware’s board has four out of 15 members from the “public-at-large,” and requires that the Chair and Vice Chair of the board are both appointed from among those four members.

**OTHER STATES
HAVE MORE CON
REVIEW BOARD
SEATS EARMARKED
FOR CONSUMER
REPRESENTATIVES.**

The definitions of consumer members differ slightly from state to state, but generally say the same thing. New Jersey defines consumer representative as “consumers of health care services who are not providers of health care services or persons with a fiduciary interest in a health care service.” Maryland defines the group as “individuals who do not have any connection with the management or policy of a health care provider or payer.”

With these definitions in mind, we recommend the designation of significantly more seats (preferably a majority) on the 24-member PHHPC for consumer representatives, as defined in ways described by New Jersey or Maryland. We suggest that at least one of these representatives be selected because of his/her ability to voice the concerns of low-income health consumers and/or those suffering from health disparities. We also suggest that a leadership role in the PHHPC should be given to one of the consumer representatives, as in Delaware’s system, and that at least one consumer representative be appointed to the Establishment Committee, which conducts the public meetings at which “full review” CON applications (such as hospital mergers and establishment of systems as “active parents” of community hospitals) are discussed and voted upon.

39. NYS Public Health Law section 220, accessed at: <http://codes.findlaw.com/ny/public-health-law/pbh-sect-220.html>

In order to ensure active and informed participation by these consumer representatives, we urge that the state take steps to “level the playing field” for them, in comparison to representatives of large health systems, nursing homes and other provider groups, whose participation is enabled with salary and administrative support. We urge that the state provide stipends for those consumer representatives whose employers cannot support their participation in the PHHPC as part of their assigned job responsibilities. Moreover, we urge the provision of technical assistance or training to help consumer representatives evaluate and assess the hundreds of pages of exhibits and attachments that often arrive just one week in advance of PHHPC meetings.

Another potential avenue for meaningful engagement of consumers in the CON process could be the use of consumer health organization representatives as advisory experts to the DOH and PHHPC for certain CON applications that present significant potential changes to health care access in a particular region. This advisory panel could be used on an ad hoc basis when

specific issues are brought to the PHHPC that would benefit from additional discussion with consumer health advocates. This process would be similar to the DOH’s procedure in 2017, when outside experts were asked to evaluate the potential impact of approving two additional heart transplant programs. An advisory committee made of consumer health organizations could assist in this way when a transaction has potential impact on consumer access to care or raises other issues of concern to affected consumers.

**NEW JERSEY
DEFINES CONSUMER
REPRESENTATIVES AS
“CONSUMERS OF HEALTH
CARE SERVICES WHO
ARE NOT PROVIDERS OF
HEALTH CARE SERVICES
OR PERSONS WITH A
FIDUCIARY INTEREST IN
A HEALTH CARE SERVICE.”**

**B. Require facilities to submit letters of intent
30 days prior to filing a CON application.**

In the current system, New York consumers do not receive timely, user-friendly notice of proposed changes at local health care facilities. The addition of a Letter of Intent requirement would serve to alert the public at an earlier stage of the CON process. A Letter of Intent could be a much shorter, uncomplicated and more consumer-friendly document than a full CON application, providing an outline of a proposed project.

Florida, Vermont and Washington all require CON applicants to submit letters of intent 30 days prior to submitting a CON application. After receiving these letters, each state handles the information differently. Vermont posts a public notification within five days of receiving the letter. The posting details the project, facility, and expected cost, which is all information from the letter of intent. Washington posts a copy of the letters submitted on a monthly basis. The Washington requirements for what should be in a Letter of Intent include name and location of the facility,

the changes proposed, the expected cost, a brief description of the service area, and a contact at the facility. Florida batches the letters received and posts the facilities, their proposed projects, and their location in a group every six months. Florida and Washington do not require letters of intent for their lowest level of CON review, equivalent to New York’s “Limited Review.” If New York State were to adopt the Letters of Intent system, it would make sense to do so with Full and Administrative review (assuming hospitals are no longer able to submit multiple limited review CONs to close units of a hospitals). This means including the information in letters of intent and posting the full copies of letters received on a frequent basis (weekly or monthly). This way, both the public and the state can plan for major potential changes being made to hospital systems on a regular basis and with as much information as possible.

C. Make complete CON application materials available to affected consumers and their representatives/advocates at least 30 days prior to PHHPC review (for full review CONs) or NYS DOH review (for limited and administrative review CONs).

The current practice of making hundreds of pages of documents about full review CON applications available just one week prior to their consideration by the PHHPC’s Establishment Committee does not give members of the public or consumer health advocates (or PHHPC members for that matter) adequate time to review the often-lengthy staff summaries and attachments prior to the Establishment Committee meetings. Those CON applications that undergo administrative or limited review are not available at all, except in truncated descriptions on the NYSE-CON system.

We recommend that completed CON applications and staff summaries be made available to the public (potentially through posting on the NYS DOH website) at least 30 days prior to their being placed on the agenda for a PHHPC Establishment Committee or prior to action being taken by DOH staff on limited and administrative review applications. This time period would give consumers an opportunity to study the details of CON applications and thus be better prepared to submit comments, either by mail or email on limited and administrative review applications or potentially in person at Establishment Committee meetings for full review CONs. We also suggest that DOH staff provide PHHPC members with any consumer comments received on full review CON applications prior to the meeting at which they are being considered.

COMPLETED CON APPLICATIONS AND STAFF SUMMARIES SHOULD BE MADE AVAILABLE TO THE PUBLIC AT LEAST 30 DAYS PRIOR TO THEIR BEING PLACED ON A PHHPC AGENDA OR ACTION BY DOH STAFF.

Other states make the entire CON application or portions of the application available to consumers for all applications – either through the relevant state agency website or upon request to agency officials. In Connecticut, the Office of Health Care Access (now a part of the Department of Health) posts complete CON files on its website. The complete file enables any observer to witness the correspondence, the filings, the source material and supporting expert studies. For the larger CON applications, for which a public hearing is held, the statements and submissions of other parties are also made available. These postings—of larger and larger files, as an application or case proceeds—do compel the public to wade through the forms and argot of the field. However, the transparency achieved—access to information from all of the parties, in a timely manner—seems valuable.

Some states do not post the full CON applications on their websites. Instead, they respond promptly to requests for CON applications from members of the public. In Florida, the CON process and access to information is enhanced by the efficiency of the Agency for Health Care Administration (AHCA). AHCA functions in a timely and open manner in response to request. The “response to request” method is perhaps less ideal than Connecticut’s practice of posting

**CONNECTICUT’S
OFFICE OF HEALTH
CARE ACCESS POSTS
COMPLETE CON FILES
ON ITS WEBSITE.**

**NEW YORK
CAN DO BETTER
IN EASING
PUBLIC ACCESS
TO CON
INFORMATION.**

the applications directly, because it requires that the public know something about how to identify and request the desired documents. AHCA is generally prompt, however. In Massachusetts, a separate agency—CHIA—is responsible for the assembly of background information and studies on hospital and health facility pricing. This model (also seen with the Comprehensive Health Care Cost Commission in Pennsylvania) has the merit of separating other public health and regulatory processes from information gathering and analysis.

New York can do better in ease of access to information, through (a) the Department of Health’s web site, (b) by response of Department officials to requests for information, and (c) by expediting the Department’s response to all “FOIL” requests pertaining to CON applications.

D. Improve the user-friendliness of the NYS DOH website so consumers can more easily find information about proposed consolidation affecting their local hospitals (including proposed mergers, affiliations, downsizing, transfer of beds to other facilities within a health system and closings of hospital units or the entire hospital).

We urge changes to the NYS DOH website to improve its user-friendliness for members of the general public who are seeking information about proposed changes at their local hospitals. It is difficult for users to find Certificate of Need information when starting from the Department of

Health homepage. If visitors do manage to arrive at the CON homepage, they find information that is clearly designed for CON applicants and not for informing the public about the CON process and current applications. Finally, it is often difficult to find CON applications that have been submitted through the DOH website. The information in the New York State Electronic Certificate of Need (NYSE-CON) database is incomplete and the database is difficult to navigate, requiring the user to guess a particularly-worded version of a hospital name to divulge recent CON applications, and giving completely different results for slightly different versions of hospital names.

WE URGE CHANGES TO THE NYS DOH WEBSITE TO IMPROVE ITS USER-FRIENDLINESS FOR MEMBERS OF THE GENERAL PUBLIC WHO ARE SEEKING INFORMATION ABOUT PROPOSED CHANGES AT THEIR LOCAL HOSPITALS.

Other states have much more user-friendly websites that are more intuitive to navigate for the average consumer. For our comparison of the NYS website to another state and our specific suggestions for how to improve the NYS DOH website, see Appendix C, “Making the NYS DOH website more consumer-friendly in providing CON information.”

4. Ensure CON-approved projects protect access to timely, affordable care and advance identified local and state health planning goals

When staff summaries of full review CON applications are presented to PHHPC members, the spot where a recommendation from a local Health Systems Agency should go (under state statute) most frequently says N/A. Only one local planning body (Common Ground Health in Rochester) still reviews CON applications and makes recommendations up to the PHHPC.

The lack of engagement of local health planning groups and the consumers they represent hampers effectiveness of the CON review process. We strongly urge the NYS DOH and the PHHPC to consider means of bringing the perspectives of local health planners and community members into the CON process.

We believe the PHHPC should consider as part of CON review whether the proposed transaction would advance or detract from the local health priorities established by one or more of the following: the relevant county or city health department, the Prevention Agenda, Community Health Improvement Partnerships (which have brought together hospitals and local health departments in some areas of the state to do joint health planning), the local Population Health Improvement Program (PHIP) or the hospitals’ own community benefit plans (if relevant).

THE LACK OF ENGAGEMENT OF LOCAL HEALTH PLANNING GROUPS AND THE CONSUMERS THEY REPRESENT HAMPERS EFFECTIVENESS OF THE CON REVIEW PROCESS.

This idea was discussed at the September 2017 PHHPC retreat where multiple members of the Council brought up the potential role of the PHHPC in considering some of these issues. Dr. Angel Gutierrez echoed a sentiment expressed by other members as well saying, “In every CON application we need to ask an open ended question, how are you contributing? How is this project going to contribute in fulfilling the Prevention Agenda? The triple aims and health in all policies.”⁴⁰

A. Ask CON applicants to articulate the proposed project’s impact on identified state and local health planning priorities and explain the process, tools and timeframe planned to inform and engage local community health partners.

The 2012 PHHPC report suggested creation of Regional Health Improvement Collaboratives (RHICs), which would be responsible for promoting the “Triple Aims” in their regions: better health for populations, better care and lower per capita cost of care. RHICs would be expected to advance these aims through many activities, which included engaging stakeholders, but also by giving recommendations to the PHHPC about facilities in their region and making state grant recommendations. There were many other suggestions of how the 11 RHICs, one for each region devised by the PHHPC, could assist in regional health planning.

The RHICs did not come to fruition. Instead, in 2015, the Population Health Improvement Program (PHIP) was introduced. PHIP objectives were the same as those set out for the RHICs. However, the PHIP activities were mostly expected to be around organizing locally and supporting other organizations’ efforts. The PHIPs were not given a role in the CON process.

Because PHIP is now an established program that has relationships with stakeholders in each of the 11 regions, we believe PHIPs could be useful in collecting and providing to the DOH, and especially to PHHPC members, relevant health status data and local health planning priorities to help inform CON decision-making. This information would provide the context in which DOH staff PHHPC members could assess the potential impact of a proposed hospital transaction on consumers’ ability to obtain needed health care in a timely manner and on achievement of local

THE PHHPC HAS BEEN CONSIDERING A PROMISING PROPOSAL TO REQUIRE “FULL REVIEW” CON APPLICATIONS FROM HOSPITALS TO SPELL OUT HOW THE PROPOSED PROJECT WOULD ADVANCE LOCAL PREVENTION AGENDA PRIORITIES.

40. Angel Gutierrez, “Strategic Retreat Meeting of the Public Health and Health Planning Council,” September 7, 2017, <http://www.totalwebcasting.com/view/index.php?func=VIEW&id=nysdoh&date=2017-09-06&seq=1>

health planning goals. Also, we recommend that PHIPs are routinely sent copies of full review CON applications filed by facilities in their regions to allow them and the local health officials with whom they are engaged to be made aware of any proposed shifts in health care service delivery and assess how these shifts would advance or detract from local population health priorities.

In the fall of 2017, the PHHPC began considering a promising proposal to require “full review” CON applications – including those for hospital mergers, acquisitions and “active parent” governance of hospitals by health systems – to spell out how the proposed project would advance local Prevention Agenda priorities identified by the community in the most recent Community Health Improvement Plan (CHIP) or hospital Community Service Plan (CSP). Proposed additional questions on the CON application include “Has your organization engaged local community partners including the local health department? Please describe the types of organizations you engaged.”

During discussion of this proposal at the December 6, 2017, PHHPC committee meeting, PHHPC Vice Chair Dr. Jo Ivey Boufford, Immediate Past President of the New York Academy of Medicine, said that “for folks that are already doing this, it should be easy for them to fill in that information, while for others it will be a little more difficult.”

A MODEL OF HOW TO INTEGRATE COMMUNITY HEALTH PLANNING PERSPECTIVES INTO THE CON PROCESS CAN BE FOUND IN MASSACHUSETTS.

This approach does not require providers to engage with other community constituents, but prompts hospitals and other providers to consider doing so and indicates Department of Health interest or concern with the issue.

Ellen Rautenberg, a member of the PHHPC’s Public Health Committee, suggested that DOH staff consider applying this proposed requirement for reporting how a project would advance local Prevention Agenda priorities to CON applications to reduce or eliminate hospital services. The DOH/PHHPC proposal under

consideration would leave out many such CON applications that can often be submitted through “limited” or “administrative” review processes.

