THE HEALTH OF ROCKLAND COUNTY’S HOSPITALS
A DOCTOR’S PERSPECTIVE

Our healthcare system is in disarray but there’s broad public misunderstanding of the country’s health care challenges. We’ve grown numb to huge inexplicable hospital bills and public discourse is full of such arcane terms as subsidies, networks and vouchers. In recent years the average citizen has been bewildered by constant debate about repealing or repairing the Affordable Care Act (“Obamacare”) and how various alternatives might effect insurance markets and patient coverage. In order to understand these complex issues, perhaps it would be helpful to get beyond politics and slogans and focus on the potential impact of systemic change on our own community. However, before focusing on Rockland County, let’s review the current status of the nation’s healthcare system and prospects for reform.

THE NATIONAL PICTURE
In her informative book An American Sickness (2017) Dr. Elisabeth Rosenthal described the devolution of our healthcare system from its traditional emphasis on patient care to a big business that exploits the trust that Americans used to place in their doctors and hospitals:

> Once acceptance of health insurance was widespread, a domino effect ensued: hospitals adapted to financial incentives which changed how doctors practiced medicine [and] revolutionized the types of drugs and devices that manufacturers marketed…The money chase was on.

Although our system is the costliest in the developed world, it is among the most inefficient and yet we’ve come to accept paying more for less. Life expectancy here is less than in other high-income countries and inequality is greater. England has some better health outcomes than we do but spends only half as much per capita. Moreover, the high cost of health care in the United States contributes to stagnant or slow-moving wages; reductions in state and local expenditures for education, infrastructure and other valuable programs; and an increase in the national debt. The nation’s annual medical bill of about $3.47 trillion currently amounts to 18.3% of the GDP (the highest on record) and while our patchwork system provides superb coverage for some, in the last quarter of 2017 12.2% of our population lacked health insurance and nearly as many had inadequate coverage. This was an increase of 3.2 million more people without coverage compared to the previous year.
Three years after the ACA was passed, the Census Bureau reported that 216 million Americans were covered by private, employer-sponsored or individually purchased plans while federal government plans (Medicare, Medicaid and the military) covered an additional 119 million people. Between 1995 and 2015 health care spending increased by nearly one trillion dollars ($933 billion) with annual spending nearly doubling to $700 billion for inpatients and an equal increase for ambulatory services (JAMA, 11/7/17.) The Medicare program alone costs approximately $650 billion annually which amounts to 3.6% of GDP, 20% of national health expenditures and 15% of the Federal budget. It had been projected to increase to 6% by 2050, but the new tax plan is expected to cut Medicare by $25 billion this year. Although repeal of the ACA's Individual Mandate might save $300 billion over the next decade, insurance premiums are likely to rise by about 10% and it’s estimated that about thirteen million people are expected to drop health insurance altogether. One thing that’s certain is that how our healthcare system evolves will be powerfully influenced by Washington lobbyists. About $400 million is spent each year on health related lobbying by some 12,000 registered K Street lobbyists; there may be greater than 100,000 more who are unregistered.

**HOSPITAL ECONOMICS**

There are slightly more than 5,500 hospitals in the United States, ownership roughly breaking down: non-profit about 3,000, state and local government 1,000, for-profit 1,000, federal government 200. Funding comes from various sources, including: Medicare and Medicaid, local tax revenues, insurance companies, out-of-pocket payments by patients, donations and grants. In New York State in 2016 the source of health insurance was 50% employer, 24% Medicaid, 13% Medicare, 6% uninsured, 7% other. After a modest surge of in-patient admissions from the ACA’s coverage expansion, in recent years there’s been a steady decline in hospital admissions and resultant cash flow. Its been estimated the net loss to hospitals over the next decade will be about $166 billion nationwide. For hospitals in New York State it’s projected that there will be a nearly 40% increase in uncompensated care and a 2% decrease in operating margin which reflects income directly from patient care.

Like other businesses hospitals require a certain number of “customers” to cover their overhead costs. With the changing dynamics of health care everyone is fighting for market share and control of the patient. This is profoundly threatening to the financial stability of hospitals who in order to protect themselves from competitors and increase their leverage with insurance companies have been consolidating into large systems at a frantic pace. Acquiring physicians’ practices protects the hospital’s patient base and
strengthens referrals within the system/network which, in turn, drives revenue. But swallowing up practices is no panacea.

Trade analysts have reported that over time, cost savings from mergers decrease and the proportion of hospitals experiencing positive financial status declines. Some have attributed the gloomy prognosis for hospitals and health systems to lack of operational discipline and a disconnect between strategy and market demand. (Administrative spending which average 25.3% of total hospital spending far exceed what is spent in other countries.) Moreover, hospital business practices can be in conflict with overall health care goals and the impact of legislation and other facts in the wake of reform is likely to be negative for many hospitals who are struggling to survive.

There is no such thing as a fixed cost of a medical or surgical procedure and Medicare typically pays two to four times more for the same service if delivered in a hospital OPD than in a private office because of a “facility fee.” (For example, in 2013 Medicare paid 80% more for a basic office visit if done in the out patient department than in a private office.) Consider just one procedure - a major joint replacement. In 2013 (before ACA) Nyack Hospital billed Medicare $54,250 (1.1% greater than the national average) and received $15,749, that being what CMS considered to be a reasonable charge. For the same orthopedic procedure Good Samaritan charged $75,012 and received $16,323. Both hospitals charged three to four times what they expected to receive, but why not since that helped establish a higher standard for their "usual" charge to non-Medicare patients? When the government determines how much to pay for a service on the basis of the site of delivery, it skews care toward hospitals who then are incentivized to take advantage of the difference by buying physician practices.

