

## **Frequently Asked Questions Concerning the Brooklyn Hospitals Safety Net Plan**

### ***Question: Whose plan is this?***

Answer: Development of the plan was originally sponsored by the unions representing public employees at the SUNY Downstate Medical Center and University Hospital of Brooklyn. Now it is under consideration by major unions representing other Brooklyn hospitals, by medical and executive leaders of those hospitals, and by the Brooklyn Delegation (Assembly and Senate) for adoption as a borough-wide safety net plan. If adopted, its implementation will hopefully be spearheaded by the Borough's President-Elect, overseen by a committee of emergency department physician directors.

### ***Question: What is the basic idea of this plan?***

Answer: to bond for \$1.3 billion, generating funds to help Brooklyn hospitals transform their “business model”—with much greater emphasis on comprehensive ambulatory care. Also, to provide funds for current hospital financial emergencies, for example, those at Long Island College Hospital and Interfaith Medical Center. Bonding of \$1.3 billion, over 40 years at 3%, will cost \$56 million per year, to be repaid from the State's receipt of section 1115 waiver funds.

### ***Question: What are alternative plans?***

Answer: No genuine alternative plans have been put forward. No other plans address the interrelated problems of the financial instability of Brooklyn hospitals and the absence of decentralized, comprehensive ambulatory care. Also, no other suggestions or comments made address this question: How do we reconfigure the curriculum for graduate medical education (residency physicians) to include continued and meaningful exposure to ambulatory care?

### ***Question: I heard that the alternatives are closing University Hospital of Brooklyn, bringing in private investment for Brooklyn hospitals, or creating a “trophy hospital” (consolidating Brookdale, Kingsbrook Jewish and University Hospital of Brooklyn) in East Flatbush.***

Answer: None of these are “solutions” to patient care and hospital stability problems in Brooklyn. Closing University Hospital will (a) compromise the medical education mission of SUNY Downstate, (b) sacrifice the federal funds under Medicare reimbursement to teaching hospitals and (c) therefore compel the State to substantially increase funding of SUNY Downstate.

Private investment is interested in profitable operations, or those which can be made profitable. The income of Brooklyn hospitals depends disproportionately on Medicaid; under payment for hospital services is at the root of Brooklyn hospital financial problems. A “trophy hospital” would (a) make medical care less accessible and (b) add new fixed inpatient cost.

***Question: What makes the Brooklyn Hospitals Safety Net Plan unique?***

Answer: This plan proposes to improve services for the under- and uninsured, and, at the same time, create jobs in the ambulatory setting to absorb those who have clinical and support skills who are working now in the inpatient setting.

***Question: How would hospitals be more financially stable after implementation of this plan?***

Answer: Hospitals would have fewer full time equivalent employees devoted to (increasing less well reimbursed) inpatient care, more devoted to (increasingly well reimbursed) outpatient care. Well run and well positioned hospitals in other boroughs (North Shore in the West Village, Montefiore in Riverdale, as two examples) are moving to create similar comprehensive ambulatory care programs. The results: less expense on the inpatient side, where revenue is declining; more revenue on the outpatient side, where services are needed.

***Question: What about education?***

Answer: The most important missing piece in any of the Brooklyn discussions to date is the graduate education of physicians (as residents) in ambulatory care settings, as part of care teams. The most significant resource for residency training in Brooklyn is the State University of New York Downstate Medical Center. Downstate has 1,000 physicians in residency training positions.

Ambulatory care education (nationwide) for resident physicians is spotty; for example, FQHCs almost universally have no residents in training, because they have no money to support residents or supervising physicians. In addition, most FQHCs have inadequate volume to provide teaching opportunities, and none of them get reimbursed for graduate medical education expenses. Only hospitals are in a position to derive income for medical education programs, and only teaching hospitals (such as University Hospital of Brooklyn) are in a position to maximize that revenue.