A model of how to integrate community health planning perspectives into the CON process can be found in Massachusetts. Recently, that state has taken steps to much more closely tie the CON process, which is called Determination of Need (DON) in Massachusetts, to community health planning.⁴¹ A new DON regulation specifically requires DON applicants to include plans for addressing state-defined health priorities through creation and funding of Community-Based Health Initiatives (CHIs). The CHIs are intended to improve primary and preventive health services for vulnerable populations with a focus on such priorities as reducing health disparities, preventing and managing chronic disease, and eliminating youth violence.

41. Massachusetts Determination of Need (DON) regulation found at 105 CMR 100.000.

DON applicants are required to demonstrate that the CHI planning process “has involved a diverse, representative group of stakeholders, including community residents” and has taken “a systematic approach to analyzing community demographics, health status of vulnerable populations, community health trends, community assets and needs and community priorities.”⁴² State guidelines issued in January 2017⁴³ require DON applicants to demonstrate “authentic community engagement” in the development of their CHIs and set forth detailed standards for achieving that goal.

In early 2018, the NYS DOH and PHHPC moved forward on the idea of taking public health factors into consideration for “full review” CON applications submitted by general hospitals. Questions about how the proposed project advances local Prevention Agenda priorities identified by the community in the most recently completed Community Service Plan will be added to schedule 16 of the CON application starting in June 2018, according to the DOH.

THE DOH AND PHHPC MOVED FORWARD ON THE IDEA OF TAKING PUBLIC HEALTH FACTORS INTO CONSIDERATION FOR “FULL REVIEW” CON APPLICATIONS SUBMITTED BY GENERAL HOSPITALS.

If the specific CON project does not advance the local Prevention Agenda priorities, applicants would be asked to briefly summarize how else they are advancing the Prevention Agenda. Applicants would be asked to briefly report on the evidence-based interventions they are implementing to support local Prevention Agenda goals, whether they have engaged local partners (including the local Health Department), what data they are using to track progress and how they are investing community benefit dollars and DSRIP Domain 4 (population-wide health)⁴⁴ funds to support local Prevention Agenda efforts.⁴⁵

B. Require CON review of proposed hospital consolidations to include assessment of the potential impact on health care prices and costs to consumers and other payers.

While one of the original purposes of Certificate of Need programs was to control costs at a time of hospital expansion, construction and equipment acquisitions, there is little evidence in the literature that this goal has been fulfilled. As trends have shifted from hospital expansion to consolidation, there is a new opportunity to employ CON to restrain price increases that are associated with health systems acquiring greater market share through consolidation, takeovers of community hospitals, and acquisition of outpatient centers and physician practices.

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42. Determination of Need Factor 9 Community Health Initiatives, Policies and Procedures, Massachusetts Department of Health, August 19, 2014, accessed at <http://www.mass.gov/eohhs/docs/dph/quality/don/don-community-health-initiatives.pdf>
43. Community Engagement Standards for Community Health Planning Guideline, Massachusetts Department of Health, January 2017.
44. Domain 4 of the NYS DSRIP program funds project designed to improve population health, such as promoting mental health and preventing substance abuse, preventing chronic diseases, decreasing HIV mortality and reducing the number of premature births. From the NYS DOH document “DSRIP Domain 4 and the Prevention Agenda.” https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/d4guidance_2015-06-08_final.pdf
45. Email communication from Sylvia Pirani, Director of the Office of Public Health Practice, New York State Department of Health, on April 4, 2018.

Consolidation in the health industry (both hospital mergers and hospital acquisitions of physician practices) is widely recognized as leading to greater market power for large health systems and thus higher prices charged to insurers. For example, a Robert Wood Johnson survey⁴⁶ of studies reported that, when hospitals merge in already concentrated markets, price increases might exceed 20 percent. More recently, Cooper, Gaynor and others⁴⁷ found that the primary determinant of health care costs is the price of provider services, and that the most powerful determinant of provider price is market power – not quality, not size, not academic status or reputation.

THERE IS AN OPPORTUNITY TO EMPLOY CON TO RESTRAIN PRICE INCREASES THAT ARE ASSOCIATED WITH HEALTH SYSTEMS ACQUIRING GREATER MARKET SHARE THROUGH CONSOLIDATION.

A 2016 study for the New York State Health Foundation by Gorman Actuarial found that “a hospital’s market leverage – its bargaining power when negotiating with insurers – is a key factor in the prices a hospital can command.”⁴⁸ The study reported that hospitals with greater market share are generally higher priced, and those higher prices extend to hospitals that are part of a hospital system with large regional market share, regardless of an individual hospital’s size or market share.

A study by the Massachusetts Health Policy Commission⁴⁹ found that market power is the primary determinant of hospital prices in that state. The Attorney General of Massachusetts made similar findings⁵⁰ in 2010. Another contributor to price increases is that community hospitals are generally paid less for their services by third parties than are “academic” health systems that are acquiring the smaller hospitals.

The NYS DOH and PHHPC reviews of CON transactions do not explicitly examine the potential impact on the price of health care in a region. Instead, the financial aspects of CON review are focused on the financial feasibility of the project – essentially whether the applicant can afford to carry it out, and what the long-term impact of the project would be on the applicant’s financial health.

46. Gaynor, M. and R. Town, “The impact of hospital consolidation – Update,” Robert Wood Johnson Foundation, Synthesis Report, June 2012.

47. Cooper, Z. et al, “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured,” NBER Health Care Pricing Project, December 2015.

48. New York State Health Foundation, “Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement,” prepared by Gorman Actuarial, December 18, 2016.

49. Massachusetts Special Commission on Provider Price Variation Report, March 15, 2017.

50. Office of Massachusetts Attorney General Martha Coakley, Examination of Health Cost Trends and Drivers, Report for Annual Public Hearing, March 16, 2010.

Recently, one of the PHHPC members – John Bennett, who is CEO of the Capital District Physicians Health Plan – has begun questioning applicants for hospital mergers about the likely impact on the price that consumers and health plans like CDPHP will pay for health care. At a November 16, 2017, meeting of the PHHPC’s Establishment Committee, he commented on a proposed merger of two nearby community hospitals that, “Everywhere that hospital mergers and acquisitions occur, costs go up.” He asked the CON applicants, “Where does the consumer stand in your plans? How can we be assured that, once this is approved, cost reductions are really going to take place? How are you ensuring that the community is going to get real value?”

“EVERYWHERE THAT HOSPITAL MERGERS AND ACQUISITIONS OCCUR, COSTS GO UP.”

**– DR. JOHN BENNETT,
PHHPC MEMBER**

Our recommendation is to include consideration of the potential impact on the price of care in DOH and PHHPC review of selected “full review” CON applications (such as system takeovers of formerly independent hospitals or mergers of nearby facilities). DOH staff time currently spent on analyzing the “financial feasibility” of a project, a procedure DOH staff describe as time consuming and most often of “low value,” could be redirected to assessing the potential impact on health care prices.

One possible method of doing this would be to ask CON applicants to predict the effect of their proposed transactions on their prices. Another method would be to require an outside assessment, such as by a consultant. Another approach would be to use data reporting submissions from health plans, as the New York State Department of Financial Services did through a mandated Request for Information it issued to inform a 2016 report on hospital pricing in New York.⁵¹ As the state move this year to implement an All Payer Database⁵², that could be a valuable resource for assessment of the actual price effects of hospital mergers.

When it comes to analyzing and monitoring projected price increases associated with a CON application, third parties may be useful. Staff of the Attorney General’s Anti-Trust Bureau, for example, have expertise in assessing the likely effect on price of anti-competitive business transactions. Insurers are also able to analyze predicted price increases associated with hospital consolidation and track the actual price increases.

ONE POSSIBLE METHOD WOULD BE TO ASK CON APPLICANTS TO PREDICT THE EFFECT OF THEIR PROPOSED TRANSACTIONS ON THEIR PRICES.

51. New York State Health Foundation, “Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement, prepared by Gorman Actuarial, December 18, 2016. <https://nyshealthfoundation.org/resource/an-examination-of-new-york-hospital-reimbursement/>

52. The purpose, design and timeline for New York’s implementation of an All Payer Database are described here: https://www.health.ny.gov/technology/all_payer_database/

Conclusion

This report sought to explore how the New York State Certificate of Need process can be made more transparent and engaging of consumers in the new era of hospital consolidation. The current CON system lacks public input at most points in the process. In addition, the CON system is difficult to navigate and understand for average consumers.

To develop recommendations for improving New York's CON process, this study reviewed processes from other states that are more transparent and consumer friendly. Some of those are depicted in Table 9 on page 52.







There are four broad categories of recommendations, each with specific suggestions of how to achieve the broader goals. The first category of recommendations looks to ensure consumers affected by hospital closures or elimination of key hospital services are notified and engaged. The second is focused on improving transparency, accountability and consumer engagement when health systems propose takeovers of community hospitals. The third is a recommendation to increase consumer representation on the PHHPC and overall transparency and consumer engagement with the NYS CON process. Finally, the fourth set of recommendations covers ensuring CON-approved projects protect access to timely, affordable care and work with state and local health planning goals.

Some of these recommendations could be immediately through improvements to the NYS Department of Health website and through changes in the policies and procedures through which the DOH and PHHPC consider applications for hospitals consolidation, downsizing and closings. Other recommendations may require changes in regulation or in statutes. We look forward to the opportunity to discuss these recommendations with consumer health advocates, health providers and with public policymakers.

TABLE 9

States with consumer-friendly CON policies and procedures

NOVEMBER 2017

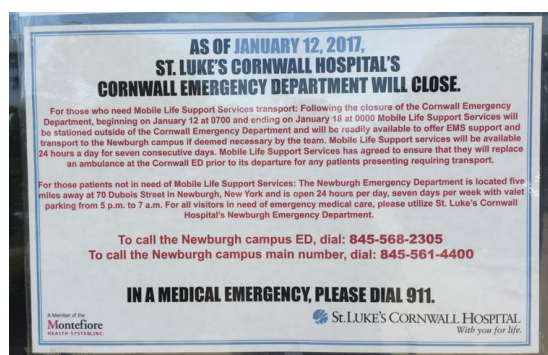
| State | Criteria Used in CON Review | Public Hearings | Online Accessibility | Post-Approval Compliance | Statutory Reference(s) |
|---|---|---|---|--|--|
|  Connecticut | Public need, access to health care, cost effectiveness, financial feasibility. | At Office of Health Care Access (OHCA) initiative, or if 3 or more individuals or entities, representing five or more individuals, request a public hearing. | OHCA publishes a weekly CON status report on its website. Most CON-related documents are posted within 24 hours of receipt by OHCA. | At discretion of OHCA, which uses three-year follow up period and specifies reporting requirements and schedule. Not statutorily required of OHCA. | State statutes 19a-638 (determining if CON is required) and 19a-639a (review process); modification requests are governed by 4-181a. |
|  Florida | Financial feasibility, competition, cost-effectiveness, quality, effect on medically underserved (in particular low income, racial and ethnic minorities, women, people with disabilities, elderly) | Public hearing(s) are held by the Agency or the Local Health Council "if requested by the applicant or another affected party." | The Agency publishes its notice of intent and State Agency Action Report, which includes the Agency's intent to deny or grant CON applications (which are batched). If there are no challenges within 21 days (there is an appeals/challenge process), the Report becomes the Agency's final order. Full applications are available only through FOIL requests. | The Agency imposes "conditions" and requires a timetable and compliance reports annually, as well as a status report on first 15 months post-issuance. Noncompliance may result in fines. | 408.039(3)(b); 408.034(8) 59C-1.013: Monitoring Procedures; 59C-1.012: Administrative Hearing Procedures |
|  Kentucky | Need, access, efficiency, economic feasibility, linkages/interrelationships. | Public notice required, public hearing may be requested by the Cabinet, the applicant or any "affected person," which includes anyone residing in the service area, regular user of services in area, similar health providers (current or future), payers. | KY Cabinet for Health and Family Services maintains a CON website (with a searchable database of CON applications) and publishes a monthly "Certificate of Need Newsletter" in print and online. Not all hearing materials are uploaded due to volume. Post-approval project reports are posted each six months. | The Cabinet for Health and Family Services requires CON holders to submit six month progress reports (at a minimum, with additional reports as considered appropriate) until a project is deemed complete, and may revoke the CON if the holder is non-compliant. | 900 KAR 6:070: Certificate of Need Considerations for Formal Review; 900 KAR 6:065: Certificate of Need Application Process; 900 KAR 6:055: Certificate of Need Forms; 900 KAR 6:100: Certificate of Need Standards for Implementation and Biennial Review Statute: KARS 216.B.015 |
|  Maryland | Unmet need, geographic and financial accessibility, quality, cost-effectiveness, financial viability, impact on existing providers and delivery system. | Maryland Health Care Commission publishes a review schedule. An evidentiary hearing may be requested by an "interested party," which includes the applicant, Commission, third-party payor, persons who can demonstrate adverse impact. | Full active and completed CON applications are available on the Maryland Health Care Commission website, in searchable format, along with staff reports and decisions. A monthly status report (covering all applications) is also posted. | The Commission may issue a CON approval with conditions. As a general condition of any CON approval, quarterly reports are required, through the period of time deemed appropriate by the Commission. If unsatisfactory, the CON approval may be revoked. | COMAR 10.24.01.14B; COMAR 10.24.01.08G(3) |
|  Massachusetts | Competition, innovation, equity, access, cost containment, quality. | "Ten Taxpayer Group" (any 10 taxpayers) may participate in review of Determination of Need (DON) application. Public hearing held at state Department of Health (DPH) initiative or in response to request by any Party of Record. | "All materials related to an Application... shall be made publicly and readily available electronically at all times..." DPH posts materials "as soon as reasonably possible in order to support the goals of transparency and accountability." Staff report made available to public at least 30 days prior to Department action. | In addition to "Standard Conditions" (with annual reports) DPH may prescribe "Other Conditions." If conditions are not met, DPH may require the DON Holder to fund project(s) which address one or more of the Department's "Health Priorities," at an expense of up to 2.5% of the total capital expenditure of the Holder's approved project.* | Commonwealth Statutes M.G.L. c.111, §§25B to 25G, §§51 through 53, 51A and 71 Regulations: 105 CMR 100.360; 105 CMR 100.405; 105 CMR 100.445; 105 CMR 100.510 |
|  New Jersey | Unmet need, enhance quality, financially feasible, promotes access, especially to low income people, racial and ethnic minorities, women, disabled, elderly, people with HIV. | The State Health Planning Board holds at least one public hearing in the facility's service area within 30 days of the application being declared complete by DOH. | Certificate of Need Decision Letters are posted on the NJ DOH website. Application materials must be sought through the FOI process at nj.gov/health/opra . | Conditions may be placed by the Commissioner on the CON approval and become part of the licensure requirements of the facility. The Commissioner can also nullify the CON approval. Progress reports on meeting the conditions are required at annually for at least two years, or when requested by the Department. | New Jersey Administrative Code, Title 8. Health, Chapter 33. |

*In January of 2017, the Massachusetts Department of Public Health issued updated guidelines on DON Community-Based Health Initiative Planning, which can be found here: <https://www.mass.gov/files/documents/2017/01/oa/guidelines-chi-planning.pdf>

Appendix A

Case Study: The Dismantling of Cornwall Hospital

When Cornwall Hospital merged with St. Luke's Hospital in nearby Newburgh in 2002, it formed the St. Luke's Cornwall Hospital system (SLCH). Both hospital buildings remained open as campuses of the merged entity. Hospital executives promised the residents of Cornwall that their small community facility would remain a viable community hospital. According to Cornwall Town Board minutes from 2004, Cornwall residents believed hospital executives when they told the community "things would not change."⁵³



However, as financial concerns grew, SLCH executives began to quietly dismantle Cornwall Hospital. Over the next 10 years, the operating room, the mental health unit, labor and delivery and radiology were eliminated. In 2016, SLCH took initial steps to join the large Bronx-based Montefiore Health System, and in January of 2017, the Cornwall emergency department was closed. Residents were told to go to Newburgh with medical emergencies, or call 911.