Whatever happened to being hospitalized for observation? There often is a gray area when distinguishing between those not well enough to go home but not sick enough to be admitted. In the past, the default decision was to admit, but this is costly to CMS and to insurance companies and there were concerns that doctors and hospitals were abusing the option. A typical example is the patient who presents to the ER with chest pain of uncertain cause. According to recently crafted rules of play, they may be admitted to a holding unit for two midnights, either in the ER or a hospital ward, where appropriate tests are performed to rule out an incipient heart attack. (Just what tests are most reliably predictive continues to be debated.) The problem is that for patients in this hospital limbo, CMS will reimburse for care only as an outpatient service.
In turn, this is likely to cause higher out-of-pocket expenses; for example patients would be responsible for co-payments and for whatever the hospital charges for medications that they usually take at home for chronic conditions. Some would argue that this is a good thing because unless patients have “skin in the game” they will always choose the more expensive option.

Pity the patient who finds that their insurance plan doesn't fully cover the procedure or is out of the hospital's network. To make matters worse, hospital bills often contain errors, usually are undecipherable and if unpaid get referred to unsympathetic outside billing and collection agencies. In order to negotiate this “medical arms-race” hospitals employ consultants who are skilled at “strategic billing” and “up-coding,” closing unprofitable departments and often promoting expensive new technology which sometimes may be unnecessary.

**BUNDLING**

One of the ideas advanced by ACA planners was to transform payment from traditional fee-for-service to a system that sets “health” as a population goal and pays for “quality” rather than quantity. To accomplish this, both public and private payers were encouraged to change financial incentives. The theory is that when hospitals and clinicians (doctors account for only about 10% of health care spending) derive most of their revenue from fee-for-service piecework, it encourages volume but when faced with a budget they might change their practices in order to promote “value.”

In 2013 the Centers for Medicare & Medicaid Innovation launched the Bundled Payments for Care Improvement Initiative (BPCI), a payment model that held participating hospitals, practices or facilities accountable for both quality and costs in 30-, 60-, or 90-day episodes of care. Participants could join for as many or as few of 48 eligible conditions as they wish and drop out without penalty. If cost targets were achieved, participants would keep a portion of the savings; if targets were exceeded, participants would reimburse Medicare a portion of the difference. After the first two years, spending and quality under global budgets remained unknown (*NEJM* 10/30/2014, p. 1704-14. Only 12% of hospitals signed up for BPCI and soon 47% dropped out.

Some analysts have suggested that if this payment approach were to succeed it would have to be mandatory (*JAMA*, January 9, 2018, p. 191-2) but in January 2018 Trump/GOP chose to keep participation in bundled payment initiatives voluntary. Some have criticized that decision to cancel mandated bundled payments as a lost opportunity to
“bend the cost curve” as Medicare expenditures and health care spending in general have continued to rise. (JAMA, January 23/30, 2018, p. 335-6.) No doubt, many of those hospitals and health systems that made significant investments to participate in the CMS’s value-based approach now must be questioning the wisdom of their costly investments.

As pressure to reduce fee-for-service rises, various innovative models emerged and in at least one state bundled payments seem to have been successful. In 2013 Maryland began all payer global hospital budgeting and by the next year more than 98% of hospital income came from the new system. Hospitals were encouraged to align their fiscal incentives with the health of the community by reducing admissions and encouraging preventive and community health programs. In its first two years Maryland’s prospective payment system saved nearly $300 million in the Medicare program with an 8.2% reduction of admissions and readmissions.

**DISPROPORTIONATE SHARE**

Consolidations and mergers presumably improve efficiency and allow hospitals to negotiate more favorably with insurers and Big Pharma, but because their financial health largely reflects federal and state policies that currently are in a state of flux, it creates great uncertainty. Hospitals must bear the burden of providing services to patients who fall below the Federal Poverty Level and for this the government has provided subsidies. A hypothetical hospital that admits 15,000 patients a year (paid an average $13,500/patient) has a total revenue of $202.5 million. Fixed costs (electricity, maintenance, property, doctors and staff salaries) account for 2/3 of its total costs; the other one third is variable. Hospitals still receive most of their revenue from fee-for-service and because most Medicaid payments track with inpatient utilization, perversely, preventing serious illness might reduce total revenue and cause a financial crisis.

Since 1985 hospitals that provide care for a large number of indigent or uninsured patients (eligibility according to a complex formula) have received subsidies from CMS’s DSH (disproportionate share hospital) program as partial compensation. These subsidies were supposed to be reduced under the ACA since many more people would be insured, but implementation of the cuts was delayed by Congress. In October 2017 President Trump announced that the federal government no longer would pay DSH subsidies for uncompensated care which he considered to be “illegal,” but the Congressional budget deal that passed in February delayed cuts for the next two years. It’s been estimated that their elimination would have reduced payment to New York State hospitals by more than $1 billion this year.
Gov. Cuomo and Mayor DeBlasio had been arguing about who should pay if it were not fully restored by Congress. Because the State’s budget is some $4.4 billion in the red, the Governor insisted that the city should pay much more; in June 2017 the state was withholding $380 million in payments to New York City hospitals which had to dip into its reserves and had only 18 days cash on hand.

