

TESTIMONY

OF

GLENS FALLS HOSPITAL

BEFORE THE

JOINT PUBLIC HEARING OF THE

NEW YORK STATE DEPARTMENT OF HEALTH

AND

NEW YORK STATE INSURANCE DEPARTMENT

ON “PARTNERSHIP FOR COVERAGE:

A PLAN FOR HEALTHCARE COVERAGE

IN NEW YORK STATE”

SEPTEMBER 5, 2007

Thank you ladies and gentlemen for the opportunity to testify before this Joint Hearing of the New York State Department of Health and the New York State Insurance Department regarding proposals for achieving health system reform, increasing health insurance coverage, and increasing access to healthcare for all New Yorkers.

And welcome, by the way, to Glens Falls. It is truly a delight for Glens Falls, the Gateway to the Adirondacks, to host this hearing.

My name is David Kruczlnicki and I am President and Chief Executive Officer of Glens Falls Hospital. As the largest health care organization between Albany and Montreal, we have a unique responsibility to provide a wide range of essential health care services throughout the expansive geography of the Southeastern Adirondack region. Our primary service area includes all of three counties and portions of two additional counties—over sixty distinct communities encompassing a total of over 3,000 square miles. In order to address this significant responsibility, we operate over 20 off-site and mobile programs including 12 primary care and physician practices, a community-based urgent care center, 4 community-based behavioral health facilities, 2 school-based primary care programs, 3 off-site rehabilitation services sites, numerous diagnostic testing facilities, mobile programs for cancer screening and children’s dental care, as well as multiple worksite programs through our occupational health center. In short, we see and experience every day the critical issues of health care coverage and of health care access.

The list of questions provided by the Health and Insurance Departments suggested for presenters is remarkably extensive and complete. There are over 70 questions and they drive to the core of

the themes of coverage and access. While I'll offer thoughts on both issues of coverage and access, the bulk of my comments are in reply to your question: "What steps can be taken to improve quality and deliver cost-effective care?", and reflect my daily experiences and practical bias.

I am deeply worried about the state of the health care delivery system in New York. I am uncertain about its ability to sustain access to healthcare, including in this region. I worry that coverage without access is an empty promise . . . i.e., expanded health insurance coverage without the health care delivery system infrastructure to provide the care that expanded coverage allows, will result in simply no progress at all.

ISSUE #1: COVERAGE

With respect to health insurance coverage, many of my views reflect those advanced by the Healthcare Association of New York State (HANYNS), and I offer these six suggestions:

1. Increase outreach and enrollment initiatives while introducing broadened initial eligibility, such as Governor Spitzer's recent proposed change for children's coverage eligibility.
2. Streamline and simplify the eligibility and certification process. For example, a short, simple application with maximum use of self-attestation and minimal documentation will likely improve the overall efficiency of the process while easing its complexity.
3. Expand the period of continuous eligibility to minimize unnecessary dis-enrollment and re-enrollment. Particularly in this region, where seasonal jobs are many due to the active tourism industry in the summer, incomes for people can fluctuate during the course of a

year . . . coverage can be lost as income rises temporarily, even though one may be under the limit shortly thereafter. Re-enrollment costs are likely substantial and time-consuming, and a policy of pursuing “lock-in strategies” to avoid involuntary disenrollment due to seasonal employment is one small way to simplify and improve the process.

4. Improve outreach initiatives by providing funding for expanded use of facilitated enrollers for all programs, including expanded partnerships with community-based organizations and health care providers such as Glens Falls Hospital and others.
5. Seek opportunities to expand automated eligibility systems and introduce other technological applications. For example, perhaps explore Medicaid or Family/Child Health Plus enrollment and re-certification in partnership with unemployment insurance benefit eligibility.
6. Strengthen NYS policy with respect to the accountability of payors. Improving health care should be a shared responsibility requiring the participation of all sectors . . . not just health care providers and government. It is well documented that profits of HMOs over the last ten years have been enormous compared to those among nearly all health care providers, and certainly that of the hospital industry in New York. We urge the State to consider:
 - establishing a voluntary or mandatory health-care-system-improvement funding expectation for HMOs. Sometimes termed a community reinvestment fund, monies might be earmarked for community physician recruitment/retention initiatives and/or information technology development

- requiring that insurers spend some minimum threshold percent of premiums on direct health care services
- exerting its influence to eliminate the referral process exercised by HMOs. . . . this bureaucratic mechanism is costly, frustrating to subscribers and providers alike, and simply serves as a roadblock to access to health care in the vast majority of cases
- establishing regulations to require expeditious credentialing of new providers.