Cornwall Hospital has ceased to exist as an acute care hospital. Its building now houses doctors' offices, a cancer center, an ambulatory surgery center and St Luke's Cornwall medical offices.

How were the residents of Cornwall kept informed about the gradual closing of their hospital? How were their concerns solicited and addressed by state officials with the authority and responsibility to oversee hospital changes in New York? What has been the impact of the closing of Cornwall Hospital on residents' access to health care?

This case study by MergerWatch staff has found troubling gaps in the engagement of affected health consumers. Residents of the town of Cornwall and surrounding communities complained about a lack of transparency concerning what was happening at the hospital. Affected community members felt they were unable to express their concerns through the official channels of the state Certificate of Need (CON) process and when they did speak up in locally-sponsored rallies and meetings, they believe they were often ignored.

The history of Cornwall Hospital

The town of Cornwall is located in the mid-Hudson Valley, 50 miles north of New York City and 20 miles south of Poughkeepsie.⁵⁴ Cornwall has about 12,500 residents and a median household

53. Cornwall Town Board, "Town Board Meeting Minutes" (Town of Cornwall, June 14, 2004), 326, http://www.cornwallny.gov/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=280&language=en-US&PortalId=1&TabId=191

54. "History of the Town of Cornwall," Town of Cornwall, 2017, <http://www.cornwallny.gov/About-Cornwall/History/History-of-Cornwall>

income of \$86,000.⁵⁵ Cornwall Hospital was founded in 1923 with a grant from Dr. Ernest Stillman, who was called to see a sick child in the community and attempted to bring her to a nearby hospital in another town because she was so ill. The child was turned away from that hospital and later died due to her lack of treatment. Dr. Stillman was greatly affected by this tragedy and, because of it, saw the need for a hospital to serve the Cornwall community.⁵⁶

Cornwall Hospital officially opened its doors in 1931 as a full-service hospital for Cornwall and its surrounding areas, “to save lives that could not make it to Newburgh.”⁵⁷ Cornwall residents are proud of the hospital’s history and often refer to Dr. Stillman and his mission to fill a need for the community.⁵⁸ Cornwall Hospital continued to operate as a full-service hospital through the 20th century, adding more beds and specialized units, such as a new endoscopy center and ambulatory surgical center in the late 1980s.⁵⁹ As recently as 2012, SLCH Cornwall added a \$20 million parking garage to its campus.

Closing of hospital units following merger with St. Luke’s in Newburgh

However, after its 2002 merger with St. Luke’s Hospital in Newburgh to create the SLCH system, Cornwall Hospital was gradually closed, unit by unit. In 2004, SLCH announced plans to close the operating room on the Cornwall campus. Community members, hospital employees and the town supervisor conveyed concerns about this closing and the implications at a Cornwall Town Board meeting. A nurse who worked at the hospital for 20 years expressed her belief that the nurses “all [felt] that the administration [was] not looking at the Cornwall community as a whole.”⁶⁰ John O’Reilly, whose wife was a nurse at SLCH Cornwall at the time, noted that “the morale of the hospital [was] suffering” and that the hospital was “being eviscerated.”⁶¹ Members of the local Service Employees International Union – who were nurses, service, technical, maintenance and clerical employees at the hospital – demanded a state investigation of the OR closure, claiming it violated the 2002 merger

AFTER ITS 2002 MERGER WITH ST. LUKE’S HOSPITAL IN NEWBURGH TO CREATE THE SLCH SYSTEM, CORNWALL HOSPITAL WAS GRADUALLY CLOSED, UNIT BY UNIT.

55. “U.S. Census Bureau QuickFacts: Cornwall Town, Orange County, New York,” United States Census Bureau, July 1, 2016, <https://www.census.gov/quickfacts/fact/table/cornwalltownorangecountynewyork,NY/PST045216>

56. Elisabeth Rosenthal, *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back* (Penguin, 2017), 217.

57. “Residents Speak out against Potential SLCH Cornwall ER Cuts,” *MidHudsonNews.com*, November 13, 2013, http://midhudsonnews.com/News/2013/November/13/SLCH_Corn_ER-13Nov13.html

58. Cornwall Town Board, “Town Board Meeting Minutes,” June 14, 2004, 325; Cornwall Town Board, “Town Board Meeting Minutes” (Town of Cornwall, September 14, 2009), 74, http://www.cornwallny.gov/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=342&language=en-US&PortalId=1&TabId=191

59. Rosenthal, *An American Sickness*, 218.

60. Cornwall Town Board, “Town Board Meeting Minutes,” June 14, 2004, 326.

61. Cornwall Town Board, 325–326.

agreement.⁶² A spokesperson from the New York State Attorney General's office said the office would look into the claim, however it does not appear there was any action after the statement.

“WHEN THEY FIRST TOLD US THEY WOULD NO LONGER HAVE PATIENTS AT THE HOSPITAL, THEY SAID YOU WOULD ALWAYS HAVE AN EMERGENCY ROOM HERE.”

– COUNTY LEGISLATOR KEVIN HINES

In 2009, SLCH continued to quietly close inpatient care at the Cornwall campus. That year, the number of patient beds at SLCH Cornwall was cut down from 36 to 17 beds, with 75 percent of the remaining beds dedicated to outpatient care. This move was accompanied by the elimination of 11 jobs and the Intensive Care Unit. SLCH argued this change was meant to reduce the duplication of services with those available at the Newburgh hospital. In response, the Town of Cornwall and Village of Cornwall-on-Hudson trustees sent a letter asking for the ICU to remain open. The Town Board sent a letter to the SLCH Board of Trustees “expressing the concerns and dismay at the virtual elimination of the traditional hospital services taking place.”⁶³ Concerned community members and neighbors signed petitions about the closure. In addition, community members spoke out at a Town Board meeting. One resident stated the town was hearing “a

bunch of propaganda” from the hospital representatives. A physician who worked at SLCH said the move came as a “total surprise” and referred to SLCH Cornwall as a “wounded institution.”⁶⁴ In 2010, SLCH Cornwall “flexed down” the remaining 17 beds, meaning the administration would not staff the beds unless necessary.⁶⁵

“When they first told us they would no longer have patients at the hospital, they said you would always have an emergency room here,” recalls County Legislator Kevin Hines, who was born at Cornwall Hospital. “So people said that’s fine, treat us and then transfer us if you have to.”⁶⁶

But, in September 2013, SLCH announced its request to the New York Department of Health for approval to limit the Cornwall Emergency Department hours to 12 hours a day as a way of ensuring “the financial viability of the health system, while continuing to serve the 250,000-plus residents of the service area.”⁶⁷

Hospital officials said the Cornwall ED did not have enough patients and did not make enough money to warrant keeping a full-time ED open just five miles from the Newburgh SLCH campus ED.

62. Michael Randall, “Union Demands Investigation,” Times Herald Record, July 13, 2004, <http://www.recordonline.com/article/20040713/NEWS/307139992>

63. Cornwall Town Board, “Town Board Meeting Minutes,” September 14, 2009, 75.

64. Cornwall Town Board, 94.

65. “SLCH’s Inpatient Unit to Flex Down,” News From Cornwall and Cornwall on Hudson, December 15, 2010, <http://cornwall-on-hudson.com/newsletter.cfm?page=6527>

66. Telephone Interview with Kevin Hines by MergerWatch staff in August 2017.

67. “SLCH Seeks to Consolidate Emergency Services,” St. Lukes Cornwall Hospital, 2014, <http://www.stlukescornwallhospital.org/news/Pages/SLCH-Seeks-to-Consolidate-Emergency-Services-.aspx>

However, local residents claimed much of the low patient traffic at Cornwall was due to SLCH purposefully driving down patient numbers by sending as many 911 emergencies to the Newburgh ED as possible, even if Cornwall was closer. The fact that there were so few inpatient beds left at Cornwall also limited use of the Cornwall ED. If patients admitted to the Cornwall ED needed inpatient care, they would have to be sent to on to the Newburgh campus, requiring two stops instead of going straight to Newburgh.

“The reason Cornwall ER wasn’t making money is that early on, when they stopped admitting people, they directed the ambulances to bring everybody to Newburgh,” said County Legislator Hines. “If they needed surgery, the directive was -- don’t bring them to Cornwall, bring them to Newburgh. So, they intentionally depleted the patients at Cornwall ER.”

Hospital executives claimed their only intention was to limit ED hours. However, a video from a state Public Health and Health Planning Council (PHHPC) meeting in September 2013 showed the President of SLCH testifying that he anticipated an eventual move to one ER between the two hospitals.⁶⁸



Five days after the initial announcement of the reduction in ED hours, a protest of more than 100 residents, hospital employees, elected officials and ambulance workers was held outside the hospital. Community members who spoke out said they felt the hospital did not communicate its plans with those who would be affected most. Elected officials and emergency responders said they found out about the initial plan to limit ED hours by being copied on a press release. The mayor of Cornwall-on-Hudson, Brendan Coyne, strongly denounced the plan, stating: “Putting our children and families’ health at risk by shutting down ER hours so that hospital executives can fund their bonuses is simply not the right health care strategy for this community.” Other residents expressed the feeling that their health relies on a “reliable, open ER.”⁶⁹

Assemblymember James Skoufis is shown rallying with constituents outside of SLCH Cornwall on Sept. 24, 2013.⁷⁰

All of the affected municipal boards passed resolutions asking SLCH to withdraw the request. New York Assemblymember James Skoufis wrote a letter to the then-New York State Health

68. James Skoufis, “St. Luke’s True Intentions Exposed,” Facebook, November 25, 2013, <https://www.facebook.com/JamesSkoufis/videos/10102236289464834/>

69. HV Insider, “Assemblyman James Skoufis Rallies Support to Save Cornwall ER,” Hudson Valley Insider, September 30, 2013, <http://www.hvinsider.com/articles/assemblyman-james-skoufis-rallies-support-to-save-cornwall-er/>

70. Photo from HV Insider.

SKOUFIS INTRODUCED LEGISLATION THAT WOULD REQUIRE THE DEPARTMENT OF HEALTH TO HOLD A COMMUNITY HEARING PRIOR TO APPROVING THE REQUEST TO CLOSE OR LIMIT HOURS OF EMERGENCY DEPARTMENTS.

Commissioner Dr. Nirav Shah, expressing concern for his constituents. The letter referred to the potential “widespread, negative ramifications” of limiting the Cornwall Emergency Department hours and said that SLCH’s press release on the subject contained “cherry-picked statistics” that provided an “incomplete view of the hospital’s performance.”⁷¹ Skoufis also introduced legislation that would require the Department of Health to hold a community hearing prior to approving the request to close or limit hours of emergency departments.⁷²

Assemblyman Skoufis and New York State Senator Larkin held a public meeting at Cornwall Middle School at which community members expressed their concerns. A representative from the DOH attended the meeting. Hospital officials were invited, but did not attend. At the meeting, the community again expressed concern about traveling the extra distance to SLCH Newburgh, particularly in hazardous weather conditions or during extremely time sensitive health emergencies. For example, Highland Falls resident Doris Koziak noted, “I’ve never been able to schedule my A-fib attacks.”⁷³ SLCH ultimately withdrew its request to limit Cornwall ED hours by March 2014, but noted the decision was not permanent.

Closing of emergency department after joining the Montefiore system

In 2014, SLCH began to look for a larger hospital system to join. The combined hospitals had been consistently reporting financial losses since 2012. SLCH operations lost \$7.4 million on revenue of \$177.6 million in 2014. The net loss that year was \$21.5 million when combined with other losses, including investments, and pension costs.⁷⁴ In 2015, it was announced that Bronx-based Montefiore Health System would assume “passive parent” management of SLCH, a relationship that did not require state approval, but gave Montefiore the ability to appoint three of SLCH’s board members and begin strategic planning with SLCH executives.⁷⁵ The passive parent agreement took effect in January 2016.

