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AMENDED TRANSCRIPT

COMMISSION ON
HEALTH CARE FACILITIES
in the
21ST CENTURY

Doubletree Metropolitan Hotel
51st Street and Lexington Avenue
Thursday, November 17, 2005
1:00 p.m.

STEPHEN BERGER, CHAIRMAN

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1 P R O C E E D I N G S

2 (1:00 p.m.)

3 MR. BERGER: It is now 1:00 p.m. We are
4 right on time and this meeting is called to order.

5 I would like to welcome everybody to the
6 meeting of the Commission of Health Care Facilities
7 in the 21st Century. What I would like to do is
8 begin by introducing some of the new regional
9 members who have been appointed to the Commission.
10 We have them sitting at the tables around us. I
11 would ask if you people would -- I will just
12 introduce you; if you can sort of wave so everybody
13 can get to know who everybody is.

14 You have Jeff Davis sitting over there.
15 I saw him here, Arthur Weintraub. I saw Arthur when
16 he came in.

17 Lawrence Tully; Bill Mooney, Bill?

18 Bert Brodsky.

19 Donna O'Brien, are you on the phone?

20 She is not -- maybe she is.

21 We have great technological ability. I
22 am going to need help.

23 Andrew Sichenze of New York City.

24 Peter Capobianco.

25 Judge Joseph Mattina and Henry Sloma.

1 Did I miss any of the new regional
2 members?

3 I'd also like to welcome to the meeting,
4 we have three appointed commissioner observers to
5 the meeting: Dr. William Streck, Public Health
6 Council; Paul Macielak from SHRPC; Lora Lefebvre of
7 DASNY.

8 MR. ALBERTALLI: One thing, this is my
9 first meeting, Steve Albertalli.

10 MR. BERGER: I'm sorry. We'll get there.

11 Now I would like to turn the meeting over
12 to David Sandman, the Executive Director. David is
13 going to begin by giving us a progress report. At
14 each meeting, David will give a progress report of
15 what the staff has been working on, and what said
16 they are going to do, and where we are along the
17 way.

18 DR. SANDMAN: Thank you, Mr. Chairman.
19 It has been a busy and productive period for the
20 Commission and I am pleased to report on our
21 progress since our last meeting.

22 With respect to our work plan, virtually
23 all aspects of Phase 1 have been completed. We do
24 now have a fully functional Commission and
25 organizational infrastructure. We are fully

1 staffed. We have recruited a superb group of people
2 and I take this opportunity to thank the staff for
3 their efforts in preparing for this meeting.

4 We have established communication
5 procedures, both for us to receive information from
6 the public and interested organizations, as well as
7 to make information readily available to the public,
8 and to the membership.

9 In the past week, we have launched the
10 website for the Commission. This is just a simple
11 screen shot of the home page. As you can see, it
12 can be found at www.nyhealthcarecommission.org, and
13 I do encourage the members of the Commission and the
14 public to visit our site. You will find that it
15 contains a wealth of information, including the
16 schedule of upcoming meetings, the full transcripts
17 of all of our meetings, an organizational scheme,
18 including links for all of the members, an
19 interactive map of the regions, the relevant
20 statutes and our bylaws adopted at the first
21 meeting. The data and other supplemental materials
22 have been distributed to the members and we will, of
23 course, be updating and adding to the site as we go
24 along.

25 In addition to the website, we have been

1 engaged in an active series of meetings and
2 presentations to communicate the Commission's work,
3 to solicit feedback from various constituencies.
4 Just by way of examples, we have recently met and
5 made presentations with the Executive Committee of
6 the Greater New York Hospital Association, the New
7 York State Association of Counties, the Continuing
8 Care Leadership Coalition, the Commission on the
9 Public Health System, the Board of the Health Care
10 Association of New York State, the Community Health
11 Care Association of New York State, and the Jewish
12 Home and Hospital Life Care System.

13 We also have presentations scheduled in
14 the next few weeks with the Mental Health Services
15 Council, the Primary Care Development Corporation,
16 the New York Academy of Medicine, the Brooklyn
17 Borough President's Office, the Corporation for
18 Supportive Housing, the New York Association of
19 Homes and Services for the Aging, and the Hospital
20 Trustees of New York State. So we have been getting
21 up and about as best we can.

22 As I reported at our last meeting, we
23 have reached baseline agreements on the data that
24 will be used by the Commission, and we have made
25 extensive arrangements to ensure that the data at

1 our disposal is both accurate and is as up-to-date
2 as possible. I want to thank the staff of the
3 Department of Health, as well as the leadership of
4 the trade associations who work collaboratively on
5 these efforts to update the data and to encourage
6 their member institutions to participate. You may
7 recall that we undertook a major effort, and we gave
8 every hospital in the State an opportunity to update
9 and resubmit their SPARCS Data. Their response to
10 this opportunity was extraordinarily enthusiastic,
11 and I believe it is fair to say that SPARCS is now
12 busting at the seams. It is probably more full than
13 it has ever been.

14 Consequently, you will, once again, find
15 before you a CD filled with data. On the CD are
16 three fundamental data texts. First, I would like
17 to say that there are ten years of corrected and
18 verified SPARCS data which will be used for
19 utilization and occupancy calculations. In
20 addition, you will find the cost-report data, which
21 is typically referred to as the ICR's, which provide
22 financial and profit-and-loss data for each
23 hospital; and, lastly, you will find an alternate
24 set of hospital occupancy rate calculations based
25 upon available beds rather than certified beds. The

1 calculation of occupancy out of either license or
2 available beds is really a long-standing controversy
3 in the industry. It pre-dates this Commission and
4 probably will continue long after this Commission.
5 Neither method can be considered right or wrong,
6 and, in fact, they're both imperfect.

7 License does have the advantage of
8 reliable data. The denominator of licensed beds is
9 taken straight off of the operating certificates and
10 is an unassailable number. The problem, however, is
11 that licensed beds may only exist on paper; some of
12 them may have been converted to administrative space
13 and so the calculation of the licensed beds can
14 misrepresent reality.

15 Calculations of available beds can be
16 equally or more problematic and misleading. First,
17 the data is a lot mushier and less reliable,
18 although we have, again, worked with trade groups
19 who can possibly have the opportunity to update our
20 numbers. The larger problem with those available
21 beds is that it does tend to track average daily
22 census over time. If you look at the numbers on a
23 trend basis, it, too, can distort reality, basically
24 because you simply keep changing their denominator
25 in order to reflect the numerators, so the trends

1 can be equally misleading.

2 Given that neither measure is perfect;
3 given that they're both arguably valid or invalid,
4 we have agreed to look at both types of measures,
5 and, thus, you have that additional data on your CD
6 as well.

7 Finally, everything I just said refers to
8 the hospital side of our work. The original focus
9 of the CD distributed to you in July on the nursing
10 homes remain valid and usable.

11 We have also had some good progress in
12 terms of completing appointments to the Commission.
13 As Chairman Berger said, it was just last week that
14 the Senate appointed most of their regional members.
15 Most of them are with us here today and we do extend
16 a warm welcome to all of them. We are equally
17 optimistic that the assembly will also soon announce
18 their regional members and we will have a full
19 Commission.

20 On the subject of appointments, the
21 statute does require that liaisons designated to the
22 Commission from the Public Health Council, SHRPC,
23 the Department of Health and the Dormitory Authority
24 attend. All of those liaisons have also been
25 appointed, Dr. William Streck, Ph.D., Mr. Paul

1 Macielak from SHRPC, Mr. Neil Benjamin from DOH, and
2 Ms. Lora Lefebvre from DASNY. Again, they are here
3 with us today, and we welcome you.

4 The one aspect where we have not made
5 quite as much progress as we had hoped to by now is
6 with respect to helping the Regional Advisory
7 Committees or RACs to get up and running. If you
8 recall, at our last meeting the Commission
9 determined that each RAC could admit up to 12
10 members, appointed equally by the Governor, the
11 Senate and the Assembly. Chairman Berger did write
12 to the leaders of the Senate and Assembly requesting
13 their appointments. The staff has compiled a very
14 extensive list of possible RAC members. Many names
15 were suggested to us by Commission members and by
16 other interested parties, and in all we did compile
17 approximately 250 names across the State. My
18 understanding is that the Governor's appointment of
19 his RAC members is imminent and I hope the same is
20 true of the legislature. We do have orientation
21 packages prepared for all of them so that we can hit
22 the ground running as soon as those appointments are
23 made.

24 That brings us to Phase Two of our work
25 plan. The first is the evaluation of future trends,

1 such as demographic shifts and changes in technology
2 and health care delivery. The staff has been hard
3 at work researching those topics. We are in the
4 process of developing a white paper on capacity
5 needs in a changing health care system, and we
6 expect to share that with the Commission shortly.

7 The second task involves the development
8 of an analytic framework and criteria for the right
9 sizing aspects of our work. We have done so and we
10 will be returning to that item on our agenda in a
11 very short while.

12 Simply to summarize, we are very much on
13 schedule making excellent progress in our work, and
14 I will be happy to answer any questions.

15
16 MR. VELEZ: I'm glad to hear about the
17 new data, but the question is: Does all of this new
18 additional data, does that change the original
19 assumptions that were made in terms of existing
20 beds, or is it still basically the same?

