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Transcript of the Meeting of the
COMMISSION ON HEALTH CARE FACILITIES
IN THE 21ST CENTURY

Held on Thursday, July 13, 2005
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New York City

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1 Meeting convened at 11:00 a.m.

2 P R E S E N T:

3 STEPHEN BERGER - Chair

4 MARK KISSINGER

5 ALBERT SIMONE

6 ROBERT HINCKLEY

7 CRAIG DUNCAN

8 R. BOUFORD SEARS

9 C. NEIL ROBERTS

10 LEO BRIDEAU

11 KRISTIN PROUD

12 ROBERT GAFFNEY

13 HOWARD HOWLETT, JR.

14 PETE VELEZ

15 DARLENE KERR

16 TERESA SANTIAGO

17 ROSA GIL

18 RUBEN KING-SHAW - (via telephone)

19 PATRICK LEE - (via telephone)

20 DENNIS WHALEN - Department of Health

21 DON BERENS - Department of Health

22 NEIL BENJAMIN - Department of Health

23 MARY GREEN - Department of Health

24

25

1 I am not going to, obviously, go through the list.
2 But I want to recognize at least two people whose
3 roles are going to be important over the next year
4 and a half as we work through this. One is
5 obviously the distinguished Commissioner of the
6 Department of Health, Dr. Novello, who is here
7 with us. And also Marianne Griddley (ph), whose
8 got the money. Well, she's got the capital money.
9 And the Dormitory Authority, also an important
10 part of how we deal with this.

11 What I would like to do before the
12 commission members sort of introduce themselves,
13 is talk a little bit about how we all sort of got
14 here. And we'll do a little bit of this today and
15 I will do some of this and Dennis Whalen will do
16 some of this. It's amazing, but almost two years
17 ago the Governor asked if I would work on and
18 chair a task force on health care reform, a
19 working group, in the State of New York. And he
20 set that task with a couple of charges, although
21 the initial discussion didn't, I think, cover all
22 three. And there were three issues.

23 The first was the issue of change. The
24 dramatic changes taking place in the delivery of
25 health care, the ability of health care, the

1 structure of health care to change based in out
2 migration from facilities and new pharmaceutical
3 treatments, new procedures, a major and dramatic
4 change which was taking place as we near the end
5 of the 20th century, which is going to accelerate
6 and move more quickly as we move into the 21st
7 century. And that change, coupled with
8 significant demographic changes, but also changes
9 in patterns of health care delivery, that are
10 going to take place.

11 The second, which everybody focused on,
12 of course, and they should, was the issue of cost.
13 The escalating cost of the Medicaid program, the
14 escalating cost of health care, the escalating
15 cost of the Medicaid program in the State of New
16 York and the role it was playing, and a very
17 serious question, not merely about its growth, but
18 a very fair question about are we getting what
19 we're paying for and what is the level and what
20 does the payment look like and does it make any
21 sense and how do we deal with those issues in
22 terms of all the other needs we have to take care
23 of the people and the population of the State of
24 New York.

25 And third was a concern over quality.

1 And a very difficult and serious issue dealing
2 with all the areas of care that we talked about on
3 our task force, issues of long-term care, issues
4 of quality in institutions, the quality of care
5 that people get.

6 I am very grateful for, first of all, a
7 lot of the staff work that was done by the
8 Department of Health during that period. But I am
9 truly grateful to my colleagues on the Health Care
10 Task Force, one of whom, Jeff Sachs, here with us
11 today and will also be around to help us with some
12 of this. But I am very grateful, because we
13 wrestled with a series of areas, and frankly, all
14 of the members of the commission and I am sure
15 almost everybody in this room has read the
16 document, although I've been told by some
17 distinguished and wonderful people that the
18 writing is a bit tepid. Guys, it's the best we
19 can do. It's serious stuff. And I think that the
20 document is -- I use the phrase in one of the
21 letters -- an architectural document. And
22 frankly, it raises a whole series of issues. I
23 want to mention a couple, but not get lost in them
24 here. And those issues relate to the three Cs of
25 change. When you talk about change and you talk

1 about -- a lot of time in the report is spent on
2 institutional care, whether it's long-term
3 institutional care or acute institutional care,
4 we've got a great deal of dollars tied up in
5 institutions. Now, if I've got to date myself,
6 there are couple of people in this room who
7 understand that, but I will date myself and say,
8 and I don't mean this literally because we're not
9 in that sector, but I started at Willowbrook
10 before the Willowbrook decree, and now I live in a
11 world of the Olmsted decision. We start in a
12 world of institutional care and move to a world
13 where we know the appropriate care is the best
14 care you can give people in community-based
15 settings. This is intellectually a total change.

16 So, as we looked at these changes, we
17 came up with a series of recommendations in the
18 Health Care Reform Task Force. And those
19 recommendations had to do with resizing,
20 restructuring, looking at creating the ability for
21 a better quality system through the use of
22 appropriate structure, creating flexibility in
23 financing which will allow technological
24 investment. You know, you live in a state where
25 we got a lot of institutions, we got a lot of

1 beds, we got a lot of excess capacity, and nobody,
2 or very few people, have the dollars necessary to
3 move from the 20th century, sometimes the mid-20th
4 century, into the 21st century in quality of care
5 delivery. And we have -- and you can't do it with
6 operating margins which are the operating margins
7 you have in institutions in the State. So, all of
8 the things we talked about in that task force
9 report were sort of the architectural framework to
10 lead to a series of engineering discussions.

11 And with all due respect, although if
12 you look at our degrees, none of us have
13 engineering degrees, this panel's goal and this
14 Commission's goal is an engineering commission's
15 goal. We, along with regional panels, which we'll
16 talk a little bit about later, the regional panels
17 on the outreach of the community -- and by the
18 way, with all due respect to the Legislature, this
19 is a commission established by the Legislature and
20 the Governor with a lot of input from the
21 Legislature and the executive branch. And
22 remember, we're talking about New York State. New
23 York State is a lot of places. New York State is
24 a big place. And the members of this commission
25 come from the entire state and there are different

1 needs in different parts of the State. There are
2 a couple issues let me just get to up front. The
3 State is different, that's we have regional
4 commissions, we've got to have broad, general
5 policies, which is what this commission has to do,
6 but working with the regional commission we have
7 to find ways to ensure that they are reasonable
8 and rational in each of the different parts of the
9 State.

10 We have financial goals, but, as I have
11 said to many people, the important institutions
12 may or may not be institutions that today have the
13 best balance sheets. So, the definition of
14 important is going to be very important for us to
15 work on.

16 So, we have a lot of issues that we
17 will have to deal with going forward.

18 I am deeply grateful to the members of
19 this commission for accepting this responsibility.
20 For those of us who have full-time jobs, to your
21 employees, to your partners, commiserations. My
22 wife has told me that it's clear that having taken
23 this she now has grounds for suing me for divorce
24 for dementia. But, this is important. This is an
25 important commission. We look to all of you to be

1 helpful and to the regional commissions and to the
2 health network to and from whom we will be drawing
3 a great deal of information.

4 What I would like to do now, if I may,
5 is allow the members to say a few words. Members
6 of the commission to sort of identify themselves
7 and say a few words. Frankly, for some of us it's
8 the first time we're meeting, so this is an
9 organizational meeting, a procedural meeting, and
10 an opportunity for us to start to get to know each
11 other and develop working relationships, which is
12 going to be important. So, I am going to start on
13 my left and ask Mr. Leo Brideau if he would begin,
14 please.

15 MR. BRIDEAU: Thank you.

16 My name is Leo Brideau. I am the
17 President and CEO of Columbia St. Mary's Health
18 System, in Milwaukee, Wisconsin. You'll wonder
19 why I am here on a New York commission, I'll get
20 into that in just a minute.

21 I've had 34 years experience in health
22 care administration. 21 of them with the
23 University of Rochester Medical Center where I
24 served in a number of positions, including CEO of
25 Strong Memorial Hospital and CEO of the Strong

1 Partners Health System that included Highland
2 Hospital and a skilled nursing facility and some
3 other facilities. I've served a number of years
4 on the Board of the American Hospital Association
5 and on their workforce commission. I have chaired
6 the -- and I do chair now -- the American Hospital
7 Association's committee on payment for health
8 services. I served many years on the board of the
9 Hospital Association of New York State, and have
10 been serving as the chair of that board. I am
11 currently on the board of the Wisconsin Hospital
12 Association, chair of their commission on
13 physician workforce. And I spent seven really
14 very fascinating years as a member of the New York
15 State Public Health Council.