**DEEP INTO THE WEEDS WITH 340B**

As if this isn’t confusing enough, in November 2017, the Centers For Medicare and Medicaid Services (CMS) changed its rule for Medicare Part B payments for prescription drugs to eligible hospital outpatient departments. *(NEJM, 2/8/18, pp. 501-503.)* Currently almost half of all acute care hospitals and their affiliated outpatient departments participate in the so-called 340B Drug Pricing Program. When it began in 1992 it was intended to expand resources for underserved populations, but in recent years the cost has doubled and redoubled. 340B had reimbursed hospitals for drugs at the average sales price (ASP) plus 6%, but according to the latest revision starting in 2018 CMS will pay ASP minus 22.5% - a potential Federal saving of $1.6 billion this year.

Fueling the controversy was the fact that while eligible hospitals could purchase drugs at a deep discount, they were reimbursed by payers at much higher rates and there were no direct incentives for hospitals to utilize any financial gains to actually enhance care for low-income patients. Some critics contended that hospitals were using the revenue to “profit” and even were purchasing community practices and clinics to take advantage of the windfall. Hospital administrators contended that this permitted them to provide services to more uninsured or indigent patients and viewed any reduction or restrictions on how they can use the generated money as a major threat to their viability. Opponents argued that the lost revenue could be offset by reducing overhead costs, executive bonuses and capital expansions. Naturally this caused much debate and the American Hospital Association sued to halt the cuts but a judge has initially denied their lawsuit. Stay tuned for the next chapter.

But what does all this have to do with our subject? It demonstrates how politicized health financing has become, how well intentioned solutions may deliver less benefit than anticipated and how hospitals are vulnerable to the relentless drive of the government to reduce costs. It’s estimated that for some small hospitals losses in CMS drug payments could amount to more than 10% of expected Part B revenues. In 2014 one third of community hospitals had negative operating margins *(AHA Trendwatch Chartbook)* and last year the number of nonprofit hospital closures increased,
bankruptcies tripled and nearly half of small rural hospitals were operating at a loss. When consolidations and mergers develop financial troubles, in order to raise cash and reduce debt sometimes they have to divest. For example, last year the aggressive Community Health System which once owned 200 hospitals throughout the country began closing the financially weakest ones at a record pace; down now to 127 in 22 states. In December 2017 Moody’s issued a negative outlook for the nonprofit hospital sector. They estimated that over the next year cash flow will decline by 2 - 4% and bad debt increase by 6 - 7%, most of this due to anticipated rise in co-pays and high deductible insurance plans which, in turn, will lead to increased self-pay and bad debt. Hard times are coming and hospital CFOs know it.

**UNIVERSAL COVERAGE**

If all of the detail described above makes you dizzy, consider whether the same complexity would be necessary if the United States provided universal coverage through a single-payer system as in most other countries. According to a 2017 poll 60% of Americans agree that the government bears a responsibility to ensure health care for all Americans (Democrats 75%, Independents 58%, Republicans 46%, Unsure 17%) and about one third said that they favor a “single-payer” system which was 12% more than in 2014. Senator Kirsten Gillibrand joined with Bernie Sanders in proposing a Medicare For All Act and single-payer legislation has gained many co-sponsors in the House and Senate. Attempts to constrain costs usually are shrouded in partisan accusations of rationing and many people are suspicious of nationalized health systems.

Most people think highly of Medicare although it is a single-payer system; indeed, one confused senior lamented, “Don’t let the government get their hands on my Medicare.” However, with passage of federal budget reform in December 2017, it’s likely that is exactly what will happen since many in the GOP are determined to “starve” federal programs including Medicare and Medicaid. By the end of last year health care had become the nation’s largest employer. This trend was driven by our aging population and the majority of jobs were in administration and management rather than in clinical care. U.S. hospitals spend twice as much on administration than anywhere else in the world and its been suggested that if this were reduced only by half it would pay for everyone and nearly everything.

A recent medical journal editorial (NEJM, 12/13/17) noted that seeking universal coverage for some 325 million people through a national system had genuine attractions. It would have the bargaining power to offset the monopoly power of drug
and device manufacturers and would substantially reduce bloated administrative costs. Although there are several alternate potential paths to universal coverage beside single-payer, all would require two fundamentals: (1) subsidies for individuals who are too poor or too sick to pay premiums and (2) compulsion for everyone else to participate and implicitly contribute to the subsidies. In a single-payer system almost all Americans would have to surrender their current insurance coverage and would have to trust a federal government to engineer a transition for more than 300 million people. It would almost certainly create the largest tax increase in history to pay for it and employers would have to be trusted to transfer their savings to increased wages and salaries. While it very likely would reduce the cost of health care by emphasizing basic care, it would inhibit the American penchant for high-priced medical specialists and perhaps overuse of the latest expensive technology - including admissions for “observation.” (see above.)

To have any chance of success a single-payer system would have to be simple, require a minimum of bureaucracy and be based on decentralized organizations to deliver care. Many experts compare our fragmented system to Canada’s “Medicare” model that is based on thirteen provincial and territorial health insurance plans rather than a national one. Some demonize their approach, others extol it and it is problematic whether their experience is applicable to our population that is ten times greater. Nevertheless, one recent analysis (JAMA 1/2/18) closed on an optimistic note: “The United States already spends so much so badly that it now has a chance to leapfrog every nation in the world as and when [it] devises and implements a home-grown solution to achieve equitable and universal health coverage.”