***Question: So this is a mixed plan, with several goals?***

Answer: Yes. Financial stability for the hospitals. New services for the community. A different structure for graduate medical education.

***Question: Does this plan benefit all of the hospitals in Brooklyn?***

Answer: The idea is to benefit all of the *patients* who are uninsured or underserved in Brooklyn. **Every** hospital has some responsibility for the “safety net” patient. Every hospital suffers the under-reimbursement from Medicaid and especially from managed Medicaid. Therefore, every hospital is involved.

***Question: How much money is being talked about?***

Answer: \$1.3 billion, 13% of the “savings” that the State of New York indicates it will achieve or has achieved from its management of the Medicaid program, savings which may be largely due to underpayment to doctors and hospitals. Under the New York State Medicaid Managed Care Program, the more poor patients you serve, the worse your financial results.

***Question: So \$1.3 billion will “give back” to Brooklyn hospitals money that has been underpaid in the past?***

Answer: Yes, but using this number—the percentage of the state’s population residing in Brooklyn—will not repay all of it. To get all of it would require a more complicated formula. However, a more complicated formula would undoubtedly stimulate unnecessary and divisive debate. Brooklyn is 13% of the State’s population, \$1.3 billion is 13% of the amount (\$10 billion) the state claims to have “saved” in the Medicaid program, a bit of rough justice.

***Question: What will the money go for?***

Answer: First, training and development of hospital staff currently caring for inpatients, so that they will have jobs in new ambulatory positions. Without a meaningful budget for training, adequate transition time to create and populate new jobs, and focused leadership for this effort, training proposals are meaningless... a laptop given to a laid-off steel worker.

Second, the development and subsidy for the first three years of comprehensive ambulatory care centers. Some hospitals will choose such centers, at an estimated cost of \$40 million per center for a 40,000 square foot operation, breaking even after three years. Some hospitals will choose alternative strategies, but should have equivalent and proportional funds with which to meet those strategies.

***Question: How will this money be divided?***

Answer: On a simple basis, hopefully self-evident and non-controversial. Every hospital has audited financial statements (and for the

Health and Hospitals Corporation, aggregated audited financial statements) which show (for all fiscal years prior to December 2011) “bad debt” as an expense item in their income statement. Bad debt can serve as a proxy for under-and uninsured New Yorkers, and especially those with no form of payment whatsoever. In the alternative, a working group of hospitals may agree on a different proxy.

Not every hospital will choose the option of satellite, comprehensive ambulatory care centers. Each hospital will, to the contrary, develop plans under its Community Health Needs Assessment. Using the care centers as a proxy, however, for two dozen comprehensive care centers (or their equivalent expenditure by hospitals that have alternative strategies for the underserved), approximately \$40 million per center. In addition, we estimate that \$40 million in training over the three years will be required. That total (\$40 x 24 = \$960 million for the services + \$40 million for the training) or about \$1 billion.

***Question: What about the other \$300 million?***

Answer: We propose setting aside an amount to “jump start” renewed services at Long Island College Hospital and Interfaith Medical Center, as a condition of settling the outstanding regulatory activity and litigation.

***Question: In other words, there would be an inducement for the parties to settle and resolve all matters?***

Answer: Yes, and a budget to assist in such settlements.

***Question: What do the hospitals need to do to participate?***

Answer: Every hospital is required by federal law to submit a Community Health Needs Assessment plan to Medicare. We are asking the fifteen hospitals to update and amend their version of that document, with specific proposals to utilize the funds which would be made available to them under this program. Further, we are asking them to designate a physician or other representative to help oversee this process.

***Question: What is the timetable?***

Answer: This plan will be reviewed by a conference on December 3<sup>rd</sup>. Hospital executives, finance officers and emergency department directors have been invited. We hope to have prompt action by the hospitals in making proposals, and to proceed, under the direction of the Brooklyn Borough President and an advisory group of emergency department physicians, in 2014.