16 So, look forward to working on this
17 commission.

18 CHAIRMAN BERGER: Thank you.

19 MR. ROBERTS: My name is Neil Roberts.
20 My career is largely committed to long-term care.
21 I've spent it almost entirely in Saratoga Springs
22 at the Wesley Health Care Center, and my last job
23 was the Administrator and Chief Executive Officer
24 for United Methodist Health and Housing, which was
25 a full-service institutional provider of long-term

1 care in a very vibrant marketplace. Saratoga
2 Springs and Saratoga County are doing very well.
3 So, it's sort of a different feel than some other
4 parts of the State.

5 I have also learned a lot serving on
6 various boards, largely related to health care. I
7 currently on two hospital system boards, Fort
8 Hudson and Port Edward, and Morning Side House, in
9 the Bronx, to give you a flavor. And the Dialysis
10 Board in the capital region.

11 I have also done a lot of work and
12 served in many positions with the New York State
13 Association of Homes and Service to the Aging, and
14 its national parent, American Association,
15 including President of its board.

16 I look forward to working with the
17 commission and it should be exciting and very
18 important.

19 MR. SEARS: Good morning. My name is
20 Bouford Sears. I work with M&T Bank. I manage
21 M&T's line of business with health care providers,
22 not only across New York State, but throughout the
23 rest of our company, which now includes the states
24 of Pennsylvania and Maryland. I have been doing
25 this for the last ten years.

1 I am also very pleased to serve in
2 several community service capacities related to
3 health care. For 13 years I've been on the board
4 of the Center for Hospice and Palliative Care, and
5 I've served as their chairman for the past two
6 years. I have been serving since 2000 on the
7 board of the Roswell Park Cancer Institute and
8 Alliance Foundation. I am also a prior board
9 member of the Niagara Health Quality Coalition,
10 based in Buffalo.

11 So, I hope I have a fairly well-rounded
12 perspective that I will bring to this process.
13 Very much looking forward to serving.

14 Thank you.

15 MR. DUNCAN: My name is Craig Duncan.
16 And I am the recently retired President and CEO of
17 Northeast Health after 21 years. The system is
18 located in the capital district, with three
19 hospitals, two general acute hospitals and a
20 county geriatric rehabilitation hospital. And
21 then the Eddie, which is a comprehensive system of
22 services for the elderly. And that provides
23 services throughout a six-county market area. So,
24 my perspective is very much on a goal of looking
25 at the world and trying to tie all of this

1 together and perhaps in a little bit of my
2 lifetime.

3 I've had the pleasure of having served
4 on the Hospital Review and Planning Council. I
5 was the former chair of the New York Hospital
6 Consortium. I am on the Pioneer Savings Bank
7 board of directors and a variety of other social
8 engagements.

9 So, I am delighted to be here. I look
10 forward to working with the commission.

11 MR. HINCKLEY: Hi. I'm Bob Hinckley.
12 I am Vice President at Capital District Physicians
13 Health Plan. This is a 400,000 member
14 not-for-profit health plan headquartered in
15 Albany.

16 Prior to that, I'd served about ten
17 years in health care under Governor Pataki, and
18 most recently was Mark's predecessor as Deputy
19 Secretary for Health and Human Services. I guess
20 I am guilty as charged for, under the Governor,
21 starting this process with the first iteration of
22 the work groups.

23 So, I look forward to continuing that
24 work and I think it's going to be very important
25 as we move forward.

1 MR. SIMONE: Al Simone. I am the
2 President at the Rochester Institute of
3 Technology. I've been President there for 13
4 years. Prior to that, I was President of the
5 University of Hawaii for nine years and I was a
6 dean for the College of Business, University of
7 Cincinnati for 10 years.

8 I am not an engineer, but I manage an
9 institution made up of engineers and computer
10 scientists. My degree is in mathematical
11 economics, so I do a lot of industrial engineering
12 work. So, don't count on me for that.

13 I have for the last several years been
14 serving on the board of directors of Lifetime
15 Health Care Company, it's an insurance provider in
16 upstate, New York. It has about \$6 billion in
17 sales, couple million subscribers, 8,000
18 employees. It's a not-for-profit, but it does
19 have a wholly owned for-profit long-term care
20 insurance company and it runs some facilities in
21 home care.

22 So, I am looking forward to learning
23 and helping out.

24 CHAIRMAN BERGER: I suppose just for me
25 to put on the table, I didn't spring from out of

1 nowhere here, maybe I should have. I am chairman
2 of a private equity firm called Odyssey Investment
3 Partners, in New York. But 30 years ago, or so, I
4 was New York State's Social Services Commissioner
5 at a time when that agency existed as a
6 single-state agency, responsible for welfare,
7 Medicaid and all services in the State. I served
8 on a variety of boards at that point in time.

9 And if there is knowledge that's
10 historical, I have it. The question is: Do I
11 have any knowledge that's present? And I am going
12 to depend upon my colleagues and the staff to help
13 me get there.

14 MR. KISSINGER: My name is Mark
15 Kissinger. I am the Governor's Deputy Secretary
16 for Health and Human Service.

17 I've worked in State government since
18 1987, starting with the Aging Committee and have
19 worked for the State Senate as well as for Bob, in
20 the Chamber, and now for the Governor.

21 MS. PROUD: Good morning. I am Kristin
22 Proud.

23 I am currently and very recently the
24 Senior Director of Community Affairs and Planned
25 Giving for the Center for the Disabled, which is

1 in the capital region. The center provides a
2 variety of health and other services to children
3 and adults with disabilities in nine counties
4 around the capital district.

5 Prior to that, I served for 14 years in
6 the State Assembly, having worked for three
7 speakers, and I spent the entire time on health
8 and human services. Toward the end of my career,
9 I had a number of other responsibilities, but I
10 always maintained a focus on health and human
11 services.

12 And I think looking back over the last
13 14 years in health care, it's clear that we are at
14 a critical juncture. So, I think this commission
15 and its work is going to be extremely valuable at
16 this time.

17 MR. GAFFNEY: My name is Bob Gaffney.

18 I am a partner in the law firm of
19 Meyers, Suozzi, English & Klein. Prior to that,
20 18 months ago, I was the Suffolk County Executive,
21 where I served for 12 years. Prior to that, I was
22 a member of the New York State Assembly for eight
23 years.

24 I am also looking forward to this
25 commission and to working with the very, very

1 qualified people.

2 Thank you.

3 MR. HOWLETT: I am Howard Howlett, from
4 Jamestown, New York. Probably the western most
5 part of the State of New York.

6 My main career is the automobile
7 business. I was an executive with General Motors,
8 in Buffalo, then I bought a dealership, in Ohio,
9 another one in Jamestown, New York.

10 My health care career goes back even
11 farther. I was born and raised in Detroit. I
12 started as an orderly in a hospital, ended up as a
13 surgical technician. Football sort of got in the
14 way of medicine and I went on to college and
15 graduated with a degree in printing management and
16 advertising. Went into the automobile business
17 with Buick Magazine and then into Chevrolet Motor
18 Division.

19 I have been on a number of hospital
20 boards, mainly in the governance area. I was one
21 of the founding members of the Hospital Trustees
22 of the State of New York.

23 I am currently on three or four
24 different health care network boards and I am also
25 Chairman of Star Flight, Inc.

1 I am looking forward to working with
2 everybody on the commission.

3 MR. VELEZ: Good morning. My name Pete
4 Velez.

5 Recently retired from my position as
6 Senior Vice President of the Health and Hospital
7 Corporation. Primarily responsible for the public
8 hospital system in the Borough of Queens, which
9 comprises two acute care facilities and a host of
10 physician practices.

11 Prior to that, I was involved with HIP,
12 the Health Insurance Plan of New York, both as a
13 consultant to HIP, as well as administrator of a
14 particular group.

15 I have been in health care
16 approximately 40 years. Through those 40 years, I
17 have actively participated in numerous boards
18 throughout the City, throughout the State and
19 throughout the country. Most recently, at least
20 the past three years, I have been an active member
21 of an organization called the Institute for Health
22 Improvement. I am a member of the board and
23 chaired various committees for them. I am also a
24 member of the American Hospital Association,
25 Region Two, which definitely has interest on what

1 this commission ultimately will decide.

2 I am pleased, Mr. Chairperson, to hear
3 that this forum very transparent, it's open to the
4 public, as a way for us to further engage the
5 individuals that potentially could be effected and
6 contribute significantly to the work that this
7 commission is about to do. So, I am honored to be
8 here.