As of January 2018, thirty-two states had approved Medicaid expansion; five of the remaining eighteen had not but were considering expansion. Oregon has had a long history of innovative approaches to health insurance dating back to the early 1990s. In 2012 the Federal government gave the state a five year waiver to develop a new model of Medicaid reform and provided $1.9 billion for start-up expenses; in 2017 the waiver was renewed for an additional five years. Approved by voter referendum, their plan expanded eligibility to everyone earning less than 138% of the federal poverty level including undocumented people. Coverage would be paid through taxes rather than by premiums to private companies and would serve about one million people. For those earning more than the threshold insurance premium increases were capped at 1.5% and a 0.7% tax on the net revenue of hospitals helped provide funds for Medicaid expansion.
By January 2018 98% of Oregonians had health insurance - one of the nation’s highest insured rates - and the latest referendum (Measure 101) was approved by 62% of more than a million voters (40% of the population.) Several other states have considered passing single-payer legislation which would first require special federal permission. Vermont was the first in 2011 but abandoned their plan in 2017 when funding mechanisms were delayed.

In 2014 a New York State coalition formed the Campaign for New York Health in 2014 in order to pass legislation guaranteeing the right to health care for all. Sponsored by Assemblyman Richard Gottfried the so-called New York Health Act would provide universal comprehensive health care to all without premiums, co-pays, deductibles or limited provider networks. The state Assembly has approved it in the last three years, the last time in May 2017 by 92 to 52, but so far the state Senate has refused to take up the issue. However, support has been inching toward a majority and the balance of power which has been controlled by nine “rogue” Democrats who have allied with the Republican minority may shift in 2018. If these nine senators return to the fold this may permit the single-payer plan to move forward in the legislature. (Curiously and conversely, a similar bill in California passed their state Senate last May but is stalled in their Assembly.) Although Governor Cuomo has publicly stated that single-payer would be “a good idea,” he cautioned that if the Federal government turns off the Medicaid spigot there would be a $91 billion short-fall to fund a state single-payer system.

METAMORPHOSIS OF THE MEDICAL PROFESSION

The word “professionalism” is derived from the Hippocratic Oath in which physicians publicly “professed” that they would place their patient’s interests before all else and spoke to their own ethical and spiritual obligations. But does that definition still apply when now 40% of all doctors are employees and 25% of their practices are owned by a hospital which, in turn, may be managed by a faceless corporation? In such a business relationship salaried doctors have to play by house rules. The days of the familiar general practitioner of yore who worked in his home-office and made house calls are long gone. Many dispirited senior physicians, nostalgic for their lost autonomy, resent being characterized as mere “health care practitioners.” As a group, physicians have become neutered, their voices muted and irrelevant. Some are skeptical of the touted virtues of costly electronic medical records. As one burnt out physician complained, “We’re spending our days doing the wrong work. We are disconnected from your purpose and have lost touch with the things that give joy and meaning to our work.” (*NEJM*, 1/25/18, p. 309.)
Some primary care clinicians have converted to concierge practices in order to spend more time on fewer patients while others have abandoned clinical work and joined the bureaucracy. Many have retired early. It’s every doctor for him or her self in this marketplace. It’s ironic that the AMA once reviled government control, but recent surveys find that more than half of doctors favor “Medicare for All.” (In 2017 52% in favor; in 2008 it was 42%.)

**DSRIP**

In 2014 CMS granted waivers to states that restructure the Medicaid system with the hope of improving overall health care while reducing costs. A specific goal was to reduce avoidable hospitalizations by 25% over the project’s five year period. HRRP (Hospital Readmissions Reduction Program) was created as part of the Affordable Care Act to penalize hospitals for higher-than-expected rates of readmissions of certain categories of Medicare patients within 30 days of discharge. It was presumed that high readmission rates were a marker for poor quality care and early reports after the program was implemented seemed promising. Indeed, readmissions were down but actual benefits to patients were not so clear. On close analysis it seems that the reductions, at least partially, reflected higher mortality - if patients died at home then they wouldn’t need to be readmitted. Moreover, apparently some of the reduction reflected more “strategic” coding practices.

New York State’s project is called Delivery System Reform Incentive Payment or DSRIP. Approved by CMS in 2014 and implemented the next year, it “reinvests” a Federal block grant of about $8 billion (half of the $17 billion in Federal savings generated by ACA) distributing it to 25 Performance Provider Systems (PPS) that, in turn, pay collaborating providers. Each PPS files detailed quarterly reports and performance payments are made semi-annually to those programs that meet specific targets.

Rockland County participates in three of New York State’s twenty-five PPS programs:

1. **Nyack Hospital** is one of eleven participating hospitals in Montefiore Health System’s Hudson Valley Collaborative which serves seven counties and receives $249 million from the NYS Department of Health.

2. **Good Samaritan Hospital** is one of three acute-care hospitals in Westchester County Medical Center’s (WMCHHealth) PPS network that serves eight counties and receives $274 million over the five year waiver period.
3. Refuah Community Health Collective provides ambulatory services mostly to ultra-orthodox/hasidic Jewish communities both in Rockland and Orange Counties and receives $46 million from the state.

If the Federal government were to drastically reduce the Medicaid budget, the impact would be profound on state programs like DSRIP. New York State has 188 registered hospitals and in 2015 had 3,343,349 people on Medicare for which CMS paid an average of slightly over $11,000 per enrollee - about $1,500 above the national average. In 2013 (the last year for which data currently is available) nearly 78,000 people in Rockland County were enrolled in Medicaid/CHIP - the seventh highest among New York State’s sixty-two counties despite having the fifth highest income. (New York State is second only to New Mexico in Medicaid enrollees.) If in the interval since 2013 Rockland County’s Medicaid enrollments grew by the same 13.4% as did the rest of the state, by now the total number of enrollees would be nearly 90,000 - more than one quarter of our total population and nearly triple the percentage that it was in 2000.