21 DR. SANDMAN: The updated SPARCS Data is
22 not especially different from the previous SPARCS
23 Data. On a Statewide aggregate basis, it shows an
24 average hospital occupancy of about 65 percent.
25 Viewed off of available beds, that does increase the

1 statewide average by about 10 percent as opposed to
2 75 percent. There is some variation at particular
3 regional levels.

4 MR. BERGER: Are there any other
5 questions?

6 (No response.)

7 What I would like to do now, I just moved
8 over here so as not to be blinded by the wonderful
9 technology. Before I turn this over to David to
10 talk about the right-sizing, I want to thank the
11 members of this Commission, because over the last
12 meeting, many of you have taken the time, the
13 effort, and have participated with the staff, made
14 comments to the staff, reviewed graphs of the
15 analytic framework, and, again, are giving us
16 feedback that has been very important. I want to
17 say what David did was, David basically made notes
18 of everybody's conversations. We sat down and went
19 over all of them. He then went back to many of you
20 and we have tried to take the broad comments and
21 incorporate them in the framework that you will now
22 see. We probably didn't get everything, I'm not
23 sure everybody is going to be totally happy with
24 every single piece, but I think what you will see
25 reflected is your work, the staff's work in an

1 effort to come up with a program that we could use
2 going forward. I really want to thank all of you
3 because it was a terrific time for members of this
4 Commission.

5 DR. SANDMAN: I would echo that. Thank
6 you.

7 Just one note to the members of the
8 public. I do know there was intense interest in
9 this somewhat long presentation, and so, if you miss
10 something, don't fear, this will be posted to our
11 website as well, so you will know what is going on.

12 With that said, let me place this in the
13 context of the overall Commission's mandate and
14 work: There are fundamentally three aspects for
15 what the Commission is doing. The first, of course,
16 is right-sizing the hospital and nursing home
17 systems; that includes, but is not limited to:
18 Consolidation, closure, and restructuring of
19 institutions. We are, of course, interested in
20 reinvestment strategies of the health care system
21 and the nature of the planning is not just planning
22 for today or yesterday, but planning for the future.
23 So as I mentioned, we are working at that white
24 paper, looking at the trends and how it will be
25 different from today.

1 So the framework I will be sharing with
2 you today is really focused on the first bullet.
3 Let's put that in full context. Why should we build
4 a framework like this? Having a framework provides
5 many benefits, advantages to the Commission,
6 guidance in our work going forward. First, it does
7 establish a set of ground rules and criteria by
8 which we can help make decisions. It turns data, in
9 which right now we are swimming, into actionable
10 information to help our decision making. The
11 framework, combines a means of judging data, along
12 with professional judgment. I have taken to saying
13 at virtually every meeting that this is not just a
14 numbers game; if it was we wouldn't need a
15 Commission, we would need a computer. But what we
16 have is the Commission relying on objective data in
17 combination with their judgment, as well as
18 providing a basis among the local community input so
19 that the data does not give us all of the answers.

20 Finally, we want to be equitable and we
21 want to be consistent. The framework is to provide
22 a standardized approach across all six of our
23 regions, or to be fancy, we call it "horizontal
24 integration," that each of the six regions are using
25 a similar set of criteria when they drill down into

1 their region's work. Similarly, we want a
2 consistency across the vertical levels as far as
3 organization, so that the RACS, the Regional
4 members, and the Statewide members literally are all
5 speaking the same language and working off of the
6 same set of criteria.

7 Lastly, we wanted to bring fairness and
8 transparency to the process so that everybody knows
9 that this criteria is being used to evaluate
10 institutions. Let me say that this work, this
11 daunting challenge, built this framework. We
12 obviously sought to learn from others and do our
13 homework. New York State is engaged in a big
14 challenge, a system-wide analysis, and to the extent
15 possible, we sought not to totally reinvent the
16 wheel but to build upon existing statewide and
17 national models. Those models are fairly few and
18 far between. Those that we could identify were
19 largely qualitative in nature. They relied on far,
20 far fewer criteria than what we are proposing today.
21 It lists quite a few of the other models or efforts
22 that we had reviewed and considered. They were
23 quite helpful in many respects. They taught us a
24 lot of lessons learned; many of them served as
25 cautionary details. Most of them were not huge

1 success stories. No State provided a road-tested
2 framework that had worked incredibly well and that
3 we could simply lift from them and adapt a little.
4 For the most part, we did have to build it for
5 ourselves.

6 I think this next slide actually best
7 illustrates the philosophical approach the
8 Commission is taking in trying to adjudicate many
9 different needs. The framework must be sufficiently
10 comprehensive to account for a very complicated real
11 world. There are lots and lots of factors that
12 affect health care delivery, health care facilities,
13 and we needed to account for that in a reasonable
14 way. At the same time, the model, by definition,
15 and its simplification have a more complex reality.
16 It had to be simple, intuitive enough,
17 understandable enough that we could actually move
18 forward with it. Again, we wanted to balance the
19 evidences of the objective with room for the
20 exercises of professional and practical judgment.
21 We wanted it to be standardized, formulaic enough,
22 allowing flexibility and sensitivity to regional
23 differences and local needs. We wanted to honor
24 both sides of our mandate by building a framework
25 that's as flexible to work for hospitals as well as

1 nursing homes.

2 Of course, we needed to consider certain
3 statutory requirements that were given to us, most
4 of them as factors that should be considered in our
5 deliberations. The statute also gave us the room to
6 identify some additional factors of importance, and
7 we have done so.

8 This was really just a quick review of
9 the nine factors that were contained in these
10 statutes. If one actually went and did a match, you
11 will see that virtually all of these nine are
12 encompassed in our criteria, but not all; a few of
13 them we felt made sense to bring out in the next
14 phase of our analysis after we were done narrowing
15 and were more focused on priority institutions.

16 To use one as an example, they do ask us
17 to consider the potential conversion for uses other
18 than education or residential facilities. There is
19 no existing set of data that one can go to at this
20 point for all 1,000 institutions in the State. It
21 is something that has to be generated and we are
22 working with the Department of Labor and other
23 agencies to do so. This was generated on an
24 individual facility basis. As we get further along
25 in our deliberations, that factor and others will be

1 brought in.

2 That said, there are six more criteria
3 that are proposed, and I will, later in this
4 presentation, go into further detail on each of the
5 six and explain the specific measures associated
6 with them. The summary criteria are service to
7 vulnerable populations, availability of services,
8 quality of care, utilization, viability, and the
9 economic impact.

10 I am going to take a detour before going
11 further on those and talk about how to use the
12 criteria to try and generate the ratings, and also
13 talk about what the framework is designed to do and
14 what it is not designed to do. A key point:
15 Ratings are a starting point for focused
16 deliberations by the Commission. They are not final
17 determinations; they are not recommendations. That
18 will come far later in the Commission's process.
19 This will take us from the starting line well down
20 our path towards December of '06.

21 Each institution will have a rating of
22 minus one, zero or plus one on each of those six
23 criteria. Those ratings are assigned relative to
24 the institutions within the same region. The
25 thought here was pretty simple, that we would not

1 want to systemize an advantage or disadvantage to
2 any particular region. The reality of New York City
3 is pretty different than the reality of Western New
4 York or Upstate New York. To the extent we can get
5 apples to apples comparisons, comparing to the right
6 peer group, that's what we aspire to do. Regions do
7 provide depth and comparisons with respect to those
8 differences. The ratings are then based on your
9 position, the facility's position relative to your
10 regional median; are you below the median path or
11 above it?

12 For example, an institution that is a
13 major provider to vulnerable populations could
14 receive a plus one on that criterion; conversely, an
15 institution with relatively low utilization would
16 receive a score of minus one on that criterion.
17 Each of the six criteria carries equal weight; so
18 that the possible summary score for an institution
19 ranges from minus six to a positive six. Let me say
20 a word about our thinking on why they have equal
21 weight. There's sort of a philosophical and
22 practical answer to that.

23 Philosophically, in the statute which
24 gave us nine factors to consider, they did not
25 receive differential weights there. So we felt we

1 were being consistent, but on a more practical basis
2 we did not feel that we could develop a weighting
3 scheme that would be non-arbitrary and
4 scientifically defensible, although it would
5 probably take us a good six months to go through
6 that exercise, and my discussions with the members
7 actually reinforced our thinking and the wisdom of
8 that approach.

9 Some of you said that quality of care is
10 clearly more important than anything and should be
11 given the most weight. Some people said that the
12 access type of measure should be given the most
13 weight. Some people said viability. Clearly it's
14 not viability, what else really matters. So just
15 the diversity of views helped reinforce our thinking
16 that this approach is probably the best and the most
17 fair way to move forward at this point.

18 Based upon those summary ratings,
19 institutions would then be assigned to one of three
20 strata for consideration, labeled either high
21 priority, medium priority or low priority for right
22 sizing. These classifications will then allow the
23 Commission to engage in a prioritized analysis among
24 233 hospitals, 665 nursing homes. There is a bit of
25 a paralysis with numbers right now; when faced with

1 more than 1,000 institutions and a sea of data, it
2 is hard to know how to move forward. I think that
3 giving some priorities to our discussion will move
4 us down that road.

5 The point that I want to emphasize here
6 is that there are no sacred cows. Throughout this
7 process, all institutions can still be considered as
8 part of hospital reconfiguration schemes. High
9 priority should not be interpreted as a hit list, by
10 which I mean that a facility with a score of "high
11 priority" by no means is automatically going to be
12 among the Commission's final recommendations. That
13 decision will come later based upon your
14 deliberations. Similarly, a medium or lower rating
15 does not mean that you are on the so-called "safe
16 list." Those facilities could still be a part of
17 possible reconfiguration schemes developed by the
18 Commission.