9 Thank you.

10 MS. KERR: I am Darlene Kerr. I am
11 from Syracuse, New York.

12 Recently retired from the utility
13 industry as President of National Grid U.S.A.
14 Service Company, and President of Niagara Mohawk
15 Power Corporation. My career with the utility
16 industry, electric and gas utilities, spanned 30
17 years. And I have to say that although it wasn't
18 the health industry, we experienced many of the
19 same challenges and problems that the health
20 industry is experiencing. So, over my career, we
21 were constantly engaged in reengineering
22 right-sizing and restructuring and introducing new
23 technologies and quality improvement initiatives.

24 So, I look forward to applying some of
25 that experience here.

1 Also, over those 30 years, I have
2 served on business boards and not-for-profit
3 boards, including two Syracuse-based hospitals.

4 I look forward to working with this
5 esteemed commission toward improving quality of
6 health care and reducing its cost.

7 Thank you.

8 MS. SANTIAGO: Good morning. I am
9 Teresa Santiago.

10 I am currently the Chair and Executive
11 Director of the New York State Consumer Protection
12 Board. We are currently doing many programs,
13 working with hospitals and senior centers on
14 consumer-related issues in the health care
15 industry. Prior to that, I am an expert in
16 marketing, advertising and public relations.
17 That's my background.

18 I look forward to working with the
19 members of the committee, bringing my expertise to
20 this committee. And I thank you all for being
21 here.

22 MS. GIL: Good morning. My name is
23 Rosa Gil.

24 I have over 35 years of experience
25 working in the health care field. I have worked

1 at Roosevelt Hospital, Columbia Presbyterian and I
2 have served for many years at the Health and
3 Hospitals Corporation as Senior Vice President for
4 Mental Hygiene. I was a senior vice president for
5 HHC Generations Cross Network, which included
6 Lincoln Hospital, Metropolitan Hospital. And for
7 four years I was delighted and proud to serve as
8 the chairperson of the New York City Health and
9 Hospital Corporation, where we also did
10 reengineering and right-sizing the system.

11 During the tenure of Mayor Giuliani, I
12 was the Health Policy Advisor and we had to tackle
13 the challenges of bringing managed care to the
14 State of New York and the City.

15 I have served on many boards at the
16 national level and at the City and the State. I
17 was a board member of the Surgeon General Report
18 on Mental Health, and currently I serve on the
19 board of trustees of GHI. I am currently the
20 President of Community Life, Inc., which is a
21 not-for-profit organization and its mission is to
22 obtain persons who have chronic illnesses, such as
23 HIV/AIDS and mental illness and to maintain them
24 in the community through the development of
25 housing and clinical services to make sure and

1 prevent their re-admittance to hospitals.

2 I am really delighted to be here with
3 such a group of distinguished colleagues. And I
4 hope to be able to contribute a little bit of what
5 I know about health care.

6 Thank you.

7 CHAIRMAN BERGER: Thank you, Dr. Gill.

8 Two of our members -- we are lucky to
9 have technology and virtual reality. Two of our
10 commission members are on the phone with us and I
11 am going to ask them to say a few words.

12 First, Pat Lee.

13 Patrick, are you there?

14 Can you say a few words and give us a
15 little background on yourself?

16 MR. LEE: Thank you, Mr. Chairman.

17 First of all, my apologies to you and
18 the commission that I can't be there personally.
19 A long-standing commitment this afternoon, and by
20 the way, no, it's not a golf game, precludes me
21 from coming.

22 I am the Chairman and CEO of IMC. We
23 are an international manufacturer of interstate
24 and industrial components.

25 My health care experience goes back

1 about eight years ago when the Governor appointed
2 me to the Roslyn Park Cancer Institute board when
3 it was becoming a public benefit corporation. And
4 I served as the chairman of that institute for
5 five years and I continued to be involved in
6 health care through the Roslyn Park Foundation and
7 through Florida medical centers.

8 And I look forward to serving on this
9 commission.

10 CHAIRMAN BERGER: Thank you, Patrick.

11 Also on the phone is Ruben King-Shaw.

12 Ruben, can you say hello and tell us a
13 little about yourself?

14 MR. KING-SHAW: I'd be happy to. And I
15 do apologize for not being there in person. I am
16 vacationing with my family off the coast of Rhode
17 Island. They've threatened to kill me if I went
18 anywhere near the mainland. In fact, I am doing
19 this call from my car so they don't even know I am
20 doing it.

21 My full name is Ruben King-Shaw. I am
22 a private equity investor that focuses on health
23 care. My largest holdings are in Pine Creek,
24 which is a health care financing company, Pan
25 American Risk Management Associates, which does

1 health systems development and improvement
2 projects.

3 Prior to that I've spent three years
4 with the current Bush Administration as Chief
5 Operating Officer and Deputy Administrator for
6 Centers for Medicare and Medicaid services, for
7 the most part, where I focused on Medicare and
8 Medicaid policy and operations, that intersection
9 of making their grand design actually work after
10 you've decided what you want to do.

11 I spent a lot of time with system
12 redesign waivers across the country, including
13 some exposure to the New York State, redesigning
14 waiver programs. And a lot of time on
15 population-based strategies that focused and home
16 and community-debased programs, as well as
17 eliminating or addressing disparities in ethnic
18 populations across the country.

19 Also spent some time as a Senior
20 Advisor to the Secretary of the Treasury, working
21 on some health care tax policies, of which I had
22 the opportunity to work with many good people in
23 New York, including Jeffrey Sachs, who I
24 understand is there in the room.

25 Prior to coming to Washington, I was

1 with Governor Jeb Bush, down in Florida, as
2 Secretary for the Florida agency of Health Care
3 Administration, where I had the responsibility of
4 the State's Medicaid program, certification and
5 licensure of health care facilities, managed care
6 and long-term care, initiatives for the State of
7 Florida. And then prior to getting highjacked
8 into public service, I had a great life in the
9 private sector down in Miami, working primarily
10 with a few of the provider-sponsored, integrated
11 health delivery systems, Jackson Memorial
12 Hospital, a major public and research facility
13 there in Miami, in connection with the University
14 of Miami Medical School. And then something
15 called a Neighborhood Health Partnership, which
16 was a collaboration of community hospitals to
17 provide a number of services for patients in the
18 South Florida area.

19 Very happy to be a part of the
20 commission. Looking forward to serving in an
21 honorable way and excited about what we can do
22 together.

23 So, thank you for the few minutes to
24 introduce myself and look forward to meeting you
25 all in person at the very next meeting.

1 CHAIRMAN BERGER: We look forward to
2 it. We'll try to ransom you back out of your car.

3 The last member of the commission is
4 not available today. Many of you know him. It's
5 an old friend. Bishop Joseph Sullivan, who is a
6 distinguished gentleman and somebody, I hate to
7 admit it, I worked with when I was doing this 30
8 years ago. He is away in China. He expresses his
9 regrets. He's gotten all the documents and he
10 will be with us at the next meeting.

11 What I would like to do now is turn --
12 try to do a little bit more of the orientation for
13 where we are and how we got here. And I am going
14 to first ask Dennis Whalen, who is Executive
15 Deputy Commissioner, Department of Health, to
16 begin by trying to put some context, some history,
17 around this commission.

18 MR. WHALEN: Thank you, Mr. Chairman.

19 As members of this commission, you're
20 following a long traditional in government where
21 at least the smart bureaucracies reach outside of
22 themselves to call on those in the private and
23 public sector for objective review and advice.
24 This traditional is especially strong in New York
25 and one could greatly argue, I think, that this is

1 the case because of two factors. First, the vast
2 knowledge, experience and pool of expertise in New
3 York's private sector on any range of activities
4 and subjects and our ability, as demonstrated by
5 this commission's composition, to even reach
6 outside of New York to those who may have
7 connections to New York, but also to those who
8 have expertise and recognize the national impact
9 that activities in New York can often have when
10 involving good and strong work. Second, I think
11 is recognition by the government in New York that
12 external consultation and partnership is essential
13 to sound and good policy making. Not only is a
14 structure such as this commission consistent with
15 New York State policy making, I think it's
16 particularly so in regard to health care. And, in
17 fact, the Department of Health has a long
18 tradition and has a statutorily established set of
19 councils that sort of replicate this partnership.
20 And Mr. Brideau and Mr. Duncan have both talked
21 about their membership on those groups, the State
22 Hospital Council and the Public Health Council,
23 where membership is required by statute to be from
24 those outside of State government for exactly this
25 purpose.