Medicaid accounts for 44% of Rockland County’s budget which is about equal to income from property taxes. In 2011 the county paid the state’s Department of Health more than $65 million (> $ 1 million every week) for it to administer the Medicaid program while for all health related services Rockland received about $429 million from the state. No doubt the total now is considerably higher. It seems evident that if Federal funds for Medicare and Medicaid are reduced, those hospitals that serve large numbers of fiscally disadvantaged people will be especially vulnerable and the ripple effects on their communities are likely to be substantial.

A TALE OF TWO HOSPITALS
First some more data. In 2016 Rockland County’s total population was nearly 327,000 (demography: white 77.5%, Hispanic 17.6%, Black 13.3%, Asian 6.5%.) but the recent trend has been for very slow growth, an eroding tax base and a poorer population. Overall, the county’s median household income was $85,100, fifth highest in the state, but property taxes were second highest among all counties in the country. (1.Westchester $13,842. 2.Rockland $10,550.) Although the county is relatively affluent nearly a quarter of our citizens are enrolled in Medicaid/CHIP at an annual cost of greater than $65 million. The poverty rate rose to 14.1% in 2015 (the national rate is 17%), yet about 9% still had no health insurance in 2017 and about 25,000 of those under Medicare age were uninsured. Rockland is the smallest county by size in New York State, but it is the third most densely populated. Much of this reflects the large
ultra-orthodox/hasidic Jewish population most of whom live west of the Palisades Parkway that roughly bisects the county. Nearly one in three county residents, probably between 90 and 100,000, are Jewish which is the highest proportion in any county in the nation. Between 60 and 70,000 of them belong to ultra-orthodox/hasidic communities that have an extremely high dependence on government assistance (est. 85%) which, no doubt, must effect local hospital economics.

With all of this as background, now let’s consider the “health” of Rockland County’s two acute care general hospitals: Nyack and Good Samaritan. Both opened within a year of each other at the onset of the 20th century when Rockland County was a very different place. (See histories of the two hospitals that are appended to this report.) Although their names are unchanged, in the last five years both facilities have lost their original identities as independent community hospitals. In 2014 Nyack Hospital was bought by Montefiore Health Systems, based in the Bronx, which has had a long tradition of dedication to social causes, community outreach and integrated care. Montefiore serves as a referral center for six community hospitals and other health facilities. and Nyack participates in its Hudson Valley collaborating network (see DSRIP above). In May 20, 2015 Good Samaritan Hospital (already part of the Bon Secours Health System since 2000.) joint ventured with Westchester County Medical Center. WCMC has 60% ownership and controls day to day operations. Bon Secours (see appendix), which is based in Maryland, retains a 40% interest and the Sisters of Charity of St. Elizabeth remain as “canonical co-sponsors" with no financial stake.

For 2015 (the last year that tax data is posted on-line) IRS Form 990 listed revenue less expenses for Bon Secours Affiliates (including Good Samaritan Hospital) as - $8,662,174; for Nyack Hospital it was -$1,103,719. In 2017 the American Hospital Directory reported the following data based on the most recent Medicare Cost Reports:

<table>
<thead>
<tr>
<th></th>
<th>GOOD SAMARITAN</th>
<th>NYACK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffed Beds</strong></td>
<td>286</td>
<td>235</td>
</tr>
<tr>
<td><strong>Gross patient revenue $</strong></td>
<td>1,675,450,716</td>
<td>1,075,262,453</td>
</tr>
<tr>
<td><strong>Total discharges</strong></td>
<td>14,073</td>
<td>10,883</td>
</tr>
<tr>
<td><strong>Total patient days</strong></td>
<td>66,498</td>
<td>57,780</td>
</tr>
<tr>
<td><strong>Patient experience rating</strong></td>
<td>2/5</td>
<td>2/5</td>
</tr>
<tr>
<td><strong>Net LOSS</strong></td>
<td>-$19,226,050</td>
<td>-$8,604,972</td>
</tr>
<tr>
<td><strong>Percent LOSS</strong></td>
<td>-1.1%</td>
<td>-0.8%</td>
</tr>
</tbody>
</table>
For comparison the following data from the same source indicate that during the same period nearby hospitals all were in the black:

Orange Regional Medical Center (383 staffed beds) +$6,500,695; +0.4% (profit)
Valley Hospital (356) +$73,763,513; +3.6%
Englewood Hospital (281) +$19,151,381; +0.6%
Holy Name Hospital (307) +$29,424,107; +1.9%
Hackensack University Medical Center (711) +$108,374,636; +2.2%
Montefiore Hospital (1524) +$42,216,000; +0.3%
Westchester County Medical Center (885) +$8,118,966; +0.2%

In preparing this report I did not have special access to financial data and whatever information that has been described here is derived from what is publicly available online. One wonders what business strategists in Westchester and Baltimore feel about sharing a nearly $20 million annual loss 60/40? Perhaps there are very good reasons for why Rockland’s two acute-care hospitals are substantially in the red, but if so they are not obvious from the public record and the potential impact both on hospitals and the community are worrisome. Although the reliability of the data is suspect, the most recent ratings generated by CMS also are troubling, rating both hospitals below national averages on seven quality measures that include safety, patient experience, effectiveness and timeliness of care.