19 So let me walk through these six criteria
20 and talk about each of the actual measures that are
21 being used to actualize, that criteria. You see, we
22 have tried to use, for all of them, a variety of
23 measures. It is never a good practice to rely on
24 things you can't measure, although we do possibly
25 have to hang together and correlate them. Under

1 "service to vulnerable populations," we anticipate
2 looking at the facilities' percent of uninsured and
3 uncompensated discharges; the percent of their
4 Medicaid discharges; the percent of their Medicare
5 discharges; their ER-care mix, since hospitals do
6 receive a lot of their patients via the emergency
7 room.

8 On the nursing home side, we would look
9 at the percent of the Medicaid-eligible admissions,
10 not Medicaid residents per se, because generally,
11 over time, those residents do at least spend down to
12 Medicaid, but their status upon admission is a
13 measure of service to lower-income populations.
14 Also, in nursing homes, we would look at their
15 percentage of higher care of residents, which is
16 right off of their case-mix index for each facility,
17 to determine the relative intensity of needs of
18 their residents.

19 We would also be looking at a hospital
20 for its Medicare disproportionate share status. For
21 those who may not be familiar with the acronym
22 "vegetable soup" or policy, these are so called "DSH
23 Payments." They are federal payments comprised,
24 basically based on a hospital's percentage of
25 service to low income, Medicaid and uninsured

1 patients, the federal proxy and service to those
2 populations. And, finally, does a hospital serve in
3 another acronym, a MUA, which is a "medically
4 underserved area." MUA is, again, a federal
5 designation in rural areas. They do tend to be
6 comprised of contiguous counties in urban areas.
7 They are based on zip codes.

8 A MUA is a federal index that combines
9 quite a number of measures in population and
10 community health metrics, such as infant mortality
11 rates. It looks at the physician- to-population on
12 a ratio basis. It also includes measures of
13 community income and poverty on the federal index.

14 On availability of services, we would be
15 looking at whether a facility provides a range of
16 comprehensive services and you can see that it is
17 actually broken out by service lines. Within the
18 hospital we look at acute med/surg, internal child
19 services, psychiatric and detox services, as well as
20 rehab.

21 On the other side, the corresponding set
22 of bullets for nursing homes have indicated a
23 continuum of care. The general long-term care is
24 subacute, long-term home care, and adult day
25 services. We would be looking at the provision of

1 other services, such as trauma services, current
2 services, high tech, community clinics and
3 especially sole community provider status. And
4 then, finally, or really or generally, the commute
5 time to other providers and that, of course, is
6 stratified by whether you are in an urban, suburban
7 or rural area; the travel time, real commute times
8 differ in that process, the type of care.

9 The quality of care, we intend to look at
10 a facility and change the accreditation status,
11 whether they are the holder of special designations.
12 For example, you can be a designated stroke or a
13 designated AIDS center. And then, finally, we would
14 again rely on federal data sets. There is something
15 called "CMS hospital compare" and "CMS nursing home
16 compare," these are widely available industry
17 standards at this point that measure quality. They
18 are generally based on specific, good clinical
19 practice, such as your percentage of patient to
20 receive aspirin prior to an MI and after an MI, and
21 there's about 15 or so individual measures of
22 quality of care in each of those data sets.

23 Utilization: We would be, of course,
24 looking at occupancy rates, once again broken out by
25 service time, medical, surgical, pediatric,

1 psychiatric. We would look at the volume of
2 outpatient visits in hospitals, again, in cases of
3 providers and outpatients; the primary care
4 services, in addition to more acute or tertiary
5 care, as well as their volume of visits. Just as a
6 side note, those two latter measures, it is based on
7 volume rather than on ratio, so as to verify the
8 facility's size, which again is showing an apples to
9 apples set of comparison.

10 Viability is largely based upon financial
11 metrics, which is very long, but it seems to be a
12 good summary list of financial measures. We would
13 evaluate operating profit, days' cash-on-hand,
14 facilities' capital debt as measured both in
15 absolute terms, as well as EBITDA; facilities'
16 bonding and credit enhancements, and then, finally,
17 their mortgages and reconciliations, which can take
18 many forms, financial stability and corporate. We
19 all know that many hospitals, in particular, are
20 part of much larger systems which have a great deal
21 to do with their financial status; obligated groups,
22 for example, where facilities can leverage their
23 financial assets together, and a weaker institution
24 can rely on the stronger position of their own
25 ability.

1 On economic impact, we would be looking
2 at the contribution that a facility makes to local
3 employment. Of course, in some communities, the
4 hospital, in particular, and sometimes the nursing
5 homes can be among the largest employers and major
6 contributors to the local economy, as well as look
7 into local unemployment rate as a proxy measure for
8 employment opportunities that might be available.

9 This is a little bit of a messy slide,
10 but it tries to put in all of these at a glance. So
11 in summary, there are six criteria and 25 metrics
12 which we envision applying to each and every
13 facility in the State. No doubt there can be more
14 than 25; no doubt there will be more than 25 in the
15 next phase of analysis when the Commission and the
16 RACs dive deeper into their work. We felt this was
17 very fair and valid. It's a broad and comprehensive
18 way to look at a facility, as well as doable.

19 Just to reiterate to where this all fits
20 in the conditions, the overall changes of process:
21 We really are right here in the heart of Phase Two
22 with the analytic framework, and we can develop a
23 really terrific input into things. This is the
24 product of many, many good minds working on this,
25 many iterations. We have about 25 drafts sitting

1 around at this point. We got so many good comments,
2 all with the effect of improving it. Once approved,
3 the staff will then generate the classifications
4 needed for use in the Commission discussions, as
5 well as the RACS. The Commission and the RAC will
6 then undertake a detailed analysis of individual
7 institutions, gather the local input, and based on
8 your discussions, that will help to generate both
9 multiple scenarios and make arrangements which we
10 can actually work through moving into Phase One.

11 This framework is really about Phase Two
12 and part of Phase Three. It is Phase Two and it
13 sets up Phase Three. During Phase Three and Phase
14 Four we do expect the Commission and the RACs to
15 consider other things such as framework. To give
16 you one example of what I'm talking about, we would,
17 for example, care about the physician admitting
18 privileges, and whether physicians can be requested
19 or recruited to an area. It's hard to measure right
20 now with every facility. It's on the table when you
21 get down to individual discussions of the
22 institutions, for example, that would be criteria
23 that you would bring to your discussion.

24 Then, of course, you will be moving into
25 the recommendation period of your work.

1 To summarize, this is a careful
2 balancing act. It is both an art and a science that
3 the Commission is engaged in. The framework
4 presented to you is designed to start and advance
5 your deliberations. It is not the end. It is not
6 the final recommendation. Again, it is not just a
7 numbers game, additional measures can and should be
8 considered during later phases of deliberations and,
9 as always, the Commission should be sensitive to
10 regional differences and communities as we move
11 forward in our work. Thank you.

12 MR. BERGER: Turn the lights back up,
13 please. Thank you David.

14 It's open for discussion. I know that
15 everybody has read it, right? Do we have any
16 comments?

17 Craig, are you on the phone?

18 MR. DUNCAN: Yes, I am. I want to
19 congratulate the staff on their work. Is there any
20 consideration of specialty hospitals?

21 DR. SANDMAN: Those are generally
22 outside of general hospitals.

23 BISHOP SULLIVAN: Does it measure in any
24 way the meaning of the hospital to New York State,
25 by the way? What about a hospital with significant

1 international health care, is that a factor being
2 considered?

3 DR. SANDMAN: Not the country of origin
4 or patients. It is only embedded in the entire
5 framework about utilization and so on.

6 MR. BRIDEAU: You mentioned about process
7 from this point on, because looking at the
8 methodology, the RAC here, there's been a lot of
9 work that's gone into it and a lot of time has gone
10 into it, and there are still concerns with it, but
11 it is going to be a blunt instrument and there's not
12 much you can do about that. Frankly, this has to
13 happen.

14 So the question I have is, how do we deal
15 with two things: One, the review of the initial
16 outcome of applying this methodology to the
17 hospitals to just test for face validity, because we
18 may see some very unintended things that stick out;
19 and then, secondly, I know you say it is the
20 starting point. Can you clarify for us, what about
21 those hospitals that fall into the second tier and
22 the third tier.

23 We do need to narrow our focus, I
24 understand that; I understand, what I think we're
25 going to do around the high priority hospitals, but

1 at what point and to what extent do we deal with the
2 hospitals that fall into the medium priority or the
3 low priority? How is it that they are not
4 necessarily safe and how do we take them into
5 consideration?

6 DR. SANDMAN: Starting with your line of
7 question, those other hospitals, perhaps medium and
8 low, once you have focused on the high priority
9 institutions, we need to make some changes here, we
10 could consider closure of these institutions or
11 consider some reconfiguration of the services.
12 Okay, then, this is a stable hospital, could that
13 successfully absorb some of their patients? Would
14 patients go there? Should there be more
15 regionalizational lists, location of therapies, for
16 example. So those are the kinds of scores --

17 MR. BRIDEAU: In terms of just base
18 validity, I am concerned about this, this is not a
19 criticism.

20 DR. SANDMAN: Neither are we. The staff
21 had the opportunity, we are going through the
22 process ourselves. We use the same term in our
23 discussions to go through all of this. We decided,
24 let's step back and let's make sure that it makes
25 sense, kind of midway though, if it's worth it, and

1 then rely on the Commission. It's our regional
2 members that really know in more detail, does this
3 look about right as you understand the region?