1 Even with the existence of those
2 groups, there is a long tradition for us to call
3 on groups on specific topics and to bring together
4 groups with a particular focus and charge to
5 examine issues and depth and to provide policy
6 advice and guidance. That's most often occurred
7 at times of significant policy challenge. And I
8 think that's the case here. There are numerous
9 examples in areas of policy regulation and
10 clinical services where those deliberations and
11 conclusions have impact significantly in New York
12 State, but beyond New York State. And probably
13 the most recent example of that is the
14 just-concluded group on the use of extended
15 criteria livers and transplants, where we brought
16 together a group of individuals whose
17 recommendations are now being considered as the
18 national model for adoption by the federal
19 government.

20 But in the policy area, I want to point
21 especially to two predecessor groups to the
22 commission that I think have some relevance.
23 First was the establishment by Governor
24 Rockefeller in the 1960s of the Folsom Commission,
25 chaired by Eisenhower's former HEW Secretary,

1 Marion Folsom, who was from Rochester, to examine
2 the delivery of health care in New York State.
3 And that group brought together outside
4 representatives and brought some focus on that
5 issue, and that led to really New York State's
6 steps to establish Article 28 and to really bring
7 into a regulated environment, for quality and
8 control purposes, hospital clinics and other
9 health service operations in New York State.

10 A more recent example, I think, is the
11 NYPHRM task force, the one that Governor Pataki
12 put together shortly after coming into office.
13 And that really -- that group really provided the
14 impetus for the major change in moving from a very
15 highly rate-regulated system in New York State
16 hospitals to one with negotiated rates.

17 My point being that New York State
18 knows how to use a group of experiences, wise,
19 perceptive thinkers as a means to engender change
20 and particularly to engender change in health care
21 policy.

22 More recently, I want to point to the
23 same group that Steve talked about, and the fact
24 that he chaired that as well, the Governor's
25 Health Care Reform Working Group, and its three

1 reports as having set the stage for the formation
2 of this commission. Or perhaps even as providing
3 the imperative for this commission. The three
4 reports of that working group provide a strong
5 outline for many of the major health care policy
6 challenges that we are facing now and that we will
7 continue to face over the next several years. A
8 growing and aging patient population, emerging
9 health problems in such areas as chronic disease,
10 but also infectious disease, vastly and rapidly
11 increasing health care technology potential,
12 health care infrastructure in need of attention,
13 limited access to capital dollars to do that. We
14 know all those issues. And I think we need to
15 consider the commission as the vehicle to really
16 expand, refine, detail and then come up with an
17 implementation plan based on the working group's
18 efforts.

19 I think it was a combination of several
20 factors that led to the proposal to establish this
21 commission. First, I think it was the Governor's
22 investment in health care policy analysis as an
23 essential ingredient to sound policy making. So,
24 we've had a number of health discussions going on
25 over the past several years that have been focused

1 almost solely on dollars and cents. Dollars and
2 cents are certainly important. They provide the
3 grist for the mill in delivering services. But
4 you cannot have that discussion absent the
5 critically important policy questions that are
6 necessary companions to the money questions. So,
7 I think there is a recognition and an insistence
8 by the Governor that you cannot separate these two
9 things. And you must have policy analysis and
10 discussion as part of the larger picture.

11 Second, there is a clear recognition
12 that we need to take the next steps on the issues
13 that were outlined by the working group. So,
14 there is this need in recognition that we need to
15 get beyond simply identifying those problems,
16 identifying potential solutions to them in a
17 general way and really get to the specifics, to
18 the nitty-gritty of how do we go about making the
19 changes necessary to accomplish those things, to
20 overcome those problems.

21 Third, there is an important tool
22 available to us right now. And that is in this
23 year's budget, the Heal New York Program
24 identifies \$2.5 billion over four years as a
25 program to help facilitate restructuring of our

1 health care system. And so the question becomes,
2 okay, how do we best use those dollars to achieve
3 that purpose? In addition, the Governor has
4 successfully obtained a commitment from the
5 federal government for another \$1.5 billion on top
6 of that over three years for substantially the
7 same purposes. So, we've got the money tool
8 available to us. We've got an initial set of
9 identification of the problems, now to put it
10 together and to really figure out what those steps
11 are that we need to take, we've got the
12 commission. So, I think it was really that set of
13 circumstances that led the Governor to propose the
14 legislation creating this group.

15 I want to stress that while seeking the
16 most efficient use of valuable resources was an
17 important part of the mission of this group,
18 talked about from the beginning, it is much more
19 than a closing commission. And I have stressed
20 this to everyone that I have spoken to about this
21 group. I think it's been an unfortunate label
22 that's gotten attached to this group that really
23 misconstrues the breadth and depth of the task
24 that you have before you. Hospital closures are
25 not new in New York State. They are not new

1 nationally. I read recently where something like
2 30 percent of the hospital system in Massachusetts
3 closed over the last 25 years. In New York, I
4 think from '84 to '94, we had 37 hospital
5 closures, which is more hospital closures than
6 we've had in the last ten years. But lots of
7 attention gets brought to that. And I don't think
8 it should be a surprise that we have hospital
9 closures because health care is not static. We
10 have substantial technological advances, we have
11 pharma therapeutic advances, clinical care
12 pathways and protocols that were not talked about
13 ten years ago are now common place in our health
14 care settings and patients and doctors are
15 demanding different things in the health care
16 arena as well. But, as anyone involved in
17 crafting this legislation can tell you, careful
18 time and attention was brought to bear on the
19 question of describing the mission of this
20 commission and its work. And I note, as well, the
21 presence of Assemblyman Gottfried, who has joined
22 us, who was intimately involved with Senator
23 Hannon and others in painstaking and often
24 late-night work in trying to put together language
25 that described much, much more than simply coming

1 up with a list of places to close. It's really
2 about restructuring our health care system and
3 really about trying to decide how to bring to bear
4 the best things that we can do with these tools
5 that are now available to us.

6 So, I'd argue that this group has as
7 its mission to improve access to care and really
8 to increase and protect quality of care and advise
9 us on the proper ingredients and alignment of
10 incentives, and that's critically important to
11 really invigorate our health care system because
12 what we want out of this process is not a list of
13 hospitals to close, it's really we want a set of
14 recommendations that will ensure the vitality of
15 our health care system. And the means to
16 strengthen our ability to meet these very
17 substantial challenges that are upon us now and
18 that will continue to be upon us as the years come
19 along.

20 So, as you begin this critically
21 important task, take seriously this mission and
22 understand the long traditional in New York State
23 for engaging in this kind of operation. And
24 recognize that your task is as broad and deep as
25 it is important, and that is really helping forge

1 a health care system that is prepared and equipped
2 to for meet and overcome the challenges of the
3 21st century.

4 Thank you.

5 CHAIRMAN BERGER: Thank you very much,
6 Dennis. I appreciate it, and at some point later
7 some people may have some questions for you and
8 we'll be sort of moving chairs around, but we
9 would like you to stay available.

10 I am now going to ask Don Berens, who
11 is presently the counsel to the Department of
12 Health, also the former counsel to the Ethics
13 Commission, to spend a little time to take us
14 through, sort of outline some of the legislation,
15 which is complex legislation.

16 And I do acknowledge my old friend,
17 Dick Gottfried's, presence here.

18 So, Don, would you walk us through some
19 of the outline of the commission legislation.

20 MR. BERENS: Yes, Chairman.

21 Good morning, ladies and gentlemen of
22 the commission.

23 I'll summarize and leave out some of
24 the detail, but I'll be available for questions
25 now and in the future as the commission does its

1 work.

2 The main provisions of the statute,
3 which were enacted in April, about two weeks after
4 the budget was done when the Legislature revisited
5 the last loose ends of the budget, are as follows:

6 The statute establishes a bipartisan
7 commission, separate and apart from all existing
8 bodies that are charged with oversight of the
9 health care system. The commission consists of 18
10 statewide members, plus six members for each of
11 six regions of the State. Those regions are Long
12 Island, New York City, the Hudson valley,
13 northern, central and western New York. The
14 statewide members may vote on any matter that
15 comes before the commission. The regional members
16 may vote only on matters pertaining to their
17 respective regions. The commission is charged
18 with the mission of examining the supply of
19 general hospital and nursing home facilities and
20 to recommend changes that will result in a more
21 coherent, streamlined health care system in New
22 York State.

23 The statute provides for regional
24 advisory committees. The commission can appoint
25 regional advisory committees for -- it can set the

1 size of the regional advisory committees and then
2 the Governor and the Legislature appoint members
3 of those committees, which are charged with
4 soliciting public input and making recommendations
5 to the commission related to resizing or
6 consolidation, conversion or restructuring of the
7 health care system.

8 The Commissioner of Health is required
9 by statute to appoint one or more liaisons with
10 the commission from the Department and from the
11 Public Health Council and the State Hospital
12 Review and Planning Council. Those who have
13 worked with that council for some time, sometimes
14 called SHRPC. And I encourage anything that will
15 shorten that name if our regular discussions. The
16 Director of the Dormitory Authority is also
17 required to appoint one or more liaisons to work
18 with the commission.