OVERVIEW
I have no reason to doubt that doctors, administrators and employees at Rockland’s acute-care hospitals are competent, conscientious and well meaning. My concern is not with individuals but with the current business environment in which they work. To the average citizen it might seem that both Nyack and Good Samaritan hospitals retain their historic identities as autonomous facilities but, except for their names, their governance has changed drastically. Anticipating what is likely to come for the health care industry in general and Rockland County’s hospitals in particular is fraught as Washington tinkers with healthcare related policy. No doubt both institutions seek to build on historic good relations with their communities and their publicity departments crank out glowing reports about new programs. But the neighborly hospitals of the not so distant past have been absorbed into large commercial networks. Moreover, now patients increasingly can go for treatment to more convenient and less expensive places than a hospital emergency room including independent surgical and urgent care centers and walk-in clinics. (According to the insurer Cigna, the average cost of a hospital emergency room visit is $2,259 compared to $176 for an urgent care visit.)
Nonprofit hospitals like Nyack and Good Samaritan have no shareholders to answer to and because they cannot legally show a “profit” any excess income is called “operating surplus.” They receive an indirect subsidy in the form of avoidance of sales tax, property and payroll taxes and income tax and surplus revenue can be spent on executive compensation, building projects, business consultants and billing and collection companies. As one executive remarked, “This is not a healthcare system, it’s an industry and at every point there’s a way to make money.” He cynically suggested that the goal is to spend as little as possible doing good works as is necessary to remain eligible for the tax advantages and a large recent study found that about three quarters of nonprofit hospitals received more in tax breaks than they spent for “charitable care and community benefit.”

A survey of community hospital CEOs in 2017 found that their two top concerns were Medicaid reimbursement and CMS regulations. Reductions in Medicare and Medicaid certainly would profoundly effect the financial health of small hospitals but the Republican majority in Congress is determined to cut “entitlements.” The future of hospitals is likely to be influenced by the financial well-being of the networks that have absorbed them but crucial business decisions concerning Nyack and Good Samaritan hospitals are likely to be made far removed from Rockland County. In 2017 the number of uninsured rose by roughly 3.2 million (12.2% of the total population, up from 10.9 in one year but far less than 18% before the ACA.) This bodes no good for hospitals with a significant Medicaid population which are likely to encounter drops in volume and revenues and rise in bad debt as emergency room visits increase and if hospitals have to lay off personnel, the potential ripple effects on the community could be dire.

Consider the following as just one example of what can happen when local hospitals run at a deficit. This month the Affinity Medical Center in Massillon Ohio will close after serving its community for more than one hundred years. It is owned by Quorum Health which operates 31 hospitals in 15 states. More than seven hundred employees will be laid off and the buildings turned over to the city. The hospital issued this explanation: “Like many hospitals across the nation, a challenging regulatory environment and increasing financial pressures have created an unsustainable operating environment… Declining revenues paired with a highly competitive market have led to financial losses each year for the last six years.” This was followed by regrets and thanks, but my point is that no one is safe, especially if responsibility for business decisions is transferred outside the community.
The proposed $69 billion merger of CVS with Aetna is very likely to present a new threat to the status quo by promising to provide “community-based care” close to home. Amazon, Berkshire Hathaway and J.P. Morgan were next to “offer a new front door to health care” by forming an independent health care company for their more than one million employees in the United States. Warren Buffett said that “the ballooning costs of health care act as a hungry tapeworm on the American economy.” As the NY Times noted, the merger “caused further turmoil in an industry reeling from attempts by new players to attack a notoriously inefficient, intractable web of doctors, hospitals, insurers and pharmaceutical companies.” Now Walgreen, Walmart and Apple also are showing interest and as one supporter said, the movement is “a great counterweight to what government leadership hasn’t done, which is to focus on how do we make this health care system sustainable. No one can foresee how such systemic realignments will effect individual hospitals but integration into large networks is no guarantee of continued stability. It’s instructive that this month employees at 32 Kaiser Permanente hospitals in California protested administrative plans to decrease patient care services which, in turn, would reduce salaries by 10 - 20% and hundreds of jobs might be lost as services are outsourced to distant warehouses and call centers.

The mantra of the new world of hospital economics is to improve quality of care at less cost. It’s an admirable goal but to what extent the strategy will succeed is problematic. With the emphasis on shifting more health care away from hospitals, administrators will have to hustle to retain their local monopoly. New York State has committed nearly $500 million to promote “medical villages” that link various health providers in one physical location, or at least digitally, in order to coordinate primary and urgent care away from hospitals. These days the buzzwords in healthcare are “value over volume,” but in an industry that’s focused on the bottom line, just who defines “quality” anyway?

Opponents of government programs to increase health care coverage argue that they are too expensive. However, cutting Federal or State support merely shifts the burden with hospitals absorbing most of the cost - and when hospital bills go unpaid, taxpayers and local governments are forced to pick up the tab. I have no magic solution to offer, but I’m deeply concerned about what the future holds in store. The question is not whether health care should be paid for; it’s who pays? No one benefits when people are denied access to health care so it behooves all of us to keep abreast of how all of this plays out; our lives depend on it.
What do the vignettes that are appended here have to do with what came before? It seems to me that they are relevant because they illustrate the organic connection, dare I say intimate connection, that since the onset of the 20th century Rockland’s hospitals have had with the community they served. That’s not meant to infer that such a relationship no longer exists but one suspects that the dynamic can’t be quite the same in the current environment where crucial decisions are made far distant from home. Narrative history, such as what follows next, helps us understand how we’ve come to this point and, perhaps, can provide a hint about what the future may hold.