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71. James Skoufis, “Reduced Emergency Room Hours at St. Luke’s Will Cause Hardship,” *The Chronicle*, September 11, 2013, <http://www.chroniclnewspaper.com/apps/pbcs.dll/article?AID=/20130911/OPINION03/130919980/Reduced-emergency-room-hours-at-St-Luke%27s-will-cause-hardship>
 72. James Skoufis, “Assembly Bill 8221A,” Pub. L. No. A8221A, § 2801-H, Public Health Law (2013), <https://www.nysenate.gov/legislation/bills/2013/a8221/amendment/a>
 73. Michael Randall, “St. Luke’s Cornwall Hospital’s ER Plan Raises Ire,” *recordonline.com*, November 13, 2013, <http://www.recordonline.com/article/20131113/NEWS/311130343>
 74. Melanie Evans, “Montefiore to Acquire Struggling Hudson Valley Hospital,” *Modern Healthcare*, October 6, 2015, <http://www.modernhealthcare.com/article/20151006/NEWS/151009951>
 75. “Montefiore and St. Luke’s Cornwall Hospital Announce Partnership,” *Montefiore*, October 5, 2015, <http://www.montefiore.org/body.cfm?id=1738&action=detail&ref=1259>

By July of 2016, SLCH announced plans to completely close the emergency department at the Cornwall campus, which officials said would save \$3.2 million per year. Area residents would be expected to travel to the Newburgh campus, located about five miles away, for emergency services. The hospital said there had been a decline in emergency room patients at Cornwall, with an average of 1.6 patients per hour in 2015, and that having two emergency departments in close proximity was unsustainable. However, the proposed closure meant residents of Cornwall, as well as surrounding towns like Blooming Grove, Highland Falls and Woodbury would face longer drives to the emergency room.

After the attempt to limit the SLCH Cornwall Emergency Department hours in 2013, hospital officials had promised the community they would seek input from residents prior to future significant changes to the Cornwall campus. However, according to a letter from Assemblyman Skoufis and county legislators, mayors and town supervisors from the affected region, the 2016 town hall meeting hosted by the hospital to explain their intention to close the ER was “set up in such a way to prevent people from attending.” SLCH gave the community only three days’ notice and scheduled the forum at 6 pm in the middle of the summer in an area where many residents commute and “do not return home until 7:00 pm or later,” the letter complained.⁷⁶

The hospital’s initial plan was to close the emergency department by October 1, 2017, one month before that fall’s state legislative elections. However, the closing was delayed after State Senator William Larkin, a Republican, and Assemblyman Skoufis, a Democrat, wrote letters to the New

York State Department of Health voicing concerns. The hospital delayed the closure to answer questions about the emergency department transition and access to care. Orange County Legislator Kevin Hines, who is a Republican, expressed concerns

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St. Luke’s Hospital closing emergency room at Cornwall campus

that the SLCH Newburgh campus, which was already overcrowded, would be overwhelmed with patients from Cornwall and beyond. In addition, there were worries that the closure would have an effect on the emergency plans of nearby Stewart International Airport and in case of an incident at a nearby nuclear power plant, Indian Point.⁷⁷ Despite these expressed concerns, SLCH decided to continue with the closure and on January 12, 2017, the SLCH Cornwall emergency department was closed.

After the Cornwall emergency department was closed, an ambulance was stationed outside of the building for a week to assist the community with the transition. About a week later, the chief of the New Windsor Volunteer Ambulance Corps, Michael Bigg, recounted his experience with the

76. “Letter Regarding Closing of Cornwall ER,” News From Cornwall and Cornwall on Hudson, August 20, 2016, <http://cornwall-on-hudson.com/news.cfm?page=10519>

77. Holly Kellum, “St. Luke’s Cornwall Hospital to Cut Emergency Department,” The Epoch Times, July 22, 2016, https://www.theepochtimes.com/st-lukes-cornwall-hospital-to-cut-emergency-department_2122918.html

transition. He noted that ambulance crews arriving at the Newburgh ED were facing delays of up to 15 minutes to turn patients over to SLCH Newburgh hospital staff because the parking lot was so packed even ambulances were having difficulty parking.⁷⁸ In addition, Bigg said there were patient beds in the hallway.

County Legislator Hines said the elimination of the Cornwall ED “is a very big problem, especially for the EMS system, because it’s a longer trip for everybody (to the Newburgh ED).” Moreover, he said, “In Orange County, we now have only two hospitals. We have St. Luke’s in Newburgh and we have Orange Regional in the Middletown area. Orange Regional is consistently on ‘divert,’ (meaning they won’t accept more patients) because their ER is overwhelmed.”

Hines flagged another “big problem they won’t admit to,” which he said is that “in inner-city Newburgh, where many times you have gang violence and shootings, their hospital goes on lockdown. Now they will tell you that if they are on lockdown, they will still take any patients that arrive by ambulance ... They never say they are on ‘divert.’ But, they tell the ambulance drivers there is an extended wait, so you might want to consider another hospital.” Moreover, he said, “There’s very limited rooms in Newburgh. So the emergency room becomes a secondary ICU.”

Hines recalled that he had to pressure SLCH to take down the Cornwall Hospital sign. It says St. Luke’s Cornwall now instead of St. Luke’s Cornwall Hospital. “I told them they were going to get sued, because if someone is driving by there – say a tourist who had visited (nearby) West Point – and who is having a heart attack and sees a hospital sign, there’s no way to help them.”

Montefiore system becomes “active parent” of SLCH

On October 21, 2017, the Montefiore Health System (MHS) submitted a CON application to become the active parent and co-operator of SLCH. The active parent status would give MHS the ability to hire and fire managers of SLCH and approve operating and capital budgets. The CON, which qualified for full review, detailed plans to develop the Cornwall campus as a “medical village.” Some of the plans have been announced by SLCH officials. Including introduction of “open-access primary care,” which would allow patients to see doctors without an appointment, and an increase in existing services like cancer treatment and physical and occupational therapy.

This CON application moved swiftly through the DOH and PHHPC review process, without any visible engagement of affected consumers. On November 9, 2017, the state Department of Health released the agenda for the November 16, 2017, scheduled meeting of the Committee on Establishment and Project Review, which is a subcommittee of the PHHPC. On the agenda were two applications from Montefiore to become active parent of SLCH in Orange County and of Nyack Hospital in adjacent Rockland County. When Montefiore’s application for SLCH was brought

78. Mark Gerlach, “Congestion Reported After Cornwall ER Closure.” The Orange County Post, January 20, 2017, <https://ocpostny.com/2017/01/20/congestion-reported-after-cornwall-er-closure/>

up at the meeting, there was little debate and no one from the hospital or the public spoke in favor or against the application.

Assemblymember Skoufis said he did not know the SLCH CON was moving forward until MergerWatch contacted him to ask his opinion, having spotted the SLCH transaction on the Nov. 16 committee agenda. Skoufis was unable to attend the meeting, which was being held

ASSEMBLYMEMBER SKOUFIS WROTE THAT MONTEFIORE AND SLCH OFFICIALS HAD “COMPLETELY DODGED” HIS REQUESTS THAT LOCAL REPRESENTATION BE MAINTAINED ON THE SLCH BOARD IN THE FUTURE.

in Albany, on such short notice. He attempted to send in written comments, but says he was informed by NYS DOH staff that he needed to submit comments at least 72 hours prior to the committee meeting and that he was too late to do so.

Committee Chair Dr. Peter Robinson, praised Montefiore for taking on the financial responsibility of two community hospitals, which he said would likely keep them from closing. Committee member Dr. John Bennett, who is CEO of Capital District Physicians Health Plan, voted against the application, having raised concerns about how the cost of care is affected when community hospitals enter into active parent relationships with large health systems like Montefiore.

The Montefiore application to become active parent of SLCH came before the full PHHPC on December 7, 2017. At the meeting,

Council members were given a letter of comment submitted by Assemblymember Skoufis, who wrote that Montefiore and SLCH officials had “completely dodged” his requests that local representation be maintained on the SLCH board in the future. Since “both MHS and SLCH have received enormous state funding in recent years,” he wrote, “approval of the active parent CON ought to be contingent on an annual accounting to both PHHPC as well as the local community on how these dollars are being spent.” Furthermore, he wrote, “a financial analysis ought to be required detailing the specific benefits expected of this active parent relationship for both MHS and SLCH – as it stands, their application only speaks in generalities about this important issue.”

PHHPC members were also given a reply letter⁷⁹ from Montefiore Executive Vice President Lynn Richmond which stated that “Montefiore has been committed to help maintain accessible, quality, value-based care in socially and economically challenged communities. This application to establish MHS as the active parent of SLCH is evidence of this commitment.” In response to the Skoufis comments on state funding for MHS and SLCH, she said, “MHS and SLCH comply with the

79. When MergerWatch asked for a copy of the MHS letter, which had been circulated among PHHPC members at the December 7 public meeting (but had not been included in the packet of materials distributed electronically to interested members of the public prior to the meeting), DOH staff said we would have to submit a Freedom of Information request. MergerWatch staff complied on December 8. Our letter was acknowledged on December 12. A month later, on January 12, 2018, a copy of Ms. Richmond’s letter was sent to MergerWatch by the DOH.

specific reporting requirements to account for the use of state funds, including the recent grants for the Statewide Health Care Facility Transformation Program.” As to the future composition of the SLCH board, she wrote:

Per the proposed post-closing Bylaws of SLCH submitted with the CON application, the SLCH Board of Trustees will remain in place once Montefiore becomes active parent; all of the members of the SLCH Board of Trustees will serve out the remainder of their 3-year terms. Certain SLCH Trustees will be eligible for re-election to an additional 3-year term. Thereafter, the Nominating Committee, which consists of representatives of SLCH and MHS, shall propose individuals for election or re-election.

The letters sparked a lively debate among Council members about state funding of large health systems to take over community hospitals and expectations of continued local involvement in governance of such hospitals. PHHPC member Dr. Lawrence Brown of the START Treatment and Recovery Center in Brooklyn, said: “We need to ask the applicant, what do they mean by community representation on the board?”

**“YOU CAN’T HAVE
A HOSPITAL IN
EVERY PLACE.”**

**– PHHPC CHAIR
JEFFREY KRAUT**

PHHPC Chair Jeff Kraut, who is Executive Vice President of the large Northwell Health System, which has recently acquired a number of community hospitals, jumped in to suggest that the definition of “community” has to change as the health system consolidates:

“You can’t have a hospital in every place... For Cornwall, community was just off Route 9 in Cornwall in Orange County. It wasn’t Newburgh. Now when they come together, now community became bigger.

Montefiore, when you see it having Nyack and St. Luke’s up the West side of the Hudson, community takes on a different definition as you plan and treat things regionally. I think that’s the issue. I know from having done this that you try to get people to open the aperture to understand that you have a broader responsibility to the complexity of health care today. Systems of care are changing. It’s hard for people to deal with the change.”

SLCH President Joan Cusak-McGuirk explained the SLCH board process: “Right now we have a 17-member board (of which 14 seats are filled and there are two vacancies). There are three members from Montefiore and the remainder from the local regional area. There is a nominating committee that, as terms expire ... will put new people up for the board for nomination. The intention is that the board will remain local. I cannot set that in stone. The nomination committee could bring someone from the region.”

Dr. Brown followed up with this question to McGuirk: “So, is there a process for community input?” She replied that “Yes. We have done a community assessment and also a community survey asking residents of our region what services they feel are lacking.” Another PHHPC board member, Dr. Glenn Martin, who is Associate Dean of Research at Mount Sinai’s School of Medicine, then

asked, “Do you have a community advisory board made up of citizens of the area who advise separately from the board?” McGuirk replied, “I don’t have a community advisory board.”

In the end, the Montefiore application was approved by the PHHPC and sent on to New York State Health Commissioner Howard Zucker for final action. He approved the transaction on January 31, 2018. As *Crain’s Health Pulse* coverage of the approval noted, “The addition of St. Luke’s Cornwall to the system increases Bronx-based Montefiore’s footprint in the Hudson Valley. The health system ... has looked to expand northward while its competitors acquired facilities within the city limits. St. Luke’s Cornwall has campuses in Newburgh and Cornwall. Earlier this year Montefiore completed a joint venture with Orange County-based Crystal Run Healthcare,⁸⁰ giving the health system a larger physician presence upstate.”

Dr. Steven Safyer, president and chief executive of Montefiore, issued a statement calling the approval “the final step in the process of joining our systems in order to expand the best of value-based care and clinical excellence to the region.”⁸¹

Orange County Legislator Hines, however, has a different view of what the adoption of SLCH into the Montefiore system will mean to Cornwall residents who have gradually lost their locally controlled hospital: “The DOH people wanted this all along ... They said we want to go to regional medical centers. We don’t want these small facilities.”

80. According to Montefiore and Crystal Run, this agreement is meant to provide Crystal Run patients with access to Montefiore’s network of hospitals and clinics. Partnerships and acquisitions of physician practices do not have to go through the CON process. Some physicians who were employees of Crystal Run Healthcare, as well as Scott Batulis, President and CEO of the parent company of Orange Regional Medical Center, another local hospital, have spoken out against the deal claiming that it may have a negative impact on patient choice and access to care. Source: <http://www.recordonline.com/news/20180104/crystal-run-montefiore-merger-finalized>

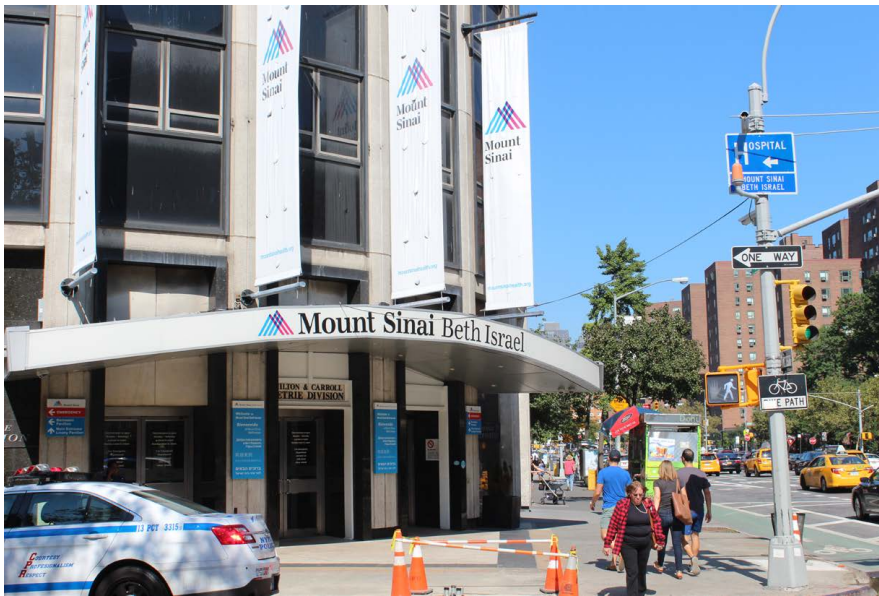
81. “After a 2-year journey, SLCH joins Montefiore system,” January 31, 2018, statement posted on the St. Luke’s Cornwall Hospital website, accessed at: <http://www.stlukescornwallhospital.org/news/Pages/SLCH-Officially-Joins-Montefiore-Health-System.aspx>

APPENDIX B

Case Study: The Transformation of Mount Sinai Beth Israel

Overview

When Mount Sinai Medical Center merged with Continuum Health Partners in September of 2013, it created a large hospital network stretching across Manhattan. Through the merger, **Beth Israel Medical Center** (located at First Avenue and 16th Street in lower Manhattan), Roosevelt Hospital on



West 59th Street, St. Luke's Hospital in Morningside Heights and the New York Eye and Ear Infirmary in the East Village all joined the Mount Sinai Health System. Mount Sinai officials touted the merger as having the potential to improve quality of care, but unions representing the hospital workers immediately voiced concerns about downsizing, closing or relocation of some services within the sprawling network.