19 Some of the significant dates set forth
20 in the statute are by the end of May, the
21 appointments were to be made, but they can be made
22 later, some of them have been. In July, just a
23 couple of days ago, the advisory commissions could
24 begin operating. The Department of Health and the
25 Dormitory Authority are required to submit factors

1 that the commission may consider and other data
2 defined in the statute. These are not the only
3 factors and the only data that the commission is
4 permitted to consider, but the statute makes sure
5 that at least those minimal factors are among
6 those to be considered by the commission. Then
7 there is a gap in the deadline or schedules,
8 milestone dates, until November 15, 2006. That's
9 the deadline set by law for the submission to the
10 commission of recommendations by each of the
11 regional advisory committees. Then on or before
12 December 1, 2006, just 15 days later, the
13 commission must report to the Governor and the
14 Legislature what it has found and what it
15 recommends. The Governor is to review that and if
16 the Governor approves, he'll transmit his written
17 approval to the Legislature, his approval of the
18 commission's report. Then, unless the Legislature
19 adopts a concurrent resolution rejecting the
20 commission's recommendations in there entirety by
21 December 31, 2006, then the Commissioner of Health
22 is required by June 30th of 2008 to implement
23 those recommendations.

24 In a nutshell, that is the statutory
25 outline of what the commission does.

1 CHAIRMAN BERGER: Don, we will -- I am
2 going to ask if any of the commission member have
3 any questions, but we're going to circulate this
4 outline to everybody. It's a touch easier to read
5 than the actual legislation itself.

6 But, do any of the members have any
7 questions for Mr. Berens?

8 We will get this circulated and have it
9 in a package that we're preparing for everybody
10 right now.

11 Don, while you're sitting there, why
12 don't you keep going. Now, sort of put on your
13 former hat as an ethics lawyer and would you take
14 us through the whole issue of the bylaws?

15 MR. BERENS: I would be glad to.

16 In fact, the bylaws will cover a number
17 of topics besides ethics and conflicts of
18 interest, but they are certainly an important part
19 of the bylaws.

20 We begin with the statutory
21 requirements that pertain to how this commission
22 is to do business. The statute says that
23 commission members shall be subject to the same
24 conflict of interest provisions that apply to
25 members of the SHRPC. And that, in fact, means

1 Public Officer's Law, Section 74, which is the
2 code of ethics, and it means the conflict of
3 interest sections of the SHRPC bylaws. The usual
4 definitions of what it takes to form a quorum and
5 an action, a majority to take action of a
6 commission, are refined by this statute. So, that
7 too, is an area where there is not room for
8 discretion in how the bylaws are set up. The
9 statute tells us that a quorum consists of a
10 majority of the members of the commission entitled
11 to vote on the matter under consideration. And
12 approval of a matter shall require the affirmative
13 vote of a majority of the members thereon.

14 The statute also says the commission
15 shall adopt bylaws and that only the statewide
16 members are entitled to vote.

17 The final statutory provision that
18 applies here is that the deliberations of the
19 commission are subject to the open meetings law,
20 provided that whenever the committees or the
21 commission are discussing medical, financial or
22 credit history of a particular hospital or nursing
23 home, then those sessions have to be in executive
24 session. The public is not permitted to see that
25 detail.

1 So, with those exceptions, we modeled
2 the bylaws after the SHRPC bylaws as closely as we
3 could. They've been circulated to you. I'd be
4 happy to answer any questions about them.

5 But, in the interest of time, I'll be
6 guided by what you to do next.

7 CHAIRMAN BERGER: Are there any
8 questions from members of the commission?

9 On the phone, any questions?

10 MR. LEE: No, not from me.

11 CHAIRMAN BERGER: You have a resolution
12 in your package which reads:

13 "Resolved, that the statewide members
14 of the commission on Health Care Facilities in the
15 21st Century, pursuant to Section 31 of Part E of
16 Chapter 63 of the Laws of 2005, on the 13th day of
17 July 2005, hereby approve the attached bylaws for
18 the management and regulation of its affairs."

19 Could I have a motion, please?

20 MS. KERR: So moved.

21 MR. VELEZ: Second.

22 CHAIRMAN BERGER: Any opposition?

23 The bylaws are passed.

24 Thank you, gentlemen, for your help.

25 Don't go too far away, we may have some questions

1 for you.

2 One of the things we have to do, and
3 we're slowly getting there, is to be able to
4 establish a schedule for these commission
5 meetings. Many of you have to come from a great
6 distance and we're still in the process of doing
7 it. What I would like to do is say the following:

8 We would like to do two more meetings
9 this year. I would like to do one in the week of
10 September 19th, and we will e-mail you and try to
11 get some dates for that week. And a second
12 meeting on November 9th. At that point, we will
13 also try to lay in place the meetings for next
14 year, so people can get themselves -- get their
15 schedules organized around it. I apologize it's
16 taking a little time, but we're in the process of
17 organizing. Hopefully, by that time, we will have
18 a staff for the commission, we will be set up with
19 offices and we will be able to communicate with
20 people a little better than we have up till now.
21 We are in the organizational stages.

22 As part of that, let me make a comment.
23 Before we actually sat down, some people in the
24 audience had come up to me, one person in
25 particular had material, they wanted to give to

1 the commission and some information. And I
2 wouldn't take it. Because here is what we're
3 going to do, and the bylaws provide for it. We
4 want to make sure that any material that comes in
5 gets cataloged, gets to all members of the
6 commission, and it's sort not scattered. And we
7 have some organized way of doing it. As soon as
8 we have a staff to better organize it, it will be
9 easier. But, under the bylaws, it says that
10 materials should come to me or somebody I am
11 decimating. I am going to designate at this
12 point, because he's the only one there, I am going
13 to designate Hilton Marcus, and we'll publish
14 this, Hilton Marcus, at the present commission
15 offices, which is the Commission on Health Care
16 Facilities in the 21st Century, 90 Church Street,
17 13th Floor, New York, New York 10007. So, Hilton,
18 and as we build the staff, we'll be able to take
19 material and catalog it and distribute it to
20 people so that we all are getting the same
21 material. I think that's important.

22 Now, moving on. Before I turn this
23 over to Neil Benjamin, many of you know Neil,
24 people who have worked with the Health Department,
25 I want to say something. In a memo I circulated

1 to the commission members -- we sent out some of
2 the data. And I said, look, data is not going to
3 be a problem for us. We will have and we will be
4 buried in data. Data from the Health Department,
5 data from many of the people in this room, data
6 from people in organizations that have not yet
7 gotten into this room. The issue for us, and
8 we're going to have to spend some time on it in
9 the next couple of months, is how to organize
10 ourselves to ask the right questions so we can ask
11 for information that helps us make decisions, look
12 at information that conflicts with some of our
13 natural sort of assumptions, prejudices and all
14 the rest and be able to use information, not data,
15 use information in a way that helps us deal with
16 some of the issues that are in front of us. And I
17 think Dennis, Dennis Whalen, I want to reemphasize
18 this, because it is very important. We are not in
19 the list business, guys. I want everybody to
20 understand that. We're not in the list business.
21 I know when the commission was announced, some of
22 our good friends in the press started publishing
23 lists of institutions. We are not in the list
24 business. We're in the factors business. We're
25 in the sort of shaping business. And we've got to

1 come to decisions, but we're not starting with
2 lists. We are going to develop models for
3 decision making and I think that is very
4 important. We've got to have criteria, we have to
5 deal with the regions of the state, and that's why
6 there are regional bodies, so that the criteria
7 which are sort of probably common criteria, will
8 have impacts in different parts of the State. And
9 by the way, we're not working in a vacuum. I
10 mean, events that are taking place will take place
11 over the next year and a half in which
12 institutions will make decisions, there will be
13 financial issues, there will be quality of care
14 issues. All of this is going to take place around
15 us. And so we're not going to be operating in a
16 static situation. We're going to be operating in
17 a situation which is undergoing dramatic change
18 and how we use information will be a very
19 important part of our own comfort and our
20 credibility in performing.

21 With that caveat, I've got to do that
22 before I give you Neil, because otherwise we're
23 finished. And that sort of -- it's less of an in
24 joke because people who have worked with Neil for
25 the last 30 years understand what I mean.

1 Neil, would you do me a favor and sort
2 of tell us a little bit about what you have
3 distributed to people and tell us what's in the
4 volumes and then if we get any questions from
5 commission members, please? So, we can understand
6 how we're starting the data distribution process.