1. NYACK HOSPITAL

During the 1890s, with the population approaching 40,000, the Rockland County Medical Society and various public spirited citizens recognized a need for a hospital rather than transporting emergency cases to New York City. In 1891 it was formally decided to pursue the idea and a committee of twenty citizens, including seven doctors. A certificate of incorporation was executed in 1894 and in December 1895 three acres were purchased on Midland Avenue from the Metropolitan Life Insurance Company for $3,000. In 1897 a “Kirmess” was held for five days that raised $2,900 to promote the project; a second Kirmess in 1899 brought in even more and in 1901 a Venetian Carnival was held as a fund-raiser. (Kirmess is derived from kirch-messe for church ale, which during the Middle Ages was that portion of brew that was given as a tithe to the church. The custom evolved to church-sponsored merrymaking and song and dance festivals.)

When Nyack Hospital opened on January 1, 1900 there were no paved roads, no cars, few bathrooms or electricity or telephones. Four years after the hospital opened, a benefit game was played between the local doctors (“The Saw Bones”) and clergymen (“The Sky Pilots”). The souvenir score card provided a sense of the occasion noting “ambulances in attendance and physicians and ministers within call for all who are overcome.” Rules included: “Dominies are permitted to swear but they must not steal bases. Doctors are permitted to make a home run, provided they knock the ball into Orange or Bergen counties.” Dr. George Leitner of Piermont who in 1887 had pitched professionally for the Indiana Hoosiers of the National League in order to earn money for medical school pitched for the Saw Bones. Several doctors placed ads in the scorecard including for Dr. Maynard’s Nitroglycerine Soap: “Not necessary to use twice, once is fatal”; Dr. Kline’s Never Grow Old Pellets: “Live forever and a day, take one every second as long as you last” and Dr. Polhemus’ Anti-Fat powders: “They reduce your weight and your bank account. Good also for swollen head.” A local newspaper
reported that “the doctors were so heavy in avoirdupois and so light at the bat that the dominies won by a score of 18 to 6.” Nevertheless, $400 was raised for the cash-strapped nine bed facility and perhaps some of this was used that year to purchase for $500 “a shiny new vehicle” - a horse-drawn ambulance. In 1935 the hospital’s annual report noted that only about one third of that year’s 26,089 patients were full paying; the average census was about 46 patients. Although the County paid $25,000 for charity care, that left a deficit of about $14,000, some of which was subsidized by individual donations.

In order to increase revenue the hospital, along with about 100 other hospitals in the region, Nyack joined Associated Hospital Services of New York, the first effort at group hospital insurance. For “Three-cents-a-day” ($10/year) a paying member of a group of at least ten employed adults (less than age 65 and claiming to be healthy) would receive 21 hospital days annually (including diagnostic and surgical services); there was a 25% discount for >21 days. Not eligible were patients over age 65, those with TB, VD or mental disorders. With a population spurt after the end of World War II, the hospital needed to modernize and aided by a $500,000 federal-state grant (from the 1946 Hill-Burton Act) and local contributions it expanded to over 125 beds in 1952 and the current main building was erected in 1955. In order to help pay the mortgage for a greater than $2 million expansion, another kirmess was held in 1962 with Helen Hayes serving as Queen, Mike Wallace as emcee and local residents Carson McCullers, Ben Hecht and Richard Kiley were among those participating.

2. GOOD SAMARITAN HOSPITAL
The hospital’s principal founders were Thomas Fortune Ryan (1851-1928) and his wife Ida Barry Ryan who in order to meet the need for a “emergency hospital” purchased the Maltbie-Messimer mansion in the center of Suffern in 1902 for $7,500. With the coming of the railroad during the 1860s, Suffern became a popular location for tourists but when a medical emergency occurred transfer to a distant hospital was contingent on the railroad schedule. Ida Ryan recruited the Sisters of Charity of St. Elizabeth, NJ, paid them $25,000 to run the facility and on November 12, 1902 four nuns arrived by train. Two weeks later the first patients were admitted to the seven bed facility. Initially there were three local doctors, seven nurses and the four nuns to serve the area; the hospital rate was $1/day and the ambulance was horse-drawn. But by 1906 with an expanding population the hospital had grown to 26 beds and in 1938 a well-equipped 80 bed new facility opened on the present site at a cost of $600,000.
In 1897 the Ryans purchased a country estate on a high location on the outskirts of Suffern that they called Montebello. They rebuilt the mansion, installed a bowling alley and an electric elevator, and soon became seasonal residents. At the same time they maintained a fashionable home on Fifth Avenue as well as residences in Washington D.C. and Virginia. Thomas Fortune Ryan was a wealthy industrialist - mainly in tobacco, insurance and railroads as well as Royal typewriters and diamond mines in South Africa. He was active in Tammany Hall politics and ably assisted by his young associate Bernard Baruch. At the time of his death in 1928 Ryan was worth more than $200 million and said to be the 10th richest man in the country. A colleague described him as “the most adroit, suave and noiseless man that American finance has ever known…If he lives long enough Ryan will have all the money in the world.” Others were less flattering - variously describing him as swaggering, slanderous and shameful.

Both Thomas and Ida Ryan were generous philanthropists, mostly supporting Catholic charities. By 1905 Ida’s own contributions, which amounted to more than $20 million ($200 million at today’s valuation), covered the building of “at least 100 new schools, churches, and homes for the aged and infirmed.” In Suffern she funded a firehouse, a church and a girl’s school in addition to Good Samaritan Hospital. In 1907 Pope Pius X proclaimed Ida a Countess of the Holy Roman Empire while Thomas was made a Marquis of the Papal Court. However there were marital problems and as staunch Irish Catholics divorce was out of the question. Ida complained that Thomas ignored her and was frequently away and as her health failed and her weight ballooned to over 300 pounds, she became an invalid. When she died of heart failure in Suffern at age 62 in 1917 Ida was buried in the Ryan mausoleum in Hyde Park on the grounds of what now is the Culinary Institute of America. Twelve days after his wife’s death Thomas married his long time mistress which caused a scandal and schism within the family. When he died in 1928 Thomas was buried on his vast estate in Oak Ridge Virginia alongside his second wife.