Less than three years later, in May of 2016, the Mount Sinai system

announced plans to close the aging and financially-stressed 800-bed Mount Sinai Beth Israel (MSBI) Medical Center. Officials said the facility would be replaced with a new 70-bed Mount Sinai Downtown Beth Israel Hospital and emergency room and with a network of outpatient centers and doctors' offices. Mount Sinai officials contend that, were they to rebuild MSBI to the capacity of the original building, "the day it opened, it would already be obsolete."

Mount Sinai officials insist the new 70-bed hospital will be sufficient to serve the needs of lower Manhattan residents. However, community residents and public officials representing them have voiced concerns. "The downsizing of Beth Israel hospital to a 70-bed medical/surgical center may be inadequate and will cause significant harm to health care services in lower Manhattan," the Village Independent Democrats stated in a resolution adopted in December 2017. "In the last decade, lower Manhattan has witnessed a significant decrease in medical services, specifically hospital beds, specialty clinics and emergency centers attached to full service hospital."

At a meeting of Community Board 3 on March 8, 2018, residents of the Lower East Side and East Village gathered to express their opinions on the new plan for MSBI. Keith Canton, who represented 10th Street Church of Christ and A1 East 10th Street Block Association, specifically

called into question the downsizing of the hospital to a 70-bed facility, noting “the population of the community is not downsizing” and suggesting he “would like to see them at least keep 200 beds.”



Residents of Greenwich Village had already been affected by the sudden closure of St. Vincent’s Hospital in 2010. Needs assessments performed after that closure demonstrated that residents of lower Manhattan were relying on Beth Israel for a significant portion of their care. In fact, Beth Israel’s inpatient admissions increased 16 percent after the closure of St. Vincent’s and its emergency room visits increased 12 percent, with Beth Israel absorbing over half of St. Vincent’s emergency room patients.⁸²

Dr. Jeremy Boal, President of Mount Sinai Downtown, has promised the community that as officials work to build their new facility, MSBI “will remain open” and “will continue to welcome patients throughout the transformation.”⁸³ The new facility is to be constructed at the site of the former residents building for New York Eye and Ear Infirmary, which will be torn down by May 2018. The new facility is not slated to open until 2021. Boal has also pointed to the creation of a new urgent care walk-in center at the existing Beth Israel ambulatory care facility in Union Square, as well as renovated extension clinics, mammography and ultrasound services and other facilities.

However, community residents have been shaken by the quiet closing of units of the existing MSBI hospital through a series of limited review Certificate of Need (CON) applications that have been approved by staff of the New York State Department of Health. “Beth Israel is not waiting four years to close. It has closed the maternity ward, cardiac surgery, pediatric surgery and neo-natal intensive care,” warned the group Progressive Action of Lower Manhattan. “They plan to substitute a 70-bed hospital for a hospital which has 300-400 beds filled every day. The partial closures must stop, with proper studies done, and a transparent and community-approved health care plan adopted.”⁸⁴ In addition, residents who spoke at the Community Board 3 meeting

82. “Post Closure Review of Service Area Access to and Utilization of Inpatient and Emergency Services” (West Side Community Health Needs Assessment, February 3, 2011), http://www.nyc.gov/html/mancb2/downloads/pdf/community_health/steeringcommittee_discussion4.pdf

83. Jeremy Boal, “The Transformation of Mount Sinai Beth Israel” (PHHPC’s Establishment and Project Review Committee, New York, NY, June 8, 2017), <http://www.totalwebcasting.com/view/index.php?func=VIEW&id=nysdoh&date=2017-06-08&seq=1>

84. Progressive Action of Lower Manhattan, announcement of a People’s Town Hall Meeting the closing of Beth Israel Hospital, which was held on May 4, 2017.

expressed concern about doctors quitting Beth Israel, noting there is currently “very low morale” at the hospital.

New York City Public Advocate Letitia James is among a group of elected officials who have been pressing MSBI to stop the piecemeal closure of hospital units and work with the community to assess whether 70 beds would be sufficient for the new hospital. “The current process subverts the intent of the regulations and consequently fails to protect the health and well-being of New Yorkers,”⁸⁵ she said.

Use of multiple limited-review CONs to close units at Beth Israel

Mount Sinai officials have packaged the closing of hospital services at the existing Beth Israel facility into multiple narrowly-framed applications that have been deemed to meet the current CON qualifications for what is called “limited review” by New York State Department of Health (DOH) staff. This is instead of “full review,” which would be conducted at public meetings of the New York State Public Health and Health Planning Council (PHHPC). Mount Sinai has filed, received approval for and completed six separate limited review applications to decertify or close services at Beth Israel, including:

- In November 2016, MSBI applied to close its 20-bed pediatric unit and 5-bed pediatric intensive care unit.
- In January 2017, the hospital applied to decertify its cardiac surgery program.
- In February 2017, MSBI applied to decertify the maternity unit, including 42 maternity beds, 14 neonatal continuing care beds and 17 neonatal intermediate care beds.

The hospital also filed and completed multiple limited review CON applications to convert existing MSBI beds to other purposes and then move those beds to other facilities within the Mount Sinai system. For example, in March 2017, the hospital applied to convert four medical beds to intensive care beds and five medical beds to pediatric intensive care beds, and then to transfer those nine beds to Mount Sinai uptown facilities.

While these limited review applications were technically still under review by the DOH, Mount Sinai took steps to close the services. In mid-June 2017, the maternity unit stopped taking elective deliveries. According to the NYSE-CON website, however, the application to decertify the maternity beds was not approved until July 28, 2017. Mount Sinai officials say that pregnant women will be able to deliver babies at Mount Sinai West (the former Roosevelt Hospital on 59th Street) or Mount Sinai Hospital in East Harlem, which are both located some distance from the current MSBI facility, with travel time that could be complicated by Manhattan traffic jams and subway delays.

85. Letitia James, “Public Comment” (PHHPC’s Establishment and Project Review Committee, New York, NY, June 8, 2017), <http://www.totalwebcasting.com/view/index.php?func=VIEW&id=nysdoh&date=2017-06-08&seq=1>

How can multiple closings of hospital services be accomplished through “limited review” CON applications? Statewide, most of the projects qualifying for limited review are minor construction projects, relocating of medical equipment or the addition of certain services. But surprisingly, hospitals have also used “limited review” to seek approval to decertify facility beds and services.

By segmenting the “transformation” of Beth Israel into multiple pieces, Mount Sinai officials have been able to submit CON applications with total cost projections that fall within the eligibility limits for “limited review” by DOH staff. At the time most of the Beth Israel CONs were submitted, the total cost of a project had to be \$6 million or less to qualify for limited review.⁸⁶ Mount Sinai’s CON applications to close the Beth Israel maternity unit, pediatric unit and the 31 chemical dependency beds, to downgrade the neonatal intensive care beds, to decertify cardiac surgery and to convert and transfer beds to other locations each declared the same predicted cost of \$500, which is simply the fee for filing the CON application.

Elected officials representing the affected areas of lower Manhattan have protested MSBI’s use of the “limited review” process to close services, and suggested a more appropriate route would be submission of a comprehensive plan that would include both the closing of the current facility and the construction of the new hospital, as well as the dispersal of some of the current hospital’s

ELECTED OFFICIALS SUGGESTED SUBMISSION OF A COMPREHENSIVE PLAN THAT WOULD INCLUDE BOTH THE CLOSING OF THE CURRENT FACILITY AND THE CONSTRUCTION OF THE NEW HOSPITAL.

services to various other Mount Sinai hospitals and outpatient facilities. Had all of those elements been contained in one large application that included construction of the new hospital, the CON likely would have undergone “full review” at public meetings of the Public Health and Health Planning Council.

MSBI has pushed back against suggestions that it is “gaming” the CON process. In an April 25, 2017, letter to Brian Kavanagh, then a State Assemblymember, Mount Sinai Downtown President Boal wrote that the hospital’s “transformation will span four years, impacting multiple sites and clinical services and include significant upgrades to physical plants. To combine all of these changes into one CON application would require us to halt the work currently being done and, more significantly, create a

massive delay in the process and a logistical nightmare for DOH.” Because Beth Israel “has sustained losses of over \$350 million over the last four years,” Boal said, the hospital transformation needs to “be able to move with requisite diligence and speed.” In any case,

HOW CAN MULTIPLE CLOSINGS OF HOSPITAL SERVICES BE ACCOMPLISHED THROUGH “LIMITED REVIEW” CON APPLICATIONS?

86. That threshold has since been raised to \$15 million by the PHHPC, at the request of hospital associations.

he wrote, “We have reviewed with outside counsel our approach to the CON submissions. We are confident that our process is consistent with current DOH policy.”⁸⁷

How have affected health consumers been consulted about these changes?

Mount Sinai officials have been meeting regularly with elected officials representing the areas served by Beth Israel, and conducting additional sessions with local agencies, clergy and members of community-based organizations. The hospital has also posted information about its plans on a website. However, hospital officials, citing mounting financial losses they say mandate

a quick closure, have rejected repeated requests to conduct an in-depth study identifying potential negative impacts of the closure and ways to address such impacts.

“WE’VE HAD OVER 30 FORUMS WHERE WE’VE ENGAGED THE COMMUNITY TO TELL US WHAT’S GOING ON.”

– MOUNT SINAI BETH ISRAEL PRESIDENT JEREMY BOAL

“We’ve had over 30 forums where we’ve engaged the community to tell us what’s going on,”⁸⁸ explained Mount Sinai Beth Israel President Jeremy Boal. But Arthur Schwartz, a resident of the West Village and leader of Progressive Action of Lower Manhattan, recalled that “I went to one of the community sessions. It was mostly them talking about what they are doing. I don’t think they were really looking for input.”

One such meeting was held on April 6th, 2017, at the Mount Sinai ambulatory facility in Union Square. At this meeting, City Councilmember Corey Johnson, Community Board 3 Chairperson Jamie Rogers, Manhattan Borough President Gale Brewer and community members spoke out against the plan. They all expressed the desire for more community involvement in the planning and for a community needs assessment and closure impact study to be conducted by the hospital.

While the closure impact study has not been performed, MSBI has released the latest Community Health Needs Assessment (CHNA) it was required to do under federal law.⁸⁹ The assessment, which was conducted by a private firm, Verite Healthcare Consulting, included interviews with 104 “key informants,” a community survey conducted online during the summer of 2017 and a community poll conducted in September 2017. One of the findings from this engagement process was “dissatisfaction and fear” generated by changes in the health delivery system, including the ongoing transformation of Beth Israel, following the closure of St. Vincent’s Hospital, and the longer travel times necessary for residents of lower Manhattan to travel to Mount Sinai

87. Jeremy Boal to Brian Kavanagh, New York City, New York, April 25, 2017.

88. Boal, “The Transformation of Mount Sinai Beth Israel.”

89. Under Internal Revenue Code, Section (501)r, all tax-exempt hospitals are required to conduct a Community Health Needs Assessment every three years and adopt an implementation strategy that addresses significant community health needs.

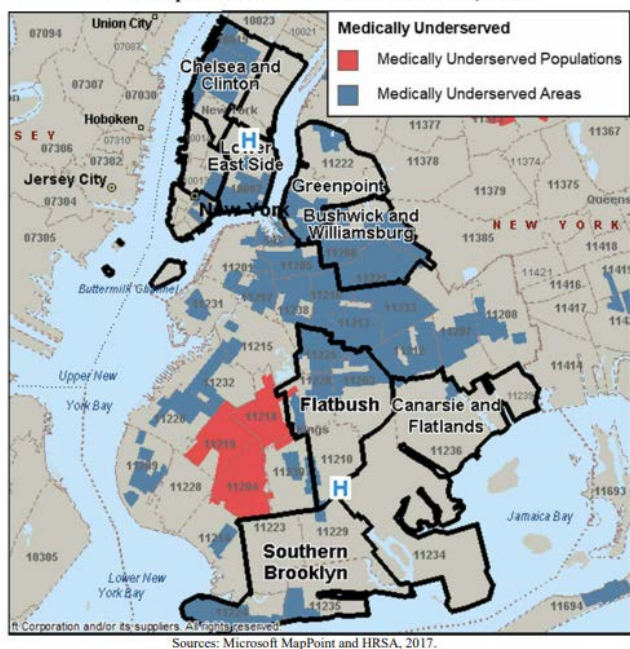
“Centers of Excellence” uptown for services that had been provided at Beth Israel. An excerpt⁹⁰ is shown below from the CHNA as it was released and posted in December 2017. This paragraph has since been removed from the copy of CHNA posted on the hospital’s website.

