Testimony of the

Iroquois Healthcare Alliance

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New York State Department of Health,
State Hospital Review and Planning Council Planning Committee,
and
Members of the Public Health Council

regarding

Health Planning and Certificate of Need

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Good afternoon members of the Public Health Council, State Hospital Review and Planning Council, and Department of Health Staff. I am Gary Fitzgerald, President of the Iroquois Healthcare Alliance, a membership organization representing 55 hospitals and their affiliated organizations in 31 upstate counties. I want to thank you for the opportunity to speak briefly on the subject of health planning. IHA's membership is diverse in that it comprises 32 rural hospitals including 8 Critical Access Hospitals, and represents the smallest hospitals in the state as well as some of the largest teaching hospitals in Upstate New York.

In anticipation of this discussion, we formed a local health planning advisory group. This group is made up of 15 hospitals, and many of these responded to the questions that were distributed with the notice of these public hearings. Their comments have been included in an attachment with this testimony. I will use my ten minutes to comment on the broader concepts of health planning.

As you listen to testimony regarding health planning, you will undoubtedly tire of hearing people talking about a "level playing field." I had the opportunity to work with a senior manager from General Electric Corporation in Schenectady in the early 1990s. We worked together in developing "critical pathways of care" for 19 hospitals based on concepts used in G.E.'s manufacturing operations. This individual often chided me about hospitals' whining and complaining about an unlevel playing field when it came to competition from other providers. He boasted that G.E. had competition from companies around the world and had to constantly adapt and innovate in order to remain profitable. He suggested that hospitals in New York could learn a lot from the private sector. I was impressed and thought for a while that he was right, until I watched how G.E. (and other companies) acted in response to competition. G.E. had almost unlimited capital. G.E. could also lay off 600 people in a week and shut down its operations in Upstate New York. G.E. could then move its operations to another state or country. G.E. does not have to sell light bulbs to individuals who can't pay for them. Obviously, our hospitals do not have those options. Some of the hospitals that I represent have been serving their communities for over 150 years. Some have gone through bankruptcy and are still providing care in their communities. All have suffered inadequate government payment rates and most have survived the Berger Commission. As of today, none have moved their operations to India.

Hospitals, therefore, have a right to insist on leveling the playing field when it is their mission to accept all patients regardless of their ability to pay, and provide access to quality health care in their communities without regard to their financial condition.

The new CON policy must encourage access by rewarding providers who are willing to accept all patients. Physician organizations and surgery centers and other practitioner-based services must comply with the same CON requirements as hospitals. "Free standing" organizations must take Medicaid and Medicare patients and must be willing to have a charity care policy similar to the recently mandated hospital charity care policy. If the Department of Health does not have the resources to monitor these requirements, local health planning groups may collect this utilization data as part of a new local health planning data set. Providers who have consistently demonstrated a willingness to accept all patients and provide community services should be given preferred CON status.

In establishing a new health planning policy in New York State, resources or more accurately the lack of resources should be given serious consideration. Given the current State fiscal problems, it is highly unlikely that the Department of Health will see an increase in staff resources to handle CON applications. This reality is not likely to change in the future. This is an opportunity to simplify and eliminate non-direct patient care items from the CON process. The updating or replacement of equipment, changes of location of services within a system, or the establishment of a physician practice by an Article 28 facility, are just a few examples of items which could easily be eliminated from the CON process. We will provide you with a more comprehensive list of these items in the very near future.

Serious consideration should also be given to an approval time requirement. Certain CON requests which are routine, if not eliminated from the CON process entirely, should be deemed approved if action is not taken within 60 days.

A major goal of health planning is the control of new, costly technology. Who decides how many of the latest high tech diagnostic machines should be approved and where should they be located? During the past 18 years that I have been working in health care in New York State, we

have successfully avoided creating a "two-tiered" system of health care; a system with one level of care for Medicaid patients and the uninsured and a different level of care for the patients with private insurance. As we consider making changes in health planning, we must be careful that we do not create or perpetuate another "two-tiered" health system, that is rural versus urban. One version of a plan that would deal with the proliferation of new technology would have the latest technology located in urban areas and have rural/small community hospitals affiliate with tertiary hospitals to access that technology. That model may work in some cases, but should not be seen as the only answer. People in New York State who choose to live in a rural community should not be denied access to the best health care available. The CON process should encourage the rural-to-urban model as well as a rural-to-rural model in which rural providers are allowed to create organizations which could owner and operate high tech health care services.

The "new" CON process must be able to address regional needs. Upstate New York is currently experiencing a severe problem in recruiting and retaining physicians. This problem has been well documented. Hospitals in Upstate are increasingly hiring doctors as employees and setting up practices or purchasing physician practices. Without this support from the hospital, in many Upstate communities, the physician shortage would be much worse, and access to care severely limited. The "new" CON process should encourage this behavior not discourage or delay these transactions as it currently does. At present, these transactions are delayed for months because the relationship requires the establishment of a new Article 28 given the hospital's involvement. This requirement has caused physicians and hospital relationships to fail and has exacerbated the physician shortage problem in Upstate New York. CON policy should be flexible to address the problems of access in a more timely fashion, not etched in stone to be addressed every ten years or so.

Finally, I'd like to address the subject of local health planning data and local health planning organizations. Health planning must occur at a local level to recognize the needs and issues of the local community. In discussing the Department of Health's recent RGA regarding local health planning, it became apparent that there are many different sources for local health planning data. There are also huge holes in that data. Census data, Medicaid data, Medicare data, and SPARCS data can be useful to <u>predict</u> future health care needs and population trends. However, that prediction is only a guess, and the great majority of that data is on <u>inpatient</u>

hospital activity. Very little data exists in those public sources on outpatient activity or physician activity outside of the hospital. To accurately plan any local health services, the outpatient and physician data is essential.

One area where that data is available is from the health insurance plans. Serious consideration should be given to mandating that certain data elements from the health plans be available to assist in local health planning. This could be done by aggregating the data and would not be plan or patient specific. It is the only way to accurately capture physician service data in this state.

A local health planning organization must be truly local. NYPHRM regions and Berger regions are not local planning regions. Local planning organizations must represent community stakeholders equally. In the Capital Region, an example of such an organization could be the Health Information eXchange of New York (HIXNY). Founded by IHA and the New York Health Plan Association (HPA), the governance structure of HIXNY allows all stakeholders equal representation.

Thank you again for your time and the opportunity to comment. I hope that during your deliberations you will seriously consider the issues that I have discussed with you today. The members of the Iroquois Healthcare Alliance look forward to working with you in making sure that quality, affordable health care is accessible to all of the citizens of New York State. I am happy to respond to any questions.