ISSUE #2: ACCESS

The opportunities to improve access are both numerous and critical, and I offer 6 suggestions:

1. Improve physician recruitment and retention, certainly across Upstate New York. This is the first and foremost imperative, from here at the front lines. Just last week, the Board of Supervisors of Warren County hosted a community forum of over 100 interested governmental leaders, health care providers, business persons, and others to explore the looming crisis of primary care physician availability in the Adirondacks. Primary care physicians and specialists as well are leaving and/or retiring and/or closing their practices in Upstate New York, including this region. At our regional community hospital, we’ve never had such difficulty in recruiting and retaining physicians.

The reasons for this crisis are several, with the major factors being financial . . . simply put, the escalating costs of private practice driven by office overhead expense to meet the endless paperwork requirements of payors, and the incredible costs of malpractice

insurance, combined with falling incomes due to fee schedule reductions have created an untenable situation.

Malpractice costs is a good example of a factor that is driving physicians from our community . . . for example, our region is supported by two full-time, Board-Certified Neurosurgeons that provide essential surgical care to a wide range of emergency and non-emergency situations every day, including their accepting of E.R. call for neurosurgery essentially as an every-other-night obligation. Each neurosurgeon's annual malpractice cost alone is \$90,000, and that cost is at the lower or basic tier level for this specialty in NYS. At the same time, Medicare fee schedules are proposed to be slashed 1/1/08, and the three major HMOs in this region will immediately follow suit since their fee schedules are tied to Medicare. In addition, it is clear that physicians will not be able to navigate the business of health care without an electronic medical record – an expense that can be overwhelming for many independent community physicians. The incomes of both these local neurosurgeons have fallen for several consecutive years. One can see how this environment is not conducive to sustaining their practices long-term, and not conducive to the recruitment of successor neurosurgeons to this region.

2. Build a reimbursement system that supports evidence-based chronic care. Establish payment methodologies that support the delivery of care at the right time, and in the most appropriate setting toward the most favorable outcome . . . not simply reimbursing for unrelated episodes of care.
3. Advance the notion being discussed at various policy levels of a primary care medical home whereby patients are dedicated to a specific primary care center and/or system that

can provide and be compensated for the range of essential health care services necessary for that individual and/or family.

4. Minimize, streamline, and reduce regulatory redundancy among DOH, OMH, and OASAS that are barriers to effective care and reinvest those dollars into prevention and treatment. For example, when one of our behavioral health services programs recently moved from one site to another in the same community and linked with an existing primary care service, we were required to secure redundant inspections and approvals from DOH, OMH, and OASAS.
5. Permit Transitional Care Units (TCUs) at all hospitals in the State willing to build programs to accommodate this elderly population of patients. Transitional care units, a pilot project introduced two years ago, has immense opportunity to provide increased Medicare funding to hospitals throughout New York State such as ours that struggle with the growing population of medical patients requiring care beyond the Medicare length of stay, but who are not eligible for or desirous of securing such care at a skilled nursing facility. My understanding is that the pilot programs have so far proven beneficial and we would urge New York State to advance this concept to all hospitals.
6. Lastly, consider dental care as part of a primary care team by exploring incentives to integrate dental care, particularly children's dental care, with primary medical care so that a family's full needs can be addressed. This is especially important in rural areas, where we see this need first-hand, for example, in rural Hamilton County where our mobile dental program is the only provider of children's dental care.

Children's dental care illustrates the false promise of coverage without access. The Center for Medicare and Medicaid Service reports that 4 of 5 children enrolled in Medicaid visit a medical provider, but only 1 of 4 children enrolled in Medicaid visit a dentist. The problem is a lack of dentists available, able, and willing to treat Medicaid children. The problem is that the average Child Health Plus dental reimbursement per visit for 2006 was \$6.20.

Let's correct the problem of lack-of-access to dental care for children, and let's redesign New York's healthcare with careful consideration of both coverage and access well in mind.

Thank you for your leadership through these many challenges, thank you for holding these hearings, and thank you for your attention here today.