4 MR. VELEZ: Have we given consideration
5 how it would be rated by the RACS, how it would be
6 integrated into the overall recommendations that the
7 Commission would come up with?

8 DR. SANDMAN: Yes. What it does say is
9 institution-specific recommendations integrated into
10 regional plans and then the regional plan is
11 integrated into comprehensive Statewide divisions.
12 So it is a building process and then making sure
13 that those pieces of the puzzle come together in a
14 rational statement.

15 MR. BERGER: I think one of the reasons
16 we think it is important to get the framework into
17 place for discussion -- and, by the way, I agree
18 that at some point when you start doing the runs,
19 there's got to be the reasonableness test that we
20 do. But one of the things that we have to have a
21 framework for is we've got to give a framework to
22 the RACs, to the Regional Commissions and the RACs,
23 so we are all working off the same set of criteria,
24 and we can all talk the same language. I think that
25 is the intention of making this a common discussion.

1 And we will discover things about it during those
2 discussions which may force us to step back and to
3 review the final piece.

4 BISHOP SULLIVAN: I have a question: One
5 of the things I am concerned about is you will get
6 people from the regions who will want to meet with
7 members of the Commission and the question is, how
8 do we proceed?

9 MR. BERGER: This question has come up
10 before. You have regional members, we have members
11 in three parts: You have regional members, who are
12 members of this Commission in the sense that they
13 participate in discussions relating to their region
14 and vote on these issues. That is the decision-
15 making group. This group, plus the six members from
16 each region are the ones that actually have
17 decision-making powers.

18 The RACs do not have decision-making
19 power but they have recommendations to make. It is
20 a very important difference in the process. We are
21 bound and should be bound by the Public Information
22 Act. Our meetings, our decision making, except
23 where we have the ability to go into closed sessions
24 on a specific institution, are open to the public.
25 We want people to understand what we are doing.

1 In many of the regions and many of the
2 locations, there are institutions and organizations
3 which will want to do what we were able to do, by
4 the way, in the previous working group of the task
5 force, is not bound by public information and to say
6 things they might not want said in public, and to
7 talk to RAC members, sort of totally open, and get a
8 closed session. The RACs have that advantage. They
9 can do that and not violate any public law.

10 Am I correct, Mr. General Counsel?

11 And that's very important, because they
12 will get -- the RACs have the ability to get color,
13 feelings, in ways that people feel protected about
14 having discussions. The RACs will also have public
15 meetings.

16 What I have said to people, RACs, is
17 this: If you are a regional member of this body,
18 and there are public meetings being held in your
19 locality, I would suggest you go and listen, not
20 participate, but listen. And I would make the same
21 suggestions to the members of the Statewide; that if
22 there are meetings you should go and you should
23 listen. Frankly, many of us have been talked to by
24 these people. It's amazing how popular some of us
25 can be.

1 But the important thing is that listening
2 is fine, but the decisions we have to make, formally
3 and as a body, we have to be very careful. It goes
4 for all of us, not to signal, not to flash and not
5 to wink. Listening is important because it will
6 help in the deliberations that you will bring to all
7 of us, but this is going to be complicated and it
8 will take a long time and we should not be sending
9 body signals, body language to people before we know
10 where we are going.

11 BISHOP SULLIVAN: My concern is we don't
12 undermine people on the regional committees.

13 MR. BERGER: By the way, one thing I
14 suggest and we have been doing it is, e-mail is a
15 wonderful thing. Nobody does anything behind
16 anyone. You know, we're not doing it, the staff is
17 not doing it. I think the regional people and the
18 rest of us will communicate. Somebody wants to meet
19 with somebody, let everybody know. We are not going
20 to let that happen. We have been around much too
21 long to let that happen, right?

22 MR. ALBERTALLI: Just a comment, I think
23 the job that was done on all of these criteria is
24 outstanding, but we all know that criteria can bias
25 things and we have to be very careful. I think it

1 would be helpful to have a formal review after the
2 first pass, and be sure that we haven't introduced
3 any biases to the thing, advantages or
4 disadvantages, certain types of --

5 DR. SANDMAN: Yes. We will be bringing
6 back the results of this at our next meeting in
7 January.

8 MR. ROBERTS: I share the comments and
9 congratulate you on the work done, and I think the
10 emphasis is it's just a starting point. When you
11 tend to start something you are going to get some
12 inferences being drawn, but that doesn't take away
13 the fact that when someone gets a score they are
14 uncomfortable with it is going to create local
15 anxiety. I think what we need to do is just make
16 sure we educate as to what this is or, more
17 important, what it isn't, but it is a very good
18 example of what it is, in my opinion, but it is very
19 good at what it is, in my opinion, a starting point.

20 DR. GIL: The concern that I think I
21 expressed regarding the rating on individual
22 hospitals, and the consideration that the hospitals
23 are part of networks and that it would be quite
24 unfair if we just did the rating per hospital as
25 opposed to include the financial information of

1 those individual hospitals to be an overall group of
2 hospitals in the network.

3 And the second thing that I am concerned
4 about is to have data around pharmacy needs. How is
5 the work of this Commission going to impact the
6 availability or the lack of availability of
7 pharmacies in the community.

8 DR. SANDMAN: Dr. Gil makes an excellent
9 point there, that many hospitals are the criterion
10 by abilities, they get prior attention to the point
11 you make about affiliations which are financial,
12 clinical and corporate in nature, such as obligating
13 groups to leverage together. So it is a great point
14 and I think it is reflected in the framework.

15 Your question on pharmacy, Dr. Gil, as I
16 promised you the other day, we have been looking
17 into it. If we can find the right data on the basis
18 of an operation like that, we will certainly do so.
19 The Department of Health does not have that because
20 those pharmacies are licensed by the State
21 Department of Education rather than DOH, so we have
22 made inquiries to the Education Department that if
23 we can identify the data we certainly will do so.

24 MR. BERGER: Pat?

25 MR. LEE: Your presentation pointed out

1 to me four minutes ago the Regional Advisory
2 Committee is beginning to get started, so I'd make a
3 comment concerning that I hope our government bodies
4 or people would quickly move to appoint this
5 committee, this Regional Advisory Committee, so we
6 can start the real work of this Commission.

7 MR. BERGER: My problem is that we have a
8 schedule we are working on because we want to
9 schedule the meetings at the beginning of the year.
10 The first guy's an appointee, you know, those get
11 the baton and they get started. We should have 12
12 in each region. The first guy who gets named, first
13 male or female who gets named, he's the captain,
14 captain of the team. He gets the package or she
15 gets the package and we start working, and hopefully
16 before we are done all three government bodies have
17 all been appointed.

18 MR. KING-SHAW: For this system to have
19 any integrity at all, so you can compare the
20 systems, some people will have to get positives and
21 some will have to get negatives. If they all come
22 up positive, then the system did not work. We
23 should be prepared for that.

24 Then, I guess, my only concern would be
25 if we start down the road, someone doesn't like it,

1 we change the system going forward, and now you have
2 inconsistencies within the process. So to the
3 extent that we can validate that this is what we
4 want to do, and we have a 95 percent confidence
5 interval that we are going to use it, then we should
6 move forward very quickly. I would just hate for us
7 to bow to someone's displeasure and then we, quote,
8 unquote, "corrupt the rating system" because we
9 don't want to raise a negative.

10 MR. BERGER: I think the point is that,
11 you know, they state the two points, we've got to
12 validate where we are. We will run it, we'll
13 validate it and 95 percent's not perfect, nothing is
14 ever going to be. You know, if they get a 90 in
15 school or a 95, they are doing real well. If we can
16 get there, we should move forward.

17 Part of what David is talking about, some
18 of the experiences that we saw outside of New York
19 which didn't work, it's very important; there were
20 some lessons in there which were very important. It
21 was told to the members of the Commission, the
22 members of the Regional Commission, and I think this
23 is the issue: That the processes broke down and
24 became invalid when they basically just became
25 political footballs. That is English and that is

1 where I come from. It is going to be tough, because
2 you're going to have to deal with this thing both
3 honestly and intellectually, as well as we're going
4 to understand your community needs, but if you turn
5 this into the three loudest people screaming and we
6 start changing the criteria, we don't have to have
7 any more meetings because we can just pack it in
8 now, because we will never get anywhere. That is
9 what happened in the other states.

10 So with that I agree. We have to explain
11 what we are doing. We have to talk, the RACs have
12 to be out there, but if we are convinced we have a
13 valid system, after we write it, we've got to stick
14 with it and we've got to run with it, otherwise we
15 are never going to get anywhere.

16 JUDGE MATTINA: What I didn't
17 understand is the third tier here. We are the
18 regional group, and then there's the third tier, are
19 they going to feed us? I don't understand. How
20 many members are in the advisory group?

21 MR. BERGER: Let me do this: You've just
22 been appointed. We will take you through it. If I
23 may, we'll go offline. We'll explain it after. The
24 Regional Advisory Committees, there are 12 members
25 in each region; there are four appointed by the

1 Governor and four appointed by the State Senate and
2 four appointed by the Assembly. They have a series
3 of responsibilities, which are different from yours
4 as a Regional Commission. There is a package of
5 information which we will get to you which will
6 explain it.