7 MR. BENJAMIN: Absolutely, Steven. And
8 thank you for this opportunity. Members of the
9 commission, we'll be working very closely with
10 you, as will all Department staff, as well as the
11 Dormitory Authority.

12 What we tried to do here was you have
13 in front of you four books, and two of them are
14 fairly small and two of them are large. And I
15 would call your attention to the two largest ones
16 if I may first. Because these I would expect that
17 you will be referencing many times as you do your
18 work, and there are names of hospital profiles and
19 residential health care facilities profiles or
20 nursing home profiles.

21 What we've attempted to do in here is
22 basically give you a historical overview, and it's
23 all data. The hospital, for example, gives you
24 the last ten years of hospital occupancy, average
25 daily census, et cetera, by service category. And

1 what we've done is we've modeled them after the
2 six commissions in the statute, the six regions in
3 the statute that the State is broken down into.
4 And if you look through it, they are color coded
5 and we have different colors for each region. And
6 they are also broken down by county. So, all of
7 this data is rolled all the up and there is
8 actually even the statewide number for all of this
9 information. There are maps. There are maps,
10 smaller maps, that precede each section, which
11 will show you the location of each hospital and
12 each nursing home. We included in there some
13 demographic data, population data from the 2000
14 census. Folks above and below the age of 65. And
15 as you look closely at this, you'll see a lot of
16 different trends begin to emerge.

17 We did the same thing on nursing homes.
18 There are 200, a little over 230 hospitals in the
19 State; there are over 650 nursing homes. So, that
20 data was a little more difficult to map out, et
21 cetera. The smaller maps in each books are
22 replicated in the back for pull outs, in case you
23 have difficulty reading the smaller ones. So we
24 did the same thing with nursing homes, by
25 commission region, et cetera. And here you have

1 occupancy numbers, which are pretty important.
2 And there is a lot of information behind this as
3 well. I am sure, as you continue to do your work,
4 we will certainly be available to answer
5 questions.

6 So, those are kind of like the bibles I
7 think you're going to be referring to many times.

8 I call your attention to the book that
9 is entitled "Factors." And what we did here was
10 in the legislation, as Mr. Berger mentioned and
11 Don, there are nine factors that we're charged
12 with providing, along with the Dormitory
13 Authority, are charged with providing you
14 information on. And they are broken down. There
15 are nine of them in this book, which are
16 consistent with the nine laid out in the
17 legislation. And I'll quickly skim them.

18 The first one, need for capacity. What
19 this really tells you is what is currently on the
20 books in the State Authority for determination of
21 hospital bed need and nursing home bed need.
22 Sometimes if you have difficulty falling asleep,
23 you may want to refer to some of this stuff. But,
24 otherwise, we'll be available to answer questions.

25 The nursing home bed methodology was a

1 major initiative, by the way, of the Department a
2 couple of years ago. It hadn't been updated in 15
3 years. And as Mr. Duncan and Mr. Brideau
4 mentioned, the State Council and Public Health
5 Council had a strong role in that. We conducted
6 public hearings, it took us about a year. We
7 think that's very representative of where we think
8 the nursing home system is going. On the other
9 hand, the hospital bed need formula has not been
10 updated in almost ten, 12 years. And we've kind
11 of tried to explain why.

12 Under existing capacity, which is
13 factor number two, we've given you a snap shot of
14 the inventory of hospitals and nursing homes in
15 the State. You are going to see some strange
16 numbers here, PFI, OPSR, et cetera, that's just
17 the way that we had to have the computer sort
18 these things. But they are broken down by county
19 and region, similar to what's in the two large
20 books. And I believe they are about as current as
21 we can be. There is always activity going on in
22 the industry and we will keep you updated on that.
23 And it's rolled up, again, into counties and then
24 into regions.

25 Also, we have a separate listing of

1 what are called critical access hospitals and at
2 some point we'll be talking to you more about what
3 that means and how that's distinguished.

4 The third factor is labeled economic
5 impact. And we really took that to mean -- to
6 look at the impact of health care right-sizing on
7 the workforce. And you have in here a lot of the
8 -- we've summarized a lot of initiatives that
9 mostly the State government, but some involvement
10 with the federal government, has undertaken over
11 the past ten years in workforce retraining and
12 retention. Those are listed. So, again, that
13 will be another work in progress in providing
14 information.

15 Factor four, amount of capital debt
16 being carried by general hospitals and nursing
17 homes and the financial status of general
18 hospitals and nursing homes. We've given you a
19 snap shot, again, of total long-term debt carried
20 by hospitals, total long-term debt carried by
21 nursing homes and we've also given you a number
22 that's -- and these are all broken down by
23 region -- called net book value. And that's
24 really the remaining value of the buildings that
25 really hasn't been absorbed and accounted for

1 within the system. And as we get into other
2 discussions, you'll need to understand what that
3 means. Then behind that, we have a snap shot of
4 hospital and nursing home profitability.
5 Comparisons. Due to data availability, we chose
6 2002 for nursing homes and 2003 for nursing homes.
7 We will have more current data as we get a
8 complete set through SPARCS and a cost report
9 system.

10 So, moving on to factor five. Factor
11 five is alternative sources of funding. And what
12 we tried to do here is begin -- Dennis mentioned
13 several of these, that we have available to us or
14 soon have available to us. The first one is the
15 health facility restructuring pool. That's a pool
16 that we have jointly administered with the
17 Dormitory Authority since the advent of HIPAA.
18 And we've used that to assist facilities in
19 addressing some critical needs and financial needs
20 and continuing to provide care in needed areas.
21 We'll be supplementing this as we go on and there
22 are snap shots of those.

23 The next one is something that there is
24 a lot of numbers in here. What it is, factor six
25 is the availability of other health care services.

1 We just talked about hospitals and nursing homes,
2 but we all know that the universe is very large.
3 What we tried to do here within the constraints of
4 our data is list for you all of the out-patient,
5 licensed out-patient facilities in the State,
6 whether they be diagnostic treatment centers or
7 extension clinics of D&Ts or extension units of
8 hospitals. Again, we had to put all those PFI
9 numbers and everything in there to be able to sort
10 this. And this was very -- this is very fluid. I
11 mean, clinics open and close every day. But I
12 think you'll get a sense of what the capacity is
13 out there.

14 Private practitioners, again we tried,
15 and this is more difficult because as know they
16 are not nearly as regulated as Article 28 and
17 other public health statute regulated facilities
18 are, so we have information in here about them and
19 that will be certainly -- that's a major factor to
20 consider as we go forward. But, again, the data
21 sources there are more limited than in the
22 regulated side.

23 We also have a listing of all of the
24 certified home health agencies across the State,
25 or CHHAs as we try to use our acronyms here. And

1 we also have listed the inventory of adult care
2 facilities. Very important continuum. Again,
3 these are all very fluid and you'll be seeing more
4 information on these as you go along.

5 The next one, number seven, is
6 something I think is pretty important, and that's
7 just a primer, a one-page primer on potential use
8 of converted facilities. So, there is really two
9 things here. One is just a summary of the
10 complexities and the problems associated with
11 converting existing health care facilities into
12 either other health care uses or other non-health
13 care uses. And we'll be having Tom Jones, he
14 works with us, he's our chief architect, and he'll
15 be giving you a presentation, I believe, in the
16 future on some of those challenges. I think
17 what's important, what's behind that, is Dennis
18 Whalen mentioned 37 hospitals closing from '84 to
19 '94 and what we've listed here are those closures
20 since 1994. But we've also, in the right-hand
21 column, tried to indicate what those facilities
22 are now used for. And if my math works right,
23 there is 28 facilities listed here and ten of them
24 are currently used to deliver some sort of health
25 care to their communities. And we'll certainly

1 talk more about that.

2 Closing in on the end of the factors,
3 number eight, services to Medicaid and the
4 uninsured. What we tried to do here was give you
5 a breakdown of -- this is difficult. This is
6 difficult to get your hands around. I think it's
7 going to be very important to you. And we have a
8 lot more data on this. We didn't want to give it
9 to you at this point, but it's very important to
10 make sure that we are cognizant of the uninsured
11 and the Medicaid population in the State. And we
12 just have one page in here that comes from the
13 Census Bureau and it lists from 2002 and 2003 the
14 number of uninsured children and uninsured adults.
15 Again, a lot more data coming on that and I think
16 you'll be much more interested.