Beth Israel Transformation and St. Vincent’s closure. Several interview participants stated that some residents are highly concerned about potential negative impacts on services of the Beth Israel transformation plans and the St. Vincent closure. Concern about the planned Beth Israel transformation may be exacerbated as residents may not fully understand the plans. There is a perception that insufficient service capacity may result due to increases in the number of residents from new residential construction and greater health needs of an aging population. Development of Centers of Excellence and concentration of specialty services at other hospitals may create barriers to care as transportation options are limited for some residents, notably seniors and individuals with mobility problems.

Results of the community survey found that the top two issues identified by respondents as the most important in their neighborhoods were “access to physician, specialist,

physician assistant and/or nurse practitioner services,” (identified by 340 people or 47 percent of all respondents) and “hospital accessibility” (identified by 296 people or 41.4 percent of all respondents).⁹¹ When asked which issues have been improving, staying the same or getting worse over the past two to three years, the top response was “hospital access – getting worse,” listed by 160 people or 27.4 percent of respondents.⁹²

Exhibit 56: Location of Federally Designated Areas and Populations in the MSBI Community, 2017



While the CHNA reports that in Manhattan, “there are numerous locations for community residents to receive hospital services,” its list of 15 Manhattan hospitals includes a number of uptown facilities, including specialty hospitals, such as the Hospital for Special Surgery, and the NY Presbyterian facilities in extreme upper Manhattan, which are not convenient for lower Manhattan residents. Only Beth Israel, Bellevue Hospital and NY Presbyterian’s Downtown Hospital are located downtown, while NYU Langone is in the East 30s. In its review of available government data on health access, the CHNA included a map of Manhattan and Brooklyn areas designated by HSRA as “medically underserved.” Two of the areas so denoted were the Lower East Side and Chelsea/Clinton, as shown in Exhibit 56.

90. Community Health Needs Assessment, Prepared for Mount Sinai Beth Israel Hospital, Verite Healthcare Consulting, December 31, 2017.

91. Exhibit 63A, Mount Sinai Beth Israel CHNA.

92. Exhibit 64, Mount Sinai Beth Israel CHNA.

Residents of the area have expressed concerns about obstacles to seeking care at other hospitals, particularly due to increased cost and distance. At the Community Board 3 meeting, one community member said, “NYU doesn’t take the same insurances that Beth Israel takes,” adding that, “you cannot assume people can go to other hospitals because their insurance may not be accepted.” Several people voiced concerns about the time it would take to get to Mount Sinai uptown. Laura Sewell, a representative of the North Avenue A Neighborhood Association and Executive Director of the East Village Community Coalition, pointed out, “Nobody zips up First Avenue, especially when UN is in session.” Judith Zaborowski, co-chair of the 9th Street A1 Block Association, explained that caregivers are “much more burdened” by having to take kids or seniors to different locations uptown.

Demographic data for lower Manhattan that were included in the CNHA show a growing and diverse population, with 30 percent of the residents being foreign born (largely Asian and Latino). In the Lower East Side, 21.7 percent of the population is considered to be “linguistically isolated” and 11.9 percent living with a disability. Navigating a decentralized health delivery system – where patients need to go to one of multiple outpatient locations, or to Mount Sinai’s uptown “Centers of Excellence,” instead of to one downtown hospital facility for all care -- could be a challenge for such residents. Nearly a third of residents (29.8 percent) live in households with incomes below \$25,000 a year.

These findings in the CNHA are supported by comments from the community on access to care for those with disabilities and chronic illnesses. One resident, Evelyn Schafer, noted that “there are many deaf people in Chinatown from 15th Street to Avenue A and we need a place that is close” for any emergencies and problems. Another resident expressed hope that the audiology department at MSBI will remain open “as the deaf individuals in the community need that service.” Similarly, David Crane, a Community Board 3 committee member, mentioned the comprehensive services for AIDS at the Peter Kreuger Center within MSBI and said “it is critical that service remains in the community.” Another concern from the community was voiced by Joann Kennedy, a resident and worker at a special care center: “Those who are disabled can’t take the subway,” making it more difficult for them to see a doctor far away and for them to be visited by other community members during hospital stays.

Special state meeting to discuss the Beth Israel transformation

After multiple complaints from elected officials representing lower Manhattan about the lack of visible state oversight and opportunities for affected consumers to present their views on the Beth Israel transformation, the New York State Public Health and Health Planning Council (PHHPC) held a special informational meeting on June 8, 2017. The session took place immediately following a regularly-scheduled PHHPC meeting, which was held on a weekday in the state Department of Health Offices on Church Street in lower Manhattan. Because no full-review CON

had been filed to create the new Beth Israel facility, and all closures of existing Beth Israel units were proceeding behind the scenes through limited-review CONs, the PPHPC members were not being asked to vote on the transformation plan.

Representatives from Mount Sinai Beth Israel, elected officials and community members were all invited to speak at the meeting. Mount Sinai Downtown President Boal detailed Mount Sinai's plan to create a "multi-campus health care system" that spans lower Manhattan "from river-to-river." He also spoke about Mount Sinai's desire to get "smaller and leaner" as well as their desire to "build a very flexible model of care," which consists of "Centers of Excellence" across the city.⁹³

After Mount Sinai officials described their plan, NYS DOH Deputy Commissioner Daniel Sheppard from the Office of Primary Care and Health Systems Management presented an "absorption analysis" of whether or not other area hospitals would be able to assume the patient burden if Mount Sinai Beth Israel were decreased in size by hundreds of beds. Sheppard said inpatient bed occupancy in lower Manhattan was only 53 percent, compared to 63 percent across Manhattan and 67 percent in New York City as a whole. Mount Sinai Beth Israel's occupancy rate declined from 73 percent in 2012 to 55.9 percent in 2015, he said, citing the shift in surgical procedures from inpatient to outpatient and the opening of an expanded NYU emergency department and the new Lenox Hill healthplex (near the former site of St. Vincent's Hospital) in 2014. The DOH analysis, he said, showed that there was capacity at other hospitals, such as NYU and Bellevue, and that "the residents of Lower Manhattan aren't going to need to leave Lower Manhattan to get inpatient care."⁹⁴



As to the impact on emergency services in lower Manhattan, Sheppard said that the MSBI Emergency Department currently receives about 90,000 visits a year and "70 percent of those ED visits could have been treated in a primary or urgent care setting." The new MSBI ED will accommodate up to 70,000 visits annually "which will meet need," he said. Moreover, Sheppard said, Mount Sinai would be expanding its "outpatient footprint" in Lower Manhattan with 16 practice locations and 600 doctors, including a new urgent care center in Union Square.

New York City Public Defender Letitia James (shown in photo) questioned the DOH's absorption study, saying that those hospitals meant to absorb the population from the downsizing of MSBI

93. Boal, "The Transformation of Mount Sinai Beth Israel."

94. Dan Sheppard, "Analysis of Mount Sinai Downtown Plan" (PHHPC's Establishment and Project Review Committee, New York, NY, June 8, 2017), <http://www.totalwebcasting.com/view/index.php?func=VIEW&id=nysdoh&date=2017-06-08&seq=1>

might not be able to do so. James claimed that the absorption study and algorithms “did not take into account the current conditions and the financial challenges at Brooklyn Hospital,” one of the main hospitals DOH cited as able absorb the Brooklyn population that had been using Beth Israel for care.⁹⁵

Other community members expressed concern about access to care, particularly for the elderly and those on Medicaid who have been accustomed to using Beth Israel. Vaylateena Jones spoke on behalf of the Lower East Side Power Partnership and expressed her belief that, “the presentation hasn’t really focused on the services, on the patient experience.” She asked the Mount Sinai officials to come to the community and “explain what is there for the people in the community” and address “how safe is the elimination of particular services?”⁹⁶

LOWER EAST SIDE RESIDENTS VOICED CONCERNS ABOUT WHETHER THE NEW 70-BED HOSPITAL WOULD BE LARGE ENOUGH TO ACCOMMODATE PATIENT NEEDS, ESPECIALLY IF WIDESPREAD FLU OR OTHER CONDITIONS INCREASED DEMAND FOR INPATIENT CARE.

Mt. Sinai Beth Israel officials agreed to hold a meeting with the Lower East Side Power Partnership, a local community group, to discuss the plans. This meeting was held on July 24, 2017, at a church on the Lower East Side. One of the primary concerns raised by community residents was whether the new hospital would continue to have a full-service Emergency Department. Boal assured them that “everything we do now, we are going to have” at the new ED. Residents also said they were alarmed by the elimination of cardiac surgery and wanted to know if they could continue to receive diagnostic cardiac catheterization (to determine if someone has coronary artery blockage), and acute treatment of heart attacks and strokes. Boal said these services would remain in place, but that if someone needed emergency cardiac surgery they would need to be transferred to another hospital, such as Mount Sinai St. Luke’s at 114th and Amsterdam Avenue.

Lower East Side residents also voiced concerns about whether the new 70-bed hospital would be large enough to accommodate patient needs, especially if widespread flu or other conditions increased demand for inpatient care. Boal said the new hospital facility would have room to build additional floors of inpatient beds, but “we are still trying to figure out if we should build these now, based on trends in the marketplace.”

95. James, “Public Comment.”

96. Vaylateena Jones, “Public Comment” (PHHPC’s Establishment and Project Review Committee, New York, NY, June 8, 2017), <http://www.totalwebcasting.com/view/index.php?func=VIEW&id=nysdoh&date=2017-06-08&seq=1>

Increasing the capacity at the new facility has been one of the primary requests from the elected officials who have been meeting regularly with MSBI officials. Community leaders such as Arthur Schwartz of Progressive Action of Lower Manhattan have also voiced concerns that “an ER with 70 beds isn’t going to provide the kind of services people need. In most cases, it will be a way station and they would transfer people elsewhere.”

No decision about changing the size of the facility has been announced, but there were indications early this year that certain steps might be taken to make the new facility ready to add more capacity quickly, if needed. In February 2018, Mount Sinai officials indicated they are leaning towards building an additional four floors that would allow for adding more beds if the hospital sees “a dramatic change in the future” in the needs of the community. Mount Sinai said they have listened to concerns from the community and local leaders, but because they still believe 70 beds at the Beth Israel location will meet community medical needs, the extra floors would be used for “programmatic use,” not beds, at least initially.⁹⁷ Although Mount Sinai announced it would be filing a full-service CON application for construction of the new facility in the fall of 2017, no such CON was filed by early 2018.

97. Lincoln Anderson, “Mount Sinai ‘leaning toward’ adding extra floors on new E.V. Mini-Hospital,” The Villager Newspaper, February 5, 2018, <http://thevillager.com/2018/02/02/mount-sinai-leaning-toward-adding-extra-floors-on-new-e-v-mini-hospital/>

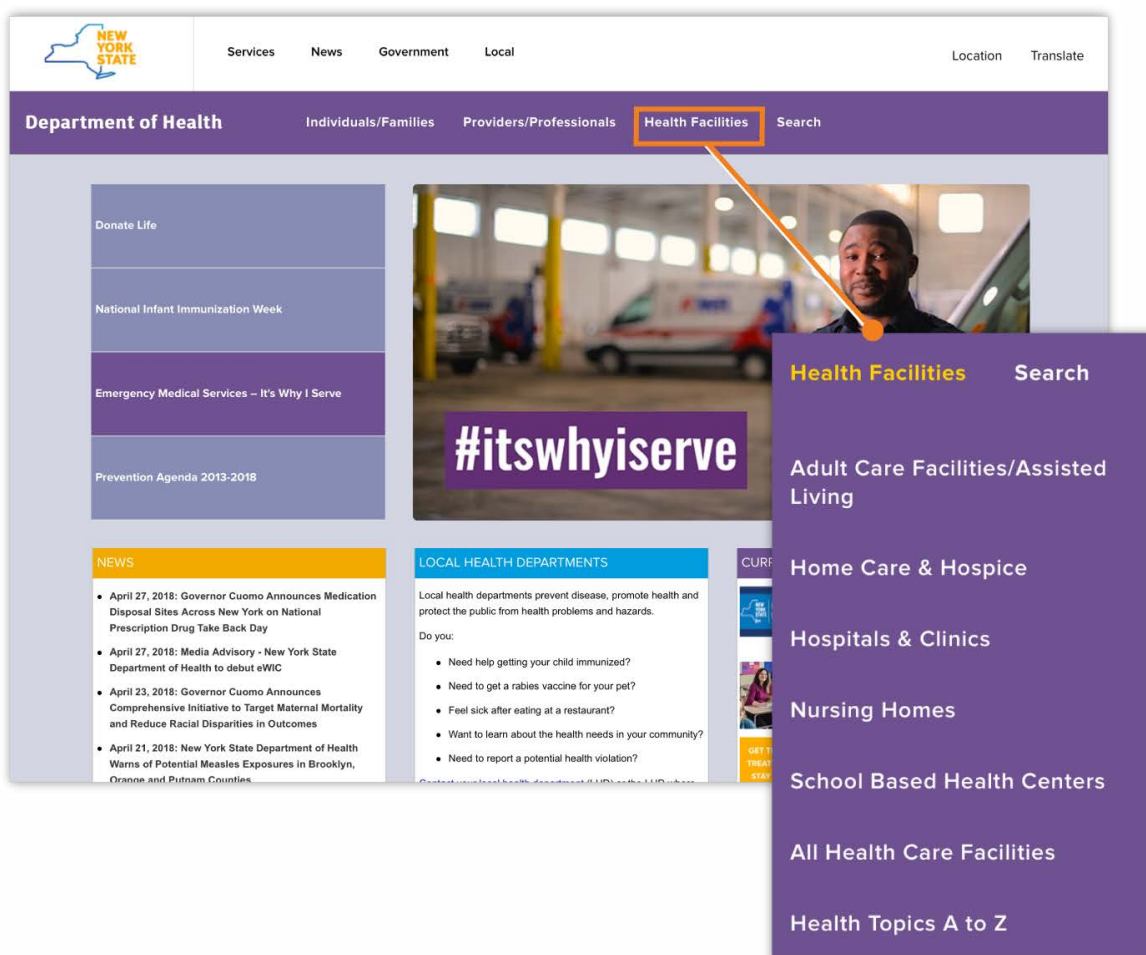
APPENDIX C

Making the NYS DOH website more consumer-friendly in providing CON information

New York health care consumers trying to learn about potential changes to their local hospitals and health systems would have a difficult time locating the information by navigating through the New York State Department of Health website as it is currently organized. MergerWatch has carefully reviewed the website and compared it to those from some other states. We recommend a series of changes to make the NYS DOH website more consumer-friendly in providing information about pending hospital transactions.