There’s a footnote to the Thomas Ryan legacy that only became public in October 2017. Three years earlier, a 22 year old archivist tasked with studying the provenance of art located in the town hall of Madison, N.J. made a startling discovery. Chiseled on the base of an obscure marble sculpture in a back room was “A. Rodin.” It was a bust of a young Napoleon and no one knew what it was doing there. After frantic research it was determined that the bust had been made in Paris in 1908 and later purchased by Thomas Fortune Ryan who Rodin previously had sculpted three times - he must have been a vain man because there other busts sculpted as well. Ryan loaned it for more than a decade to the Metropolitan Museum of Art, but after his death it was purchased
in 1933 at auction by Geraldine Rockefeller Dodge, a wealthy philanthropist, patron of the arts and benefactor of Madison New Jersey where she lived and owned extensive property. Among her donations to the town was property for a municipal building which at the dedication ceremony in 1935 was named for one of her five sons who had recently died in an auto accident. The Rodin bust of young Napoleon was installed in the building in 1942 and it’s too bad that Thomas Ryan didn’t leave it to Good Samaritan Hospital - currently it’s displayed at the Philadelphia Museum of Art and valued at between $4 and 12 million.

3. BON SECOURS
When Good Samaritan Hospital joined the Bon Secours Health System in 2000, the local designation became Bon Secours Charity Health System. In recent years Catholic hospitals have have merged with and purchased non-sectarian hospitals becoming leading players in the nation’s health-care industry. According to the latest statistics, ten of the 25 largest systems are Catholic with Ascension being the nation’s largest. About one in six patients receive acute-care in a Catholic hospital and in the last decade Catholic systems have grown 22% while other nonprofit and public hospitals declined in number. Bon Secours Ministries began in France in 1822 and established its first hospital in this country in Baltimore in 1919. Currently the system includes 19 acute-care hospitals (12 owned outright) and related facilities located mostly in the northeast. It ranks eleventh in size among non-profit networks and in 2015 when Moody’s upgraded its bond rating from A3 to A2, it noted a “transition” in New York State’s charity market and citing various positive business metrics. After the first quarter of fiscal year 2018, the Bon Secours Health System had doubled its operating income ($23.8 million) over the previous year attributing the gain to increase patient volume, especially in primary care and outpatient visits. That doesn’t mean that a financially distressed participating hospital might not have staff layoffs, reduced services or even be dropped from the network.

4. NEW YORK MEDICAL COLLEGE
When Good Samaritan/Bon Secours joined the PPS network of Westchester County Medical Center, with it came an academic affiliation with the New York Medical College School of Medicine which had a long and convoluted history. Beginning as a homeopathic school in New York City in mid-19th century, NYMC evolved to a women’s medical school and after several metamorphoses eventually emerged as Metropolitan-Flower Fifth Avenue Hospital. Threatened with mounting debt and closure, NYMC was purchased by the Roman Catholic Archdiocese in 1978 which then moved both school and hospital to Valhalla, N.Y. where over the next decade both expanded and flourished.
However, financial issues and a change in business strategy led the Archdiocese to transfer sponsorship in 2011 to the Touro College System - an orthodox Jewish network of educational programs that are located in four countries.

5. JEWISH GEOGRAPHY

During the 1950s with convenient access provided by the bridge and highways came a major influx of ultra-orthodox and hasidic Jews, many of them from Brooklyn. In fact, a few Jewish peddlers, merchants and saloon keepers began to settle in Rockland County during the mid-19th century, most of them settling in the river towns of Haverstraw and Nyack (where the first congregation was established in 1890.) Their diverse businesses ventures included bungalows, hotels and resorts that rivaled the Catskills.

At the time of the last census in 2010 the County’s total Jewish population had grown to greater than 90,000; by now it probably exceeds 100,000, nearly 1/3 of the total population. Although reliable data is unavailable, it’s estimated that the non-orthodox community currently amounts to between 20 and 25,000 and is fairly stable in size while the three times larger orthodox population, numbering between 60 and 70,000 is rapidly growing. About 90% of ultra-orthodox and hasidic Jews live west of the Palisades Parkway while about 75% of the non-orthodox live to the east where 8 of the 10 reform or conservative synagogues are located. Although there are certain religious differences between the insular orthodox communities, the cultural difference between them and Rockland’s secular communities is profound and sometimes contentious.

Of nine major hasidic sects in the United States, two are primarily based in Rockland County (Viznitz in Kasar, and Skverer in New Square.) After surviving World War II and immigrating to Brooklyn, the Rumanian Rebbe Yaakov Yosef Twersky was horrified by materialism and decadence he found and wished to create a rural community. In 1954 Twersky bought a 130 acre dairy farm in New Square. By 2010 his Skverer sect (named had grown to some 7000 members and at about the same time Orthodox Rabbi Moshe Tender helped establish a non-hasidic ultra-orthodox community in Monsey. By 2003 its population of about 45,000 was the third largest concentration of orthodox Jews after Israel and Brooklyn with more than one hundred small synagogues and 45 yeshivas. In 1990 Rabbi Yoel Teitelbaum established Kasar, a village within the hamlet of Monsey, exclusively populated by the Vignitz hasidic sect whose more than 5,000 members were so closely packed together that Kasar became the most densely populated municipality in New York State and fifth in the nation.