17 The last one, number nine, while it's
18 much more lengthy in the statute, what it really
19 says is the ability to redirect resources. The
20 ability to redirect resources from, I'll call it,
21 heavy work from Mr. Berger and the previous work
22 group, stranded costs. And by stranded costs it's
23 really the resources that are directed towards
24 supporting the cost of excess capacity and how can
25 those dollars be redirected into appropriate

1 health care resources and the improvement of
2 quality. And what we tried to do here is just
3 give you a quick overview of quality and outcomes
4 as a measure of health care performance. And it's
5 complicated and those of you who are in the
6 industry and the government certainly know, there
7 are many initiatives ranging from Medicare to
8 improved facilities in a given area. We are
9 working to get a lot more information for you on
10 that.

11 So, those are the factors.

12 Then we have one last book called
13 "Supplemental Information." And this is broken
14 down into four categories. One is simply health
15 information technology, very important, a lot of
16 attention being paid on the national and State
17 level. It's referenced in the Heal New York
18 legislation and we've given you a lot of
19 background on federal initiatives, state
20 initiatives and how we're meshing the two
21 together. And what are the most important
22 components when you begin to look at that.

23 Interoperability, is the key word here.
24 Long-term care. Very important. A lot of this
25 was extracted from the work group report on

1 long-term care. It references, as Mr. Berger
2 mentioned before, implications of the Olmsted
3 decision. And our work towards a point of entry
4 system that would basically manage the patient
5 through the most appropriate setting. Not have
6 the setting basically dictate where the patient
7 goes. So, there is a lot of reading in there on
8 that. And Kathy Kumark (ph) and her folks in the
9 Medicaid section of the Department have done a lot
10 of work on this.

11 Quality health care, we've given you a
12 little more work on that. Broken down to some of
13 the buzz words that hear: Centers of excellence,
14 improving quality, paid for performance and
15 assorted literature that we extracted over the
16 years, ranging from cardiac services to oncology
17 services and how some of these initiatives may or
18 may not effect quality nationwide.

19 Last, but not least, is a little
20 two-page snap shot that actually I put together
21 comparing the state of the hospital industry from
22 1994 to 2004. Just take a look at it. It's all
23 based on averages. But I think what it shows you
24 is the gap between licensed beds and average daily
25 census, or occupied beds, in hospitals in those

1 ten years. It's kind of striking to see, in my
2 view, the number of excess beds that remain on a
3 hospital's license. You can pretty much see that
4 here. We've also given you some snap shots on
5 another important factor that feeds into that,
6 average length of stay, FPEs, et cetera. We have
7 all the background as to how these numbers are
8 derived and most of it is in the two large
9 binders.

10 So, I hope I wasn't too long, Mr.
11 Berger, and I'd love to answer any questions.

12 CHAIRMAN BERGER: Do we have any
13 questions for Mr. Benjamin, please?

14 MR. VELEZ: How can we ensure that the
15 most recent data is integrated into the data
16 elements we have here so when we convert data into
17 useful information we know what we're talking
18 about?

19 That goes through quickly a lot of
20 data, some of SPARCS data is not updated.

21 MR. BENJAMIN: Thank you, Mr. Velez.
22 That's a very good questions.

23 Actually, going through this initiative
24 has really, internally in the Department, we are
25 now focusing in on the SPARCS system itself. And

1 we have an initiative underway because we realize
2 there is a lot of underreporting across the State.
3 We chose 2003 because 2004 is short by about five
4 percent of reporters. We are putting a concerted
5 effort into updating all this with 2004 data. On
6 the nursing home side, that may take a little
7 longer to update that year because they have
8 different and later reporting deadlines because
9 that information comes from their certified cost
10 reports. But as this goes on, I believe that we
11 will have a complete set updated to '04 for
12 hospitals, and a complete set updated to '03 for
13 nursing homes. And we'll be as current as we
14 possibly can.

15 MS. PROUD: You mentioned that there is
16 a list of hospital closures from 1994 to the
17 present time in the factors book, which I looked
18 at.

19 Is there a similar list for nursing
20 homes during that time period?

21 MR. BENJAMIN: Yes, there is. We have
22 it and we'll be glad to provide it to you.

23 MR. BRIDEAU: A couple of things.

24 First, I commend you for putting all
25 this on CD. I appreciate that. It's a huge help

1 for our backs.

2 The other, I want to focus on
3 occupancy, which is going to be a key issue we'll
4 talk about. In terms of data that we need to try
5 to get our hands around.

6 One is we're using licensed beds and I
7 know we need to do that, but there is the whole
8 issue of how many beds are really being operated
9 by the hospitals, and that may be quite different
10 from licensed beds. In fact, many of the
11 hospitals may not have the physical facilities to
12 operate the beds they have licensed. So, I think
13 that's one aspect of how many beds are really
14 there.

15 The other has to do with just a
16 sensitivity that the census numbers we use or
17 midnight census. And in hospitals, midnight
18 census are the lowest census of the entire day.
19 The high census tends to come during the morning
20 time basically, up through noon, one o'clock,
21 while you still have the patients you have not
22 discharged yet, and then you have the new patients
23 that you acquire overnight, between midnight and
24 noon. So, some factor that understands that and
25 how -- because that doesn't make capacity

1 complete.

2 MR. BENJAMIN: I can quickly respond to
3 both of those.

4 We certainly are very sensitive to the
5 issue of -- I mean, there is really three
6 categories and we've had discussions fairly
7 regularly with the Hospital Association about
8 this. They've brought it to our attention.
9 Obviously, it's very easy to get licensed beds.
10 But then you come down into something that's
11 called available beds. And that's a calculation
12 that comes on a cost report, et cetera. And
13 that's something that we are in the process of
14 developing that number for the whole State. It's
15 this whole big, complicated mathematical formula.
16 We'll have that for you fairly shortly.

17 But the last one is a little more
18 difficult to get your hands around. And that's
19 staff beds. What was the hospital staff up to?
20 And we continue to talk internally, as well as
21 with the Association as to the most appropriate
22 and effective way to get at that number. Because
23 it's not really required to be reported anywhere,
24 and even if it's voluntary, it's not available in
25 a consistent manner. But we are very sensitive to

1 that issue and know it will be important to you
2 and we'll have more information on that most
3 assuredly.

4 Now, the other thing that you
5 mentioned, and it's also something that's
6 important to us, because as you read -- if you
7 read a lot of this formula-based information, we
8 make certain assumptions about what's optimal
9 capacity. And you're right, optimal capacity is
10 just average or midnight census. And again, what
11 we're trying to do, with the assistance of the
12 Hospital Association, is try and take a look at
13 trends. In certain hospitals, what is their bed
14 capacity and what would that do with their ability
15 to treat patients on those peak days? So, we're
16 putting together a program to be able to test
17 that.

18 CHAIRMAN BERGER: Let me, if I can, the
19 three questions raised some points which I would
20 like members of the commission to think about and
21 we'll have to noodle about over the next bunch of
22 months. Number one, this is an area, and there
23 are enough people on this commission who
24 understand, there will never be perfect data.
25 There is no perfect data in the health care

1 industry. And no every piece of data is
2 absolutely perfect. Part of the reason we are
3 here is we are going to have to make some
4 judgements based upon the best data we have. I
5 will resist, I would tell you as Chair, not making
6 any decisions because we don't have perfect data
7 coming together. So, you just have to think about
8 that. For many of us in our careers and our
9 lives, the quality of the data and the immediacy
10 is better than what we have here. We have to
11 understand that. The reason the members of the
12 commission are here is they bring judgement to
13 bear on what is there. That is the first point I
14 know to make.

15 The second point I want to make is we
16 do have the multiple tasks, as Dennis Whalen
17 pointed out, it's not just a bed-closing
18 commission, that's not what we are, we have a
19 broader responsibility. We also have a
20 responsibility on long-term care. This is not
21 just a hospital-based set of issues. We have to
22 deal with the acute care issues as well. We
23 should not forget that.

24 Third, we're going to have to do some
25 work and we'll need some help from both the

1 Dormitory Authority as well as some other folks I
2 want to talk about in a minute, of understanding
3 the operating and economics of institutions that
4 are partially used, not partially used, so we can
5 understand the true costs so we're not just
6 talking theoretically and not just to care issue
7 when we talk about beds that are staff beds
8 versus, in fact, licensed beds and all the rest.
9 If we're trying to also deal with the cost issues,
10 we have to understand the differences in costs
11 between a partially-operating institution and a
12 closed institution and a fully-operating
13 institution. And that's part of the financial
14 discussion we're going to have to have down the
15 road.