7 DR. SANDMAN: Just to clarify: We have
8 sent to your mailing address a fairly extensive
9 orientation package and/or a chart, and descriptions
10 of the various levels and how they interact with
11 each other, but we will be happy to send additional
12 to clarify any of that.

13 JUDGE MATTINA: If not done still
14 already, I think it would be very helpful to have
15 that information available to the public on the
16 website so they know exactly what the reporting
17 structure is.

18 DR. SANDMAN: It is.

19 MR. BERGER: Now I am going to move
20 forward. Is there any other --

21 MS. PROUD: Just a couple of questions
22 with respect to the service of vulnerable
23 populations criteria. The effect of the criteria
24 that will be used to evaluate nursing homes, is
25 there any consideration given to the number or the

1 percentage of Medicaid admissions, if you could
2 clarify, so people can go in as Medicaid and not
3 necessarily become anything else down the road. Is
4 there any consideration given to those who are
5 admitted to nursing homes who not only are not
6 Medicaid, but who in all likelihood will not ever
7 become Medicaid recipients by virtue of their
8 immigration status they are not insured privately,
9 they are not capable of making a private pay
10 arrangement nor are they going to become Medicaid
11 eligible under the federal law.

12 DR. SANDMAN: It is actually a question
13 that Dr. Gil also has raised with us. It's a good
14 idea. My understanding though is because there is
15 no source of reimbursement, that there really is no
16 statewide data available to count the facilities.
17 It's a really good idea but we couldn't find
18 anything operational to look at.

19 MS. PROUD: Perhaps one of the nursing
20 home associations, in terms of having surveyed its
21 own membership?

22 DR. SANDMAN: We will look into that
23 further.

24 MS. PROUD: The other one is with respect
25 to the availability of specialty services and other

1 services, not necessarily medically underserved
2 areas as designated by the federal government but
3 also other areas that are underserved purely with
4 respect to specific specialties. OB/GYN is one that
5 comes to mind, because that's one that's placed in a
6 rural area and also certain areas in urban settings.
7 But is there any way to consider the availability
8 given the vicinity of the hospital but outside of
9 the hospital's delivery system, availability of
10 subspecialty care? Because if we were to recommend
11 down-sizing a facility, whether or not the people
12 could get access to any of those services in a
13 private practice, for example, would be particularly
14 significant.

15 DR. SANDMAN: Yes. In fact that is
16 consistent with one of the nine factors that the
17 legislature charged us with, about the availability
18 of other services in the community. In the original
19 books that were distributed to you in July, there
20 was a passage about primary care resources. So it
21 absolutely makes sense, again, in the next phase of
22 analysis for the Commission, in looking at specific
23 facilities, to see what else is around it, but this
24 framework is really about scoring and evaluating.

25 MS. PROUD: Will data be an issue with

1 respect to the specialty type services?

2 DR. SANDMAN: As least some of it is, the
3 primary care stuff, but it gets into more
4 detailed.

5 MR. BERGER: Can I ask for the adoption
6 of the framework?

7 (Seconded and moved.)

8 MR. BERGER: Motion adopted.

9 Thank you, we can move forward.

10 Let me turn now to the next item on the
11 agenda. At the last session we had a discussion
12 about capital spending in the State and the series
13 of large numbers of capital dollars that are waiting
14 for you. And we had a discussion about whether we
15 should or should not give some indication that we
16 are in existence. We are going to spend the next
17 year doing an awful lot of work. We have 3 or 4
18 billion in projects, I need you to raise capital.
19 And people said, "what do you mean?"

20 So we spent some time trying to explain
21 what we mean. We were trying to explain what we
22 mean, and there were a lot of things stated that it
23 is not.

24 Why don't I ask Bob Hinckley to walk us
25 through and lead the discussion.

1 MR. HINCKLEY: I think you are absolutely
2 right, that there are a lot of things that this
3 statement is not, and I will use the "M" word right
4 off the bat, it is not in any way, shape, form or
5 intent to be anything close to a moratorium.

6 The sense of the staff that helped
7 prepare this and I think the Commission in the last
8 discussion, was that we are going to be doing a
9 significant amount of work during the next year and
10 while that work is going on in the hospital system
11 and the nursing home system, the delivery system is
12 going to be changing and growing. We thought that
13 there was a need to express to the two councils that
14 make decisions in that regard, the Public Health
15 Council and the State Hospital Review and Planning
16 Council, that we are here and we are making
17 decisions over the next year that might impact your
18 decisions.

19 In that line, I think the legislature
20 clearly saw our need for coordination between what
21 we are doing, and the city councils, by the fact
22 that they appoint liaisons from both SHRPC and the
23 Public Health Council to this Commission. We don't
24 have any role in terms of approving or disapproving
25 CON applications. We don't have any role revising

1 specific CON applications that appeared before. But
2 I do think we do have a role in terms of alerting
3 the Commission or alerting Council as to what we are
4 looking at, what are our criteria that we are
5 looking at, and some guidance for them as they go
6 forward doing their work.

7 The staff has drafted this statement, and
8 I think it is a very good job because it provides
9 the opportunity, and I think everyone's gotten a
10 copy of it, it provides the opportunity and just
11 guidance to this Council. There is a set of very
12 significant criteria, emergency construction to
13 correct deficiencies. Certainly, if a project is
14 looking to decertify beds or services or right size
15 on its own, or undertake activities that make that
16 system more efficient -- I am not going to go
17 through each of the criteria but they're broad
18 criteria -- I think that what we would be doing by
19 providing these sayings is very simply telling SHRPC
20 and Public Health Council: We're here. We're
21 making some very, very important decisions. You
22 should be cognizant of those decisions as you're
23 going forward and improving the coordination and
24 improving the coordination of the activities from
25 our side."

1 MR. KING-SHAW: If we have a liaison, why
2 do we need to give them any guidance at all. They
3 know what we're doing, they're involved. They've
4 got to make their decisions, they're entitled to
5 make them. Why would you have to give them any
6 guidance at all?

7 MR. HINCKLEY: I think more than anything
8 else it give a sense of what our intention is and
9 where we are heading. I think it sends a fairly
10 reasonable statement from us if we were to approve
11 this statement.

12 I agree with you. We do have liaisons
13 who can share information back with the groups, but
14 I think it's a fairly reasonable statement from us.

15 MR. BERGER: There is another piece to it
16 also, which actually clarifies what has been a very
17 murky set of discussions for the public and for the
18 community. I mean, the statement, or some of the
19 comments on the statement before it was read, as
20 well as some after; you know, comments that we want
21 to stop the world, we want to be involved in the
22 decision process, we want to have votes on this,
23 which is not true.

24 I think what is important, and it is part
25 of what we were talking about before, we were

1 talking about how we begin the educational process
2 which will take us to a point in a year so that we
3 are not springing onto the communities the notion of
4 our existence, is to begin to set a stage which says
5 that the Commission and the whole issue of right
6 sizing is, in fact, an essential part of what's
7 going to happen, and while we're not interjecting
8 any decisions ourselves, this is the shape of the
9 kinds of things that is important for people to
10 consider, and that is why I think the statement is
11 important.

12 MR. DUNCAN: Mr. Chairman, this is
13 Craig.

14 I would be interested to hear what the
15 liaisons have to say, in terms of their comments.

16 MR. BERGER: Paul?

17 MR. MACIELAK: I think, from the SHRPC
18 viewpoint, this would be taken as guidance. It does
19 give evidence to the sentiment, to the things that
20 are important, that it knows how to deal with that.
21 So I would take it that you could do something like
22 the prior presentation as an example of the kind of
23 other side which could be done. We could have an
24 overlay and an additional consideration.

25 MR. BERGER: The way we are organized, we

1 have time.

2 Dr. Streck?

3 DR. STRECK: I was afforded the
4 opportunity to comment last week. And my comment at
5 that time was I thought this proposal was
6 unnecessary, primarily because I thought there was
7 profound respect at the Public Health Council for
8 the work of the committee personally. More than
9 unnecessary, I thought that it underestimated the
10 complexity of the CON process. I also conveyed in
11 my comments and in writing to them that I thought
12 the specificity of criteria in this proposal was not
13 helpful and was minimalist in its approach, and
14 whether its intention was, it was said to be a
15 general guideline, that I felt that this would be
16 interpreted as somewhat provocative, minimalist and
17 distracting. That is what I said last week.

18 And I would answer primarily with I think
19 a statement assuring the fact or a clarification
20 that the SHRPC and the Public Health Council are
21 cognizant of the significant work that is going on
22 is not a problem, I think we are. So perhaps there
23 is some disagreement, but I will close by pointing
24 out that the Public Health Council meets tomorrow,
25 and I don't feel it is my prerogative to discuss

1 this in any way with the Public Health Council prior
2 to the deliberations of this group.

3 I would venture to say that if this
4 resolution passes, it will change the tenor of the
5 discussions of the health bill.

6 MR. BRIDEAU: My reaction goes through
7 different filters and that is as a long-time member
8 of the Public Health Council. My reaction was
9 essentially the same as Dr. Streck's. The Public
10 Health Council was appointed by the Governor; very
11 smart people who, I believe, have trust for the kind
12 of work we're doing here in the Commission and are
13 smart enough to figure this out themselves.