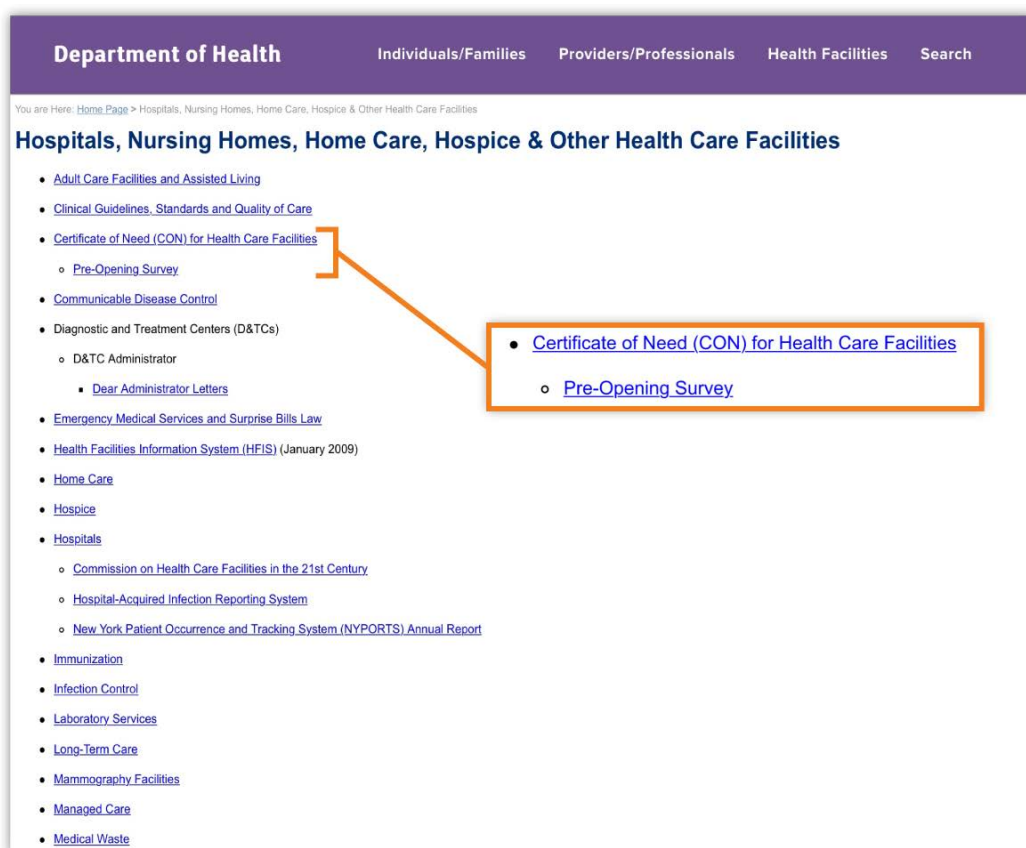
What are the impediments to easy consumer navigation?

The first issue is getting to the CON homepage from the DOH homepage. On the NYS website, to get to a page with an easy-to-find link to the CON page, consumers first have to click on the tab reading **"Health Facilities."**



Those looking for information about their local hospitals would likely assume they should click on the **“Hospitals and Clinics”** section. However, that section does not lead to a page of relevant CON information. Instead, consumers must choose the **“All Healthcare Facilities”** section, which will take them to a manageable list of choices.

Once a visitor lands on the **“All Healthcare Facilities”** page, the fourth choice on the list is the **“Certificate of Need (CON) for Health Care Facilities”** link. However, there is no explanation of what Certificate of Need means, so a consumer might not know to make this choice.



We recommend including an explanation on the **All Health Care Facilities** page of what CON means so consumers know that is what they are looking for and are prompted to click on this link.

However, we believe that consumers looking for information about their hospitals are more likely to click on the **Hospitals & Clinics** tab, rather than the **All Health Care Facilities** tab.

Clicking on the **Hospitals & Clinics** tab takes them to a page called **Hospitals and Diagnostic and Treatment Centers (Clinics) in New York State**. In fact, that page’s text already describes

the Department’s responsibility for “regulatory oversight of all hospitals and their off-site clinics,” so it is a good place to provide more information about the CON process.

The **Hospitals & Clinics** page is the place to add text explaining that hospitals must submit Certificate of Need (CON) applications for state permission to add new facilities, beds or programs, to merge with a health system or to consolidate, downsize or close hospitals or units of a hospital. A link to the CON homepage could be added in this explanatory section and also in the menu on the left-hand side of the **“Hospitals & Clinics”** page, under the **“Information for Consumers”** heading, which now has links pertaining to **“Patients’ Rights,” “Paying for Your Hospital Care”** and other topics. This new heading could say **“Proposed Changes to Hospitals.”** Below is a depiction of the current page with indications to where this new information could be placed.

The screenshot shows the Department of Health website page for "Hospitals and Diagnostic and Treatment Centers (Clinics) in New York State". The page has a purple header with navigation tabs: "Individuals/Families", "Providers/Professionals", "Health Facilities", and "Search". The main content area is titled "Hospitals and Diagnostic and Treatment Centers (Clinics) in New York State" and includes introductory text, a list of facility types, and program information. A left-hand navigation menu is visible. Two orange callout boxes with arrows point to specific areas: one points to the list of facility types with the text "Insert 'Proposed Changes to Hospitals' heading here", and another points to the introductory text with the text "Insert CON explanation here".

The other likely choice consumers would make on the DOH website home page when looking for information on their local hospitals is the tab labeled **Individuals/Families**. We propose adding a drop-down menu item under that tab called **My Hospitals** that would take visitors to the current Hospitals & Clinics page. Visitors who have chosen the Individuals/Families tab might also click on the **Consumer Health Information** item in the drop-down menu. There, they can find out about enforcement actions at their local hospitals, but not whether their hospitals have submitted CON applications to merge, downsize or close. To aid such visitors in navigating to the hospital information they are seeking, add a boxed section called Hospitals and Health Systems to

the **Consumer Health Information** page. Include in this section the “Proposed Hospital Changes” link, referred to above, which would again take a website visitor to the **CON homepage**. See depiction of these proposed changes on the next page.

Consumer Health Care Information

The information on this web site includes physician credentials and disciplinary actions, results of recent hospital and nursing home surveys, performance measures for managed care plans, and physician and hospital performance for cardiac bypass surgery.

Consumers and providers will also find information on how to file a confidential complaint about healthcare quality, review public health laws and regulations, and gain access to clinical guidelines and other healthcare best practices.

| Profile Sites | Performance Measures | Resources | Complaints about Care |
|--|---|---|---|
| <ul style="list-style-type: none"> • Home Care Profile • Hospice Profile • Hospital Profile • NYS Provider & Health Plan Look-Up Tool • Nurse Aide Registry • Nursing Home Profile • Physician Profile • Prescription Drug Price Website | <ul style="list-style-type: none"> • Cardiac Surgery and PCI (Angioplasty) Reports and Forms • Managed Care Performance | <ul style="list-style-type: none"> • Patients' Rights in New York State • Patient Safety Center • Laws and Regulations • Medicaid Fraud | <ul style="list-style-type: none"> • Adult Care and Assisted Living: 1-866-893-6772 • Funeral Homes/Directors: 518-402-0785 • Home Care and Hospice: 1-800-628-5972 • Hospital Patient Care: 1-800-804-5447 • Hospital and Diagnostic and Treatment Center: 1-800-804-5447 • Laboratory Complaints: 1-800-682-6056 • Medicaid Fraud: 1-877-87FRAUD • Managed Care (including commercial health plans and Medicaid managed care): 1-800-208-8125 • Nursing Home: 1-888-201-4563 • Professional Medical Conduct: 1-800-863-6114 |

Insert Hospitals Health Systems box here

The next set of recommendations has to do with the CON homepage itself. **The Certificate of Need (CON) homepage should be more consumer-friendly.** It is currently designed for CON applicants, not for members of the general public, and is difficult to navigate. There is a brief explanation of the Certificate of Need process under the grey box. The explanation notes that the process is responsible for oversight of the “establishment, construction, renovation, and major medical equipment acquisitions of healthcare facilities.” There is no explicit mention of closings, mergers, or downsizings on the page so members of the public must assume those are also covered in the CON process if they do not already have that information.

Department of Health Individuals/Families Providers/Professionals Health Facilities Search

You are Here: [Home Page](#) > [Hospitals, Nursing Homes & Other Health Care Facilities](#) > Certificate of Need

Certificate of Need

Certificate of Need (CON)

CON Homepage

Pre-Opening Survey

Public Health and Health Planning Council

NYSE-CON

Construction Notices

FQHC Capital Projects

State Environmental Quality Review Documents for Public Health Law § 2802 Construction Approvals

Medical Technology Demonstration Project Proton Beam Therapy

Join the CON Listserv

Amendments to 10 NYCRR Section 710.1

Effective September 6, 2017, Section 710.1 of Title 10 of the New York Codes, Rules, and Regulations (NYCRR) was revised with the following changes:

- Revised Application Project Cost Review Level Thresholds for Hospitals**
- Revised Construction Notice submission Thresholds
- HIT projects are now eligible to be submitted as Construction Notices

The following may be helpful in determining the correct application type.

- [Section 710.1 Effective 09-06-2017](#)
- [Matrix of Project Cost Review Level Thresholds**](#) (PDF)

**Review Level Thresholds are only one component in determining the correct application type to be submitted. Please consult Section 710.1 to determine, for individual project level.

If you have any questions regarding these changes, please email cons@health.ny.gov

New York's Certificate of Need (CON) process governs establishment, construction, renovation and major medical equipment acquisitions of health care facilities, such as hospitals and diagnostic and treatment centers.

The objectives of the CON process are to promote delivery of high quality health care and ensure that services are aligned with community need. CON provides the Department with information on duplicate beds, services and medical equipment which, in turn, limits associated health care costs.

- [How to Determine if CON Submission is Required](#)
- [How to submit a CON application](#)

By contrast, the Washington State DOH website has a more comprehensive initial explanation of CON with a simpler interface, as shown below.

The screenshot shows the Washington State Department of Health (DOH) website's 'Certificate of Need' page. The breadcrumb trail at the top reads: 'Licenses, Permits and Certificates > Facilities - New, Renew or Update > Certificate of Need'. The sidebar on the left contains the following links: Certificate of Need (highlighted), Application Fees, Application Forms, Applications Submitted, Decisions and Evaluations (+), Letters of Intent, Need Methodologies, Program Contacts, Public Notice (+), Reports and Guidelines, Resource Links, Review Process, Rule-making Activities (+), and Statutes & Rules. The main content area is titled 'Certificate of Need' and includes a 'Program Overview' section. The overview text states: 'The Certificate of Need Program is a regulatory process that requires certain healthcare providers to get state approval before building certain types of facilities or offering new or expanded services. Program staff members are available to provide technical assistance to you before submitting your application. Staff members are also available to help you determine if a Certificate of Need is necessary. For example, a Certificate of Need is required if a hospital wants to add to the number of its licensed beds. The Certificate of Need process is intended to help ensure that facilities and new services proposed by healthcare providers are needed for quality patient care within a particular region or community.' Below this, a section titled 'Certificate of Need review is required for:' lists 'Construction, development or establishment of the following healthcare facilities:' with a bulleted list: Hospitals, Nursing homes, Kidney dialysis centers, Medicare or Medicaid home health agencies, Medicare or Medicaid hospice agencies, Ambulatory surgical centers, and Hospice care centers. An example is provided: 'Increases in the number of stations at a kidney dialysis center.'

We recommend starting the NYS DOH's CON homepage with a more inclusive explanation of the CON process, including a description of the types of transactions that require CON approval, with an explicit mention of mergers, downsizing and closures. Explain the process by which CON applications are submitted, reviewed and approved, disapproved or withdrawn.

We also suggest dividing the NYS DOH website's CON home page into two sections, one for consumers and one for health facilities. By clicking on "for consumers," website visitors would be moved down the page to the correct section. Include in the consumer section and in the sidebar menu a direct link to the **"Public Comment on CON Applications"** page, which brings website visitors to a page with information on how to comment on CON applications in writing and in person. It would be useful to move this page to a more prominent place on the website than where it currently can be found.

Consumers have a strikingly different experience in finding how to submit comments about pending CON applications when looking at the New York State versus the Washington state website. On the NYS CON page, the **"Public Comment on CON Applications"** page is currently buried at the bottom of the CON homepage under the **"Public Health and Health Planning Council"** bullet, as shown on the next page.

11:33 AM
health.ny.gov

- [3.10.0 Programmatic Design Guidelines for Renal Dialysis Centers \(PDF\)](#)
- [3.11.0 Programmatic Design Guidelines for Outpatient Psychiatric Centers \(PDF\)](#)
- [3.12.0 Programmatic Design Guidelines for Outpatient Rehabilitation Therapy Facilities \(PDF\)](#)
- [3.14.0 Programmatic Design Guidelines for Dental Facilities \(PDF\)](#)
- ASHRAE Tables for Healthcare Facilities
 - [ASHRAE Table 7-1 Design Parameters \(PDF, 273KB\)](#)
- Waiver Submission Guidelines
 - [Drawing Submission Guidelines: DSG-06 Waiver Request](#)
 - [Submission Requirement for Time Limited Waivers P](#)
 - [Submission Requirement for Time Limited Waivers P](#)
- Construction Waiver/Equivalency Request
 - [Construction Waiver/Equivalency Request Form - DC](#)
- [Pre-Opening Survey](#)
 - [Environmental Documentation Checklist \(PDF, 115KB\)](#)
- [Section 711.2 - Pertinent Technical Standards](#)
- [Public Health and Health Planning Council](#)
 - [Report of the Public Health and Health Planning Council on Redesigning Certificate of Need and Health Planning](#)
 - [Public Comment on CON Applications](#)
 - [Local Planning](#)
 - [Join the CON Listserv](#)
- CON Applications Distributed and Approved 1996-2010
 - [1997 - 2010 Applications Approved](#)
 - [1996 - 2010 Applications Distributed to DOH Staff for Review](#)
- CON History and Historical Documents
 - [Questions from Nursing Homes Applying to Enhance Vent Bed Services in New York City](#)
 - [State Hospital Review and Planning Council](#)

By contrast, Washington State has its link to the information about public comments on the sidebar of the homepage under the tab **“Public Notice”** as shown at right.