16 There will be -- the information data,
17 I want to make two points. One is process. We
18 will circulate to the members of this commission
19 the way you can access people like Neil Benjamin,
20 Dennis Whalen, the other senior staff people at
21 the Department, and others in the Dormitory
22 Authority and other places. What I'll ask,
23 because we don't want to cut you off if you have a
24 question, I am going to ask them, and we'd
25 appreciate it, if you ask them a question, that

1 you'll also let the staff of the commission know
2 so we know what everybody is sort of noodling
3 about. But I want to make sure, Neil, I just made
4 your lives complicated, but you are going to put
5 out data, somebody is going to ask you questions
6 about it and that's life.

7 Lastly, on the data issue, I would like
8 you to read the material provided by --
9 particularly in the Supplemental Book. The Health
10 Department, meeting the mandates of the
11 Legislature, has put out a great deal of
12 information, given us a lot of data. On the
13 long-term care, if you read the words and read the
14 essay that goes along with it, it's very clear
15 that the struggle you will have in these
16 discussions is that it's easy to take the system
17 we have now, the way we go about delivering health
18 care and take demographic numbers and project
19 forward and you end up having a set of numbers.
20 What you do not have at that point is system
21 change. Because the problem is not asking -- the
22 problem in terms of projections is not to ask for
23 linear projections, but to say -- and I'll use a
24 simple example, we've used it several times
25 today -- if governance of our goal on long-term

1 care is to meet sort of the directions of the
2 Olmsted decision, which is care for people in the
3 most appropriate setting, then your projections on
4 institutional beds are different if you are going
5 to project the number of institutional beds based
6 on the way we run the system today. We are going
7 to have to work with the people who are giving us
8 information to shape how the information makes
9 sense to us. By the way, they say that in
10 introduction to the data. The data doesn't quite
11 reflect that because we haven't given them
12 direction on what to do.

13 And lastly, I'll ask all of you as we
14 go forward in the next period of time, many of you
15 -- and I've already had calls from some terrific
16 pro bono offers from people around the State, from
17 people who have done data work or accounting work
18 and all the rest in the health care industry --
19 frankly, at this point, I am not sure how we would
20 use them. We're not far enough along. But as we
21 go forward, there are some people who have done a
22 lot of work on health care who have said we would
23 like to help and contribute. When we have a staff
24 and we have some questions, and if any of you have
25 people who come to you and say we would like to

1 help, please let me know or let the staff know so
2 we can try and integrate and use this, we can
3 leverage information that's out there and people
4 who are willing to help us deal with these
5 problems.

6 Anything else for Neil?

7 Now, we come to the high point of any
8 organizational meeting. We're going to ask Mary
9 Green -- Mary, would you take us through some of
10 the other administrative issues that people have
11 to know so that we can all get in and out of
12 buildings, people can get paid for expenses and
13 whatever else they have to do.

14 I know this is fascinating for the
15 audience, but, guys, this is how the real world
16 works.

17 MS. GREEN: You've been given three
18 documents in your packet. One is the basic
19 instructions for filling out your travel expense
20 reports. The per diem regulations for Albany and
21 New York City through September 30, 2005, as well
22 as several copies of your travel documents with
23 instructions and who to send them to.

24 I'll just run through them very, very
25 briefly.

1 CHAIRMAN BERGER: I want you to know
2 that was prepared to be read by somebody who is
3 one-third of the age of anybody in this room.

4 (Laughter.)

5 MS. GREEN: You do have the documents
6 in front of you in your packet.

7 Obviously, item one, social security
8 number, last name, first initial, middle initial
9 is required.

10 Line number two, leave that blank. You
11 are not DOH employees, for those who are not DOH
12 employees.

13 Your home address is required. Mailing
14 address as to where you would like your
15 reimbursement check mailed to. Your regular work
16 hours, your official statement.

17 Line number four, blank, not required,
18 you are not an employee.

19 Line number five, for one-way commute
20 time, again, not required.

21 CHAIRMAN BERGER: Mary, I don't think
22 you have to go through them line by line.

23 MR. GREEN: Line number seven, you will
24 check in this case, for those who are not DOH
25 employees, please mark your travel as a volunteer.

1 This effects how it's reported for tax purposes.

2 Payee certification line, we do need
3 your original signature as well as your title.

4 Once the document is completed, it will
5 be forwarded to the address that's indicated in
6 your packet. Please retain a copy for your
7 records.

8 We are mandated by the Office of the
9 State Comptroller, as well as the Department of
10 Health and some other agencies.

11 The second page is another required
12 document along with the cover sheet. Please be as
13 specific as possible with each and every one of
14 these questions. Especially when it gives the
15 purpose of travel, don't put "council meeting,"
16 please put the name of the council.

17 CHAIRMAN BERGER: I am going to ask
18 everybody if anybody has any questions, we're
19 going to circulate your number.

20 MS. GREEN: Just a couple of quick
21 ones.

22 We will only pay for coach air travel.
23 We will not pay for first class.

24 We will need passenger receipts and/or
25 itinerary if you spend any money on food or rental

1 car. Lodging receipts are required. The
2 guidelines are here in your packets, the maximum
3 amount. Also sales tax exempt forms are in your
4 packet.

5 Your meal reimbursements for the area
6 of New York City and Albany are here through
7 September 30, 2005. After that point, in October,
8 when they change, you will be notified by your
9 council what the new rates are.

10 Your mileage reimbursement, set up by
11 the IRS, is 40 and a half cents per mile.

12 There are also two other documents that
13 you may need and those instructions are in your
14 packet.

15 CHAIRMAN BERGER: Now, I am going to
16 assume that everybody on the commission, you'll
17 read the documents, look at the packages. You'll
18 decide if you have any questions and any problems
19 you find, we'll talk to the staff and try to fix
20 it for you.

21 Now, I would like to ask any of my
22 colleagues if they have any questions, any
23 comments, any issues you would like to raise now?

24 Anybody on the phone, if we haven't
25 bored you or driven you away by now?

1 MR. KING-SHAW: This is Ruben. I am
2 still here.

3 Were you question for questions
4 regarding the administrative procedures or --

5 CHAIRMAN BERGER: No. I am asking for
6 questions regarding -- I stepped back to the
7 broader issues.

8 MR. KING-SHAW: Got it. Thank you.
9 No questions at this time.

10 CHAIRMAN BERGER: Any of my colleagues
11 here?

12 MR. BRIDEAU: The duration of the
13 future meetings, how long do you expect they'll
14 from start to end?

15 CHAIRMAN BERGER: It's very hard to
16 determine. We're going to start getting into some
17 more extensive discussion and I think we're going
18 to have -- you get into some policy discussions
19 and you try to understand some pieces. We are not
20 going to let them get out of control. I think we
21 can't because people are traveling from all over.
22 My hope is we can work in the two to three-hour
23 range and try to do it that way.

24 Part of it is, if we send material out,
25 you'll get a chance to look at it. If you got

1 questions, you get it back to us, we'll have some
2 staff people and other people to answer questions.
3 We can circulate it. So, we can make our time
4 together more efficient. Because travel, with all
5 due respect, I think travel is a nightmare for
6 everybody and getting around the State or even the
7 City sometimes is just real hard.

8 Anything else?

9 I want to thank all of you for being
10 willing to undertake this. It's almost two years
11 ago, Jeff, we started with the task force. It was
12 a monumental. We looked at this -- I'll be very
13 honest -- we looked at this and said we're
14 clueless as to if anybody is going to listen to
15 anything we say because it was -- and we're amazed
16 that people did. We're starting again now with a
17 much broader mandate, much more detailed and with
18 a mandate important to the Governor of the State
19 of New York, the Governor and the Legislature, in
20 a year and a half, to -- by the way, not to solve
21 all the problems of health care in the State of
22 New York in that 18-month period -- but to do a
23 couple of things. To create a process for
24 decision making and the first steps along that
25 process, to lay in place the changes.

1 And I want to thank you all for
2 embarking on this. It is not going to be easy.
3 It is not going to be simple. It's going to
4 require a lot of thinking about some of the issues
5 that are placed in front of us. And ultimately
6 judgement and decisions based on judgement. There
7 will not be perfect answers. There will no more
8 be perfect data than there will be perfect
9 answers. But what we're asked for his our best
10 judgment. And I thank you and I look forward to
11 working with you over the next year and a half.

12 I will take a motion for adjournment.

13 MR. VELEZ: So moved.

14 MS. GIL: Second.

15 CHAIRMAN BERGER: Thank you very much.

16 (Time noted: 12:29 p.m.)

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C E R T I F I C A T I O N

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I, KELLY FINE-JENSEN, a Registered Professional Reporter and a Notary Public, do hereby certify that the foregoing is a true and accurate transcription of my stenographic notes.

I further certify that I am not employed by nor related to any party to this action.

KELLY FINE-JENSEN, RPR