14 I think, even though we say there is no
15 intention of there being a moratorium, the fact that
16 we are specific as we are here in what project
17 should or shouldn't be considered, I think will
18 effectively create a moratorium, and that's very
19 damaging to a hospital system. So my sense is that
20 If you look at the criteria that both the SHRPC and
21 Public Health Council use in their evaluation of
22 CON's in particular, they look at national viability
23 of institutions. They look at service to the
24 vulnerable population. They look at essentially
25 most of the elements that we look at during the

1 criteria we just reviewed.

2 So it seems to me, I took it as a little
3 insulting, but I think that both councils are going
4 to be very keenly interested in what we are doing
5 here, will stay very aware, and I have great
6 confidence that they are not going to do something
7 that in the end will run afoul of our orders to the
8 institutions.

9 MR. VELEZ: I basically was going to say
10 the same thing. Before I support that statement, I
11 happened to be visiting one of my office facilities
12 yesterday, and this was to find out how they were
13 doing. The CEO came to me and said, "Pete, now that
14 you're a member of this Commission, what additional
15 obstacles are you people putting in our way, in the
16 cumbersome process of the CON's." I said, "Well,
17 what do you mean specifically?" And he walked me
18 through some of the difficulties and some of the
19 perceptions that exist out there.

20 I think we have to begin to change our
21 perceptions. I think this thinking is too specific
22 in its intent. I see it as being much more global
23 and the guidelines will be critical. My concern is
24 how they are going to interpret what we are
25 discussing here if we don't get this global

1 guideline out there.

2 My recommendation is reconsideration of
3 how this is worded, not necessarily what its
4 intentions are but how it's worded, and how to
5 proceed.

6 MS. PROUD: The last time we met, and
7 this issue was raised and discussed, it was
8 mentioned there are \$3 billion of projects or \$4
9 billion now, is it? I asked whether it would be
10 possible to get some data given the very broad
11 criteria that we discussed initially about health
12 and safety and those kinds of things, whether or not
13 at this point there is any data that can be shared
14 about how that between 3 and 4 billion dollars worth
15 of projects is breaking out? Are the vast majority
16 of things already health and safety? Are they
17 technology related to try and gain efficiency in
18 that way?

19 DR. SANDMAN: We did go through that
20 exercise in part with the department, based on that
21 request. The nursing home side is actually serving
22 virtually all cases about facility renovation
23 upgrades in its physical plants in many nursing
24 homes because it is all out of date and not up to
25 code even.

1 The hospital side is hard to break out.
2 They are virtually all a capital expansion of some
3 sort: Building a new wing, renovating a wing
4 sometimes, which would then be a physical move. "We
5 are going to build this new building and we are
6 going to move additional beds into it." Other
7 times, it's the Margolian (ph) building and we want
8 to add X number of beds to that facility.

9 There were a handful of, say, "We need a
10 parking lot" or occasional IT for many projects.

11 MR. BERGER: Go ahead.

12 MR. KING-SHAW: I don't see any reason to
13 have the memorandum, also known as causing a stir or
14 controversy, when it is not really needed. They are
15 here and they're hearing everything that we are
16 doing and what positions we are taking. Why go any
17 further?

18 DR. GIL: Bob, I am sure you have very
19 good intention in doing this, but in fact I think it
20 is overreaching the legislative intent of what the
21 Commission is for. I think that the other two
22 entities, they have been validated by legislation
23 and they have a mandate and they have responsibility
24 by legislation.

25 I am further concerned with the fact

1 that, from a general statement that we spoke last
2 time, now we have really developed more, as you
3 said, a criteria and guidance; and I am very
4 concerned to think that if I understand it, if I
5 remember well, the part process that needs to take
6 place, communities do have to meet expense when it
7 starts.

8 The local community authority looks at
9 it, approves it before it is sent somewhere else.
10 By proposing this type of criteria, what we are
11 presuming is also ignoring and essentially
12 forgetting the needs of the community, which I think
13 is kind of problematic as to what communities need.

14 Furthermore, I am kind of troubled by the
15 process here. I have to echo my colleagues when
16 they indicated what a great job the staff did with
17 the framework that we just approved a few minutes
18 ago. We went through that process for about two or
19 three weeks. We have been all involved in looking
20 carefully at what that means. Quite frankly, I was
21 surprised to get this today with no information
22 about data. What is it that I am voting on? What
23 does this \$4 million mean?

24 I am surprised, because I was very
25 impressed with the process before. And if we are

1 going to do this, I don't want to do things blindly,
2 I want to do things in a rational way, but I cannot
3 support this statement; the reading undermines two
4 bodies and I don't want to approve the process when
5 I don't have the facts to be able to be tranquil
6 with a million dollars here or \$2 million. To me
7 that is not a real process.

8 MR. ROBERTS: I take a slightly different
9 view to that.

10 In a relatively short period of time this
11 Commission, through its various arms, is going to be
12 releasing information that creates anxieties in
13 communities and, as I earlier said, we need to do
14 everything we can to keep that under control. In a
15 sense, this can be seen as a positive statement on
16 what we don't need to be anxious about doing.

17 My personal view is, one of the ways of
18 respecting these other organizations is to give them
19 credit. We're standing on our own feet and not
20 worrying about it. They should know what we're
21 doing, but they've got a long-standing history, they
22 are not going to let us boss them around. In any
23 case, they are going to do their thing. So in a
24 sense, at the same time that we're creating anxiety,
25 we are also giving directions on things that we

1 don't need to be anxious about.

2 So rather than seeing the letter as a
3 negative direction, in the context of the
4 information we're going to be putting out there and
5 the unintended consequences it might have, this is a
6 letter also of empowerment. This is fair game and
7 the only thing it does, it says everything else
8 needs careful consideration. These other
9 committees, my experience with them, I know them and
10 it is very respectful, and I think these
11 organizations are not going to let us bully them in
12 any case.

13 MR. BERGER: Well, we also don't have the
14 power, just to understand that. I will say that in
15 all of the confusion that exists with multiple
16 bodies that, in fact, that would help create a
17 framework process for the Commission. The
18 environment is saying exactly what you were saying:
19 Here is where we are, here is where we are not, and
20 I think it would make sense. But, you know, let's
21 leave it in fairness.

22 In a funny way the reaction of different
23 members of the Commission is partly a reaction to
24 use the statement to solve rather than create the
25 anxiety, and clearly it didn't work. I still think,

1 I happen to believe and maybe, Rosa, you are
2 absolutely right, maybe what we should do is
3 withdraw it now, take another crack with everybody's
4 help, because I think there is actually importance
5 to the point that was just made, which is not to be
6 an anxiety adder but actually to be an anxiety
7 reliever is what we were trying to accomplish.

8 We are, even with the liaisons here -- by
9 the way, the two gentlemen who are here have large
10 public councils and large bodies of individuals who
11 are from all over the State, and not all of them are
12 in this room or reading our website. Okay? And not
13 all of them will be sitting and setting the
14 framework issues, and at some point they will get
15 involved, but they don't know where we are going
16 with some of this. While our liaison will, in fact,
17 communicate this, this stuff is starting to get
18 serious, technical, complicated, and will get more
19 so as we go down the road.

20 Part of what we were trying to do was
21 actually exactly clearing things up. We didn't do
22 it well. It's my fault, I take responsibility for
23 it. I signed off on that. I voted for the draft.
24 Let's withdraw this draft. We will come back to you
25 at the next session with something which we will

1 talk through and try to receive those goals.

2 MR. WHALEN: You might think about a
3 slightly different process and that is to ask the
4 Public Health Council and the State of New York
5 Planning Council what would be helpful to them in
6 their deliberations.

7 MR. BERGER: Great.

8 MR. WHALEN: The point I would add is
9 that the department has a primary responsibility
10 here and, in fact, with the construction that we
11 have been talking about. The Commissioner of Health
12 can overrule the presentation. So I think the
13 audience here is really the Council. We, as a
14 department, whatever the Commission says, we'll have
15 to interpret and build into our process so that the
16 councils are sure that what they need will be
17 processed.

18 MR. BERGER: So we are going to talk to
19 you, as we talk to you anyway?

20 (Laughter.)

21 MR. LEE: I also take the view that I
22 think this is a document that should be in front of
23 this Commission. I don't think we should concise it
24 that easily. So I support the fact that we should
25 go back and rethink this, but I am more in support

1 of something of this sort rather than opposed to it.

2 MR. BERGER: We will come back. I was
3 very literal when I said that. We will come back.

4 MR. HINCKLEY: I think the fact that we
5 have had this kind of an open discussion on this
6 issue, you can definitely see the polarity of
7 viewpoints. I think that is a good thing and I
8 think that it is a major step toward coordinating
9 with SHRPC and Public Health. I think it's a good
10 idea to go back and get comments from everybody and
11 try to prepare a document that takes the next step
12 into coordination of all the bodies.

13 BISHOP SULLIVAN: My first reaction was
14 very positive about this. It was talking about
15 coordination and announcing that we are present, but
16 maybe we were too specific, that's what I found out,
17 but I think that the resolution here is a positive
18 resolution. It says we are not caving in. We
19 listened and we heard. There were positive
20 interventions here and there's a lot of smart people
21 in this room.

22 MR. BERGER: I think that's right. I
23 agree with what Bob said and I agree with what
24 Bishop Sullivan just said. I think part of what we
25 are going to have to learn to do over the next year

1 is not be afraid to disagree, to have serious
2 discussions. We are going to do them in public,
3 gang, which is not easy. We are going to do it in
4 public. Those are the rules.