We also propose adding a FAQ link to the consumer section on the NYS DOH CON page to address questions patients and consumers may have about CON, similar to the one Washington State calls **“Hearing FAQ,”** under its **“Public Notice”** tab. As shown on the next page of this appendix, the **“Hearing Washington FAQ”** provides a long list of questions and answers about the CON process and how members of the public can get involved and express their opinions. The questions and answers are both clear and concise, making it easy for any member of the public to understand.

| | |
|---------------------------|----------|
| Certificate of Need | |
| Application Fees | |
| Application Forms | |
| Applications Submitted | |
| Decisions and Evaluations | + |
| Letters of Intent | |
| Need Methodologies | |
| Program Contacts | |
| Public Notice | + |
| Reports and Guidelines | |
| Resource Links | |
| Review Process | |
| Rule-making Activities | + |
| Statutes & Rules | |

| | |
|-----------------------------|--|
| Certificate of Need | <h2>Certificate of Need</h2> <h3>Frequently Asked Questions about Public Hearings</h3> <ul style="list-style-type: none"> ▼ What is the purpose of the hearing? ▼ Do I register to speak on an issue and then present information to you or the applicant? ▼ To whom will I be speaking? ▼ Will the hearing be recorded? ▼ Will representatives from the applicant be present? ▼ Will I be able to ask the department and the applicant questions? ▼ How will my comments be used? ▼ Are our comments and questions to be addressed by the department later? ▼ Must questions and comments be presented in writing? ▼ What is the time allotment for each commenter? ▼ What happens after the close of the public hearing? ▼ How do I get copies of the written comments and hearing recording? ▼ How do I find out what the decision is? |
| Application Fees | |
| Application Forms | |
| Applications Submitted | |
| Decisions and Evaluations + | |
| Letters of Intent | |
| Need Methodologies | |
| Program Contacts | |
| Public Notice - | |
| Hearing FAQ | |
| Reports and Guidelines | |
| Resource Links | |
| Review Process | |
| Rule-making Activities + | |
| Statutes & Rules | |

In the consumer section of the NYS DOH CON homepage, there should also be a link to the latest Public Health and Health Planning Council meeting dates and agenda information, updated regularly. Washington's website provides this when users click on the **"Public Notice"** section (see next page).

| | |
|-----------------------------|--|
| Certificate of Need | <h2>Certificate of Need</h2> <h3>Public Notices</h3> <p>Schedule of public hearings</p> <h3>Beginning of Review Notices</h3> <h4>April 2018</h4> <ul style="list-style-type: none"> • April 26 – Northwest Eye Surgeons (App#18-23) (PDF) – application proposing to establish an ambulatory surgery center in Sequim, Clallam County. • April 16 – Northwest Eye Surgeons (App#18-25) (PDF) – application proposing to establish an ambulatory surgery center in Seattle, within north King County. • April 16 – Northwest Eye Surgeons (App#18-24) (PDF) – application proposing to establish an ambulatory surgery center in Mount Vernon, within east Skagit County. • April 4 – CHI Franciscan Health (App#18-19) (PDF) – application proposing to add 11 Level III neonatal intensive care (NICU) beds to St. Joseph Medical Center in Tacoma, Pierce County. • April 2 – Public Hospital District No. 1 of King County dba Valley Medical Center (App#18-18) (PDF) – |
| Application Fees | |
| Application Forms | |
| Applications Submitted | |
| Decisions and Evaluations + | |
| Letters of Intent | |
| Need Methodologies | |
| Program Contacts | |
| Public Notice - | |
| Hearing FAQ | |
| Reports and Guidelines | |

Public Notices

[Schedule of public hearings](#)

Finding the list of meetings on the New York website is more complicated. The meeting agendas are not posted until shortly before the next PHHPC meeting, usually a week before. So, if consumers click on the **“View upcoming Public Health and Health Planning Council Meetings”** link on the **“Public Comment”** page prior to the posting date, they will find meetings that are not relevant at all to what they are looking for.

Public Comment on CON Applications Subject to Administrative and Full Reviews

- To find an application, [Search NYSE-CON](#)

How to comment on a CON application

The Department reviews comments on CON applications from interested stakeholders concerning the certificate of need review criteria: public need, character and competence of the operator, and financial feasibility. Comments concerning issues that are unrelated to these review criteria, such as zoning or historic preservation, are not considered.

There are two ways to comment on a CON application:

- 1. In writing**

You may submit written comments to either address below:

 - cons@health.ny.gov
 - Bureau of Project Management
Division of Health Facility Planning
New York State Department of Health
Corning Tower - Room 1842
Empire State Plaza
Albany, New York 12237

Please identify the application in question **by name and application number** and provide a concise statement, limiting your comments to the relevant CON review criteria. Commencing with applications [distributed for review](#) on or after August 1, 2009, comments received **more than 20 days** after the date the application in question is distributed may not be considered, unless there are extenuating circumstances that would justify an extension of the deadline.
- 2. In person**

If an application is subject to [full review](#), you may testify before the Establishment and the **Committee's agenda**.

To determine if an application is on an upcoming agenda:

 - [View upcoming Public Health and Health Planning Council Meetings](#)

To find an application:

 - [Search NYSE-CON](#)

[View upcoming Public Health and Health Planning Council Meetings](#) is on the

Department of Health Individuals/Families Providers/Professionals Health Facilities Search

You are Here: [Home Page](#) > [\(none\)](#) > Meetings, Hearings and Special Events

Meetings, Hearings and Special Events

- [Record of Appearance](#)
- [NYSDOH Webcasts](#)

April 2018

Friday, April 27, 2018

Please be advised that the New York State Transplant Council will be meeting on April 27, 2018 from 10:00 am to 4:00 pm. The meeting will be held at the following location:

- Dormitory Authority of the State of New York
1 Pennsylvania Plaza
New York, New York, 10119

Video conferencing will also be available at the NYS Department of Health, Western Regional Office, 584 Delaware Avenue, Third Floor, Buffalo, New York, 14202.

Persons planning to attend this meeting must send their name to Tammy Irizarry at tammy.irizarry@health.ny.gov prior to the meeting and bring a picture ID to gain access to the DASNY and New York State Department of Health buildings.

May

Wednesday, May 2, 2018

Making the pages that are dedicated to consumers more accessible will greatly increase transparency and user-friendliness of the website.

The final recommendations we have for the website have to do with **enabling consumers visiting the website to more quickly and easily find CON applications that have been submitted by their local hospitals**. Currently, consumers must find and then attempt to navigate through a search on the **New York State Electronic Certificate of Need (NYSE-CON)** page, which they can find on the main CON homepage. However, even conducting a “simple search” for an application through this NYSE-CON system is difficult and searches often come up empty unless the visitors have the exact legal name of the facility or the project number. For example, a search for applications relating to “Mount Sinai Beth Israel Hospital” produced a “No projects” result, but a search for “Mount Sinai Beth Israel” produces many results, some relevant and others outdated.

The screenshot shows a web browser window at apps.health.ny.gov. The page header includes the New York State logo and navigation links for Services, News, Government, and Local. Below the header is the Department of Health logo and a search bar. The main content area is titled "Search Applications" and includes a "Certificate of Need (CON)" sidebar with links to the CON Homepage and NYSE-CON Homepage. The search form contains the following fields:

- Facility Name:
- Operator Name:
- Facility Type:
- County:
- Region:
- Project Description: (Any Keyword)

Buttons for "Search" and "Clear" are located at the bottom right of the form. A "Notice" section at the bottom of the page provides a disclaimer regarding the accuracy and completeness of the information.

Other states have clearly labeled sections of the websites for “pending applications” and update those weekly, such as Washington’s **“Applications Submitted”** section on the sidebar. Washington’s website has a page that has tables of information on received applications, including the date the application was received, the project type, project number, project county, and applicant name. There is no need to search for the information and sift through pages of irrelevant projects. All of the information is clearly laid out for consumers.

Certificate of Need Applications Submitted

Last revised date: April 24, 2018

The Certificate of Need Program reports the following applications are in the pre-review stage or have been submitted.

Nursing home bed banking applications submitted

| Date received | Project type* | Applicant | Project county | Project number |
|-------------------|-----------------|--|----------------|----------------|
| September 8, 2017 | AU Bed Banking | Woodland Convalescent Center | Cowlitz | BB #18-03 |
| December 22, 2017 | AU Bed Banking | Providence St. Joseph Care Center | Spokane | BB #18-07 |
| February 16, 2018 | FFC Bed Banking | Health and Rehabilitation of North Seattle | King | BB #18-09 |

Determinations of reviewability or exemptions submitted

| Date received | Project type* | Applicant | Project county | Project number |
|-------------------|---------------|---|----------------|----------------|
| May 17, 2017 | ASC | Proliance Surgeons, PS | Pierce | DOR #17-19 |
| August 16, 2017 | ASC | Washington Center for Pain Management, PLLC | Thurston | DOR #18-02 |
| November 15, 2017 | ASC | Pacific Cataract & Laser Institute | King | DOR #18-09 |
| December 15, | ASC | Sound Plastic Surgery | King | DOR #18-13 |

Summary of recommended website changes

We suggest that the NYSE-CON system be supplemented by adding to the new proposed consumer section of the CON home page three links to new proposed pages (or sections of a page) modeled on those from these other states:

1. **Letters of Intent**, which would be updated frequently with the full Letters of Intent received by the DOH for potential CON applications.
2. **Pending CON applications**, which would provide a list of completed CON applications scheduled for upcoming review with attachments of the full CON that was filed.
3. **Recently Reviewed CON Applications**, which would provide a continually updated list of CON applications that have recently been reviewed and either approved, disapproved or withdrawn.

Each of these lists should include the exact facility name and project number that could then be used to search in the NYSE-CON system for further information. A link to the NYSE-CON system should be included as well.

Aside from webpages that are simple, informative, and easy to find on the Washington State DOH website, the visuals of the WA website are also accommodating for average members of the public. The font is generally large and easy to read. There are not too many choices on each page and links are spread out enough that it is easy to click on exactly what users are looking for. The CON process is confusing, and the Washington State DOH website is not perfect, but it is much more user-friendly and transparent than the current NYSDOH CON homepage.

To recap, we have three major recommendations:

1. **Include links to information about hospital transactions in the drop-down menus launched by two “tabs” on the homepage of the DOH website, which are the ones consumers might logically choose to look for information about their hospitals.**
2. **Make the Certificate of Need (CON) homepage more consumer-friendly.**
3. **Enable consumers visiting the website to more quickly and easily find CON applications that have been submitted by their local hospitals.**

We believe these changes would improve the website and allow consumers to better engage with the CON process.

APPENDIX D

Hospital data: Sources, methods and analysis

Patricia HasBrouck of Madison Healthcare Advisors, an independent health care consulting firm in Saratoga Springs, NY, worked with MergerWatch staff to research and analyze hospital data for this study, including assembling the list of hospitals closed over the last 20 years and the list of the dozen largest hospital systems, ranked by staffed acute care beds.

For the list of the dozen largest hospitals ranked by staffed acute care beds, hospital utilization and affiliation data were acquired from Definitive Healthcare, a health care informatics company that maintains an integrated comprehensive hospital database that is updated daily. Definitive Healthcare uses hospitals' most recently filed Medicare cost reports for the financial and utilization data. Medicare-certified institutional providers are required to submit an annual cost report that contains provider information such as facility characteristics, utilization data, cost and charges, and financial statement data. The data used for this report were mostly reported for hospital fiscal year 2016 (82 percent of hospitals reporting) with 16% reporting 2017 data and the remainder for earlier time periods. Psychiatric, long-term care, rehabilitation, pediatric, federal and developmental facilities are excluded from the analysis.

Consultant Fred Hyde and Associates of Ridgefield, CT, assembled and analyzed the audited financial statements of the dozen largest hospital systems in order to produce our table showing the systems ranked by net assets. Hospital and health system financial data were obtained directly from 2016 audited financial statements.

Additional information on hospitals such as current hospital name; status as open, closed or merged; current use of former hospital facilities; and network affiliations were obtained through primary research accessing a number of resources. The Medicare Provider Number was used to link data from various resources to the appropriate hospital.

Findings from the data have been used in connection with other information sources to develop a more complete picture of the healthcare environment and the dynamics of the changing systems of care.

Data Sources:

Definitive Healthcare – Hospital Database

<https://www.defhc.com/hospitals/HospitalSearch>

note – accessible only by licensed users

New York State Department of Health – NYS Health Profiles, NYS Hospital Profiles

<https://profiles.health.ny.gov/hospital/> accessed between 10/01/2017 and 10/26/2017

Hospital names, services and beds were verified/updated.

New York State Department of Health - New York State Health Care Reform Act (HCRA) General Hospital List as of September 1, 2017

<https://www.health.ny.gov/regulations/hcra/provider/provhosp.htm>

Hospital Status: Open, Closed, Merged

New York State Department of Health, Health Facility General Information

<https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r/data>

This dataset contains the locations of Article 28, Article 36 and Article 40 health care facilities and programs from the Health Facilities Information System (HFIS).

New York State Department of Health – SPARCS Hospital Inpatient Discharges 2011 Reporting Data Completeness Issues.

Citations of hospitals that have closed and include notes on date of closure or current status.

<https://www.health.ny.gov/statistics/sparcs/annual/ip/2011/>

Other sources – detail available upon request

Hospital and health system audited financial statements

Newspaper articles – hospital mergers and closings

Hospital websites – hospital history, facilities, locations, services and system affiliations

Health care system websites – affiliated hospitals