5 We are going to talk to each other. We
6 are going to treat each other as serious people. We
7 are going to listen. We will compromise, we will go
8 back. We will all think about it some more. You
9 know, we're going to be making these kinds of
10 decisions in a public body and all the rest is in
11 and of itself probably as good a test as anything
12 that can do, and we are going to have to do that.
13 And, by the way, the fact that somebody doesn't like
14 a draft, you come and say it. Somebody doesn't like
15 something, you say it. We will go back and forth
16 until we find ways of doing them. We will work with
17 other people, I agree with you. We will work with
18 the two bodies.

19 By the way, this is the beginning. The
20 discussion we had today, Bob, you were absolutely
21 right. The discussion we had today is going to be
22 the beginning of a series of processes where we will
23 have discussions in public where we will be civil to
24 each other but not necessarily nice, and that is
25 important if we want to come to conclusions in a

1 year out of this Commission.

2 I would like to move forward now. I
3 would like to go to the next item on the agenda and
4 part of what we have done, and while the criteria
5 deal with both of the institutional networks that we
6 are charged with looking at, in all honesty, for the
7 last few months, we have spent a great deal of time,
8 and perhaps more time because of some of the complex
9 issues and data issues as well, on the acute care
10 system.

11 Part of what I want to do today is put a
12 stake in the ground to sort of remind us and to
13 remind the public that we have two parts of this
14 that we are going to have to look at, as well as a
15 lot of sort of connecting tissue along the way. And
16 just as a beginning, I have asked Dr. Jeffrey Sachs,
17 who was a member of the original task force, one of
18 the regional Commission members from New York City,
19 to just take us through a little bit on some of the
20 things that the original working group suggested
21 that be looked at in the State.

22 I would like him to start and then I'm
23 going to ask Chris Delker to just take a minute or a
24 few minutes to talk us through some of things that
25 are going on in the residential health care facility

1 right sizing demonstration. As a beginning to sort
2 of opening up, we are going to have to open up that
3 second area of inquiry as we move forward.

4 Jeffrey?

5 DR. SACHS: Thank you very much, Mr.
6 Chairman.

7 I think it is very interesting as you go
8 through these things, what goes around comes around.
9 Chris and I worked together in Albany when I had
10 black hair and he had totally blond hair, 25 years
11 ago in the Governor's office, so it is nice to be
12 back up here.

13 I think when the working group looked at
14 long-term care, it was perhaps a little clearer to
15 us with acute care what needed to be done. I think
16 if you look at the demographic capacities in New
17 York and the rate of increase in Medicaid,
18 especially as it relates to long-term care, you
19 don't have to be a mathematician to figure out as
20 the numbers of elderly go up, as people over 65 or
21 75 go up, we often hear a statistic that 78 or
22 80 percent of the Medicaid program was spent on the
23 chronically ill, that it is not sustainable. It is
24 not only not sustainable on an economic basis, it
25 wasn't sustainable based on different trends that

1 are occurring in the country right now.

2 Many of you might be familiar with
3 something called the Olmstead decision. That is a
4 Supreme Court decision that people have the right to
5 live in the most community integrated setting. That
6 is really not a new concept to people in New York,
7 because although the court precedents are a little
8 bit different, we were all, those of us in the Carey
9 administration, were faced with the Willowbrook
10 Consent Decree and we had to move out of
11 institutions thousands and thousands of
12 developmentally disabled people who are now living
13 in various community settings -- and if we didn't do
14 it, the Governor would have gone to jail.

15 I don't know how the Olmstead thing is
16 going to evolve, but I think it's incumbent on all
17 different levels of government to think about how we
18 need to reorganize resistance. I think that was
19 very much on the working group's mind when they made
20 their recommendations.

21 What is interesting to me, for many
22 years, under one of your predecessors, I chaired a
23 committee in Suffolk County when the nursing home
24 was going to close there. We brought five heads of
25 developmental centers in the room with five nursing

1 home administrators. We were thinking, at that
2 point, we said: Can we look at a different model?
3 Can we copy the OMRDD model instead of building a
4 new nursing home? Can we figure out a way to have
5 more community-based types of programs?

6 So we had those nursing home
7 administrators, beginning with the DD
8 administrators. The nursing home people said, "You
9 could never take care of our people in a community
10 setting, it is impossible."

11 And the MR people said, "That is
12 ridiculous. Our people will score disabled and
13 they're challenged, we do it all the time." And
14 then for a variety of reasons that I won't go into
15 here now, I think a new nursing home was built and
16 we didn't pursue that community alternative.

17 Well, I think that we very much want to
18 pursue an alternative in this state. There is
19 probably not a person in this room who has not had a
20 parent or a grandparent that has been in a nursing
21 home. And there probably isn't a person in this
22 room who, if I asked you to raise your hands now,
23 who would say that ideally, "If I need at some point
24 to have care, assistance, that I want to go into a
25 nursing home."

1 That is not to say that a nursing home is
2 not an appropriate place for lots of people, but I
3 do think that we need to, in looking at the fiscal
4 imperatives and looking at -- and this what the
5 working group felt -- looking for fiscal imperatives
6 and looking at the different changes in how services
7 are provided and looking at the courts, that we need
8 to move onto a different system. I think what we're
9 lucky about is that in a working group, that this
10 change isn't going to happen quickly. We have time.
11 It is not until 2030 that people like me are going
12 to be at that stage in their life where they are
13 going to this kind of assistance.

14 So how do we think about it? How do we
15 look at institutions, and how do we think about
16 taking those resources and reconfiguring the
17 service system to a more community-based system? I
18 think that the basis of the working group was based
19 on a number of principles: One was compliance with
20 the Olmstead decision. The second was right of
21 self-determination and personal choice. The third
22 was encouragement of personal responsibility. The
23 next is a very important one. I think you're
24 beginning to see it in some of the new regulations
25 coming out of Medicare under the Medicare Advantage

1 Programming, patient focused services constructed to
2 meet the consumer's physical, social and
3 psychological needs.

4 You need to make choices in care
5 accessible to consumers and their families in a
6 timely manner. Right now there are just so many
7 places that people go. The advice that you give is
8 uncertain. It's very difficult to find a case
9 manager to give information. People are working,
10 they have an elderly parent, it is really a very
11 debilitating situation when one is confronted with
12 these challenges. We wanted to bring more order to
13 the system, and that was part of the recommendation.

14 So the working group wanted to develop
15 more home and community-based services and it is
16 very important that we look at the existing
17 institutional capacity and right size it, but with
18 the very important principle that as the resources
19 are taken out of the institutions, that they are
20 reinvested back in those communities, maybe back
21 into those very same providers on a community-based
22 model. I think there are lots of examples where
23 this is occurring right now.

24 The most important thing, and the reason
25 we were not successful in the state, in terms of the

1 reinstitutionalization of the disabled, and maybe
2 it's one of the reasons we weren't so successful in
3 Suffolk County in my example, was that we didn't pay
4 attention to the workforce and the retraining or
5 redeployment of the workforce to protect them from
6 obsolescence as the service system changes. And I
7 think one of the things we were successful with in
8 the State is taking this valuable resource and
9 retraining and redeploying the resource back into
10 the community. This is something that I care about
11 very deeply. I am Chairman of an organization
12 called the John F. Kennedy, Jr. Institute for Worker
13 Education. John F. Kennedy started it. It is part
14 of the community. It works directly on workers. It
15 is critically important to provide the tools to
16 these individuals so they can be relevant if the
17 system changes.

18 The specific recommendations that the
19 working group made, and I think it would help the
20 parties when they go through where they are now --
21 so in certain cases I am going to kind of skim over
22 them -- is to create a single point of entry. What
23 we discovered is there's lots of different silos
24 where people can enter a long-term care center in a
25 system -- nursing home, long-term health care,

1 connected hospitals -- we want to try to bring them
2 all together, in a statewide coordinated way. That
3 doesn't mean that it has to be everything controlled
4 by the state, but at least there should be a set of
5 policies that are developed by the State in
6 cooperation with local government, and I think this
7 will become more important as the State proceeds to
8 take over the Medicaid public share for long-term
9 care.

10 The second is that we need to work with
11 the federal government. We need to coordinate
12 through Medicaid and Medicare. Right now there is a
13 tremendous tension that is really destructive to the
14 system. Many of you are aware that if you are
15 admitted to a nursing home on a long-term basis, it
16 is paid for through Medicaid. If you get admitted
17 to the hospital for three days, you become Medicare
18 eligible. You then become eligible to go out into
19 the community and get, I think, 90 days of Medicare.

20 We need to take a look at all of the
21 money we are spending now and we need put those in a
22 pool and keep people out of the hospitals. And the
23 State needs to have an incentive because right now
24 there is no incentive. If someone is paid on
25 Medicaid and it's not on Medicare, then that's a

1 state cost and a local cost. The federal government
2 is sharing 50 percent. If they're on Medicare, the
3 federal government is, through the Medicare program,
4 paying the freight. We need to create more
5 partnerships and I think we're trying hard to fill
6 some of the Medicare Advantage Programs, as they are
7 looking at ways of melding those funders' fees.

8 MR. BERGER: They had to make and deal
9 with that sooner or later.

10 DR. SACHS: That is true.

11 There needs to be more case management
12 services to direct the base. We need to expand
13 eligibility and provide different packages for
14 different people and services based on their needs
15 and that is something we can only do if you get a
16 federal waiver.

17 The idea is to keep people at home. We
18 also, in some cases, might want to expand the
19 eligibility for Medicaid, to keep people who may not
20 have stepped down to the Medicaid level, but it's a
21 way of getting the services to them at their home so
22 they don't deteriorate from being institutionalized,
23 that maybe there are more flexibilities working with
24 Medicaid under a waiver that we could keep people in
25 the least restrictive environment.

1 The other thing is that we need to
2 educate the public and we need to make long-term
3 insurance more available. How many in this room
4 have long-term health insurance? And this is a
5 really educated group of people.

6 That is really something that we need to
7 work with the insurance department at the State
8 level, work with employers, work with unions, work
9 with the public, and really make this whole concept
10 of long-term insurance something that people think
11 about. And there might be initiatives that the
12 government can participate in. In Healthy New York
13 we have reinsurance that the State provides, that we
14 have certain protection. Perhaps there are ways the
15 government can consider in terms of long-term care
16 insurance, provide more of an incentive to private
17 insurance companies to participate.

18 MR. BERGER: I think that part of the
19 problem is that as a working group we were trying to
20 decide -- we were trying to do architectural
21 designs. There are pieces of this architectural
22 design that are actually -- the difference between
23 the working groups' part of the design of this
24 initiative is that we are going to have to take sort
25 of theoretical working drawings, theoretical

1 architectural drawings, and try to take some of the
2 ideas that are working, and turn them into
3 engineering drawings, and turn them into the
4 practical implications for the system.

5 So, I think that we believe -- you know,
6 I think there are some core principles there, and I
7 think the Olmstead decision may be one of the best
8 decisions of the Supreme Court, but implement
9 basically in the face of the institutional framework
10 that we have, is really the long-term challenge.

11 Chris?

12 MR. DELKER: I think the rest of my
13 remarks were kind of presented already.

14 It may be a tall order, but I think it is
15 the segue into the nursing home rights legislation
16 which passed early this year, and it is aimed at
17 reducing excess capacity at nursing homes and, at
18 the same time, encouraging the development of the
19 less restrictive form that the Olmstead decision
20 favors, as well as when one reflects the development
21 that has been going on in long-term care facilities.
22 It is designed to encourage nursing homes to do some
23 of that reinvestment in the communities which you
24 have alluded to, and to at the same time help them
25 kind of improve themselves fiscally by ridding

1 themselves of excess capacity.

2 What the legislation provides for is a
3 demonstration program. It allows nursing homes to
4 decertify beds temporarily for up to five years or
5 to decertify them permanently by converting them to
6 the alternative forms of care, such as assisted
7 living and health care, the long-term home health
8 care and so on, many of those other activities.

9 Now, how do they do this? Well, in
10 accordance with the legislation, the department
11 announced in September this program, this
12 demonstration program, and invited nursing homes to
13 apply. In applications, they are required to
14 describe the impacts that the reduced production of
15 beds will have on their Medicaid costs, because from
16 a legal point of view too, it will reduce Medicaid
17 expenditures and institutional care.

18 They have to describe the potential that
19 bed reduction would have for improving the financial
20 viability of their particular facility. Just as
21 importantly, they have to describe what benefit this
22 would be for consumers in this community; what
23 impact would it have on the quality of long-term
24 care, the availability of more diversified long-term
25 care in their communities?

1 The legislation does authorize the
2 petitioner to consider these various criteria as
3 well as to weigh these methodologies, some of these
4 alternative forms of care. So it is an innovative
5 program in that respect. The application deadline
6 closed on Tuesday, two days ago, November 15th.
7 Counting as of noon today, post marks, late
8 stragglers that came in, we have received 17
9 applications proposing to convert a total of about
10 1275 beds. The legislation provides for the
11 conversion of 2500 beds statement, so we got
12 requests for about half of those. About 1,000 of
13 those, a little over 1000, were for permanent
14 conversion to things like adult day health care or
15 assisted living. The remaining 275 or so are for
16 temporary decertification.

17 That is where that stands now. We will
18 be going through these applications over the next few
19 weeks and we hope to make decisions on them, would
20 like to make decisions on them sometime in the first
21 quarter of '06. I think how long it takes will
22 depend on what we read when we start reading. How
23 complicated are these? Are there some from the same
24 area that may have to be looked at competitively?
25 What are the innovative aspects of these?

1 I think that some of what Mr. Berger said
2 about architectural approaches, we're hopeful that
3 some of these, along with their production and bank
4 capacity may be proposing some sort of
5 reconfiguration of their facilities so it's more
6 efficient runs better. Those were the kind of
7 things that we're kind of looking for.

8 2500 beds may not sound like much, given
9 that there are about 120,000 nursing home beds in
10 the state right now, but again, this is a
11 demonstration. We want to take a first step and see
12 what kind of models we get. Perhaps those could
13 become sort of models that would be transferrable
14 elsewhere and encourage that kind of innovation
15 among other nursing homes. So perhaps by the next
16 meeting we will have a few things to report, at
17 least about the type of applications we're seeing,
18 some of the models we're seeing.

19 MR. BERGER: The other piece of this for
20 the next meeting is we will have a discussion from
21 the state as to where they are in the RFP system.
22 So the point of entry system is an effort, among
23 another things, to see to it that people can
24 understand what is available in long-term care not
25 just for the Medicaid population.

1 MR. GAFFNEY: Of the 1200-some-odd
2 applications where were they from?

3 MR. DELKER: As you would expect, a lot
4 of it in the downstate area, the Hudson Valley, New
5 York City, Long Island area, but it's fairly widely
6 distributed throughout the state.

7 MR. VELEZ: Will incentives be provided
8 to help make that conversion?

9 MR. DELKER: For the right sizing and
10 reduction?

11 MR. VELEZ: Yes.

12 MR. DELKER: Well, it assumes that with
13 excess capacity, you know, these nursing homes are
14 incurring additional cost for staffing and so on.
15 It assumes that there would be approval of
16 alternative forms of long-term care -- for example,
17 don't pay health care for assisted living -- that
18 might not be available to them outside of the
19 demonstration programs, because the methodologists
20 say there is no need. The waiver authority in this
21 legislation does provide the department the capacity
22 to improve those things that we haven't been able to
23 before. So presumably these operators have in mind
24 what they'd like to do but haven't been able to do
25 until now, and the waiver source here gives the

1 Commission permission to provide that.

2 BISHOP SULLIVAN: Talking about five
3 percent of the people in nursing homes. The
4 question is: If you have people who are at home,
5 they're getting services, whether it is really
6 cheaper, I think that is a legitimate question.
7 It's not automatic, I don't think, that 24-hour
8 care, personal services is \$100,000.

9 DR. SACHS: I think it is more in keeping
10 with the spirit of the Olmstead decision, but you
11 are right it may not save as much.

12 MR. HINCKLEY: I think when we had the
13 single point of entry discussion at our next
14 meeting, we'll shed some light on that as well,
15 because part of the goal there is to get to people
16 earlier so that they can get the kind of supportive
17 services they need so they are not acutely ill when
18 they do enter the system.

19 MR. BERGER: Part of the issue is that
20 the provision of appropriate care, at least there is
21 a belief in some cases, is it will be just as
22 expensive. However, if you really had the ability
23 to provide appropriate care, you would get a mix of
24 some that would be lower cost, particularly in
25 regards to long-term care. It would change the

1 whole model.

2 MR. ROBERTS: There are shortcomings to
3 the system, one is money and the other is staff.
4 Will anyone be looking at the models of care to ask
5 the question, "What happens?" Is this more
6 dependent on staffing because it is critical?

7 MR. BERGER: There is also a whole new
8 generation which I don't want to get off there.
9 We'll come back to this at some point. There is a
10 whole generation of technology available for adult
11 care which make historic discussions sort of to a
12 late start, and that raises other questions
13 regarding investment, capital investment as well as
14 certain kinds of training. We are going to get
15 there, but we're not going to get there today.

16 Let me ask the members if there are any
17 other comments or questions?

18 (No response.)

19 I want to remind everything this is a
20 Statewide Commission. Many of you come from
21 different parts of the state. Sometimes when we
22 have it in a place, particularly in the city, people
23 tend to forget that there's stuff north of the city
24 border.

25 Our next meeting will take place on

1 January 12th in Albany, under the egg. All right?
2 We will get the addresses right. We will get the
3 addresses out and we will get the location out. The
4 next meeting is January 12th in Albany. One of the
5 things we are going to ask, David, is we're going to
6 hear some more on their future trends, it's very
7 important. We will look forward to that. We will
8 come back on that issue and we'll have some other
9 material for the next meeting.

10 We will come back to this room, hopefully
11 we'll control the lights better for the
12 presentation, February 9th here in this room.
13 March 9th in this room, and this will go out e-mail,
14 on April 5th in Rochester. So we are going to try
15 to take our meetings around the State.

16 This is all on the website and all the
17 information locations, dates and times will be on
18 the website.

19 Ladies and, Gentlemen, anything else?

20 I'll take a move to adjourn.

21 (Moved and seconded.)

22 Thank you.

23 (Time noted: 2:45 p.m.)

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

I, Ellen Sandles, a Shorthand Reporter and notary public, within and for the State of New York, do hereby certify:

That I reported the above proceedings on November 17, 2005, at the Doubletree Metropolitan Hotel, on 51st Street and Lexington Avenue, New York, New York, and that this transcript is a true record of what transpired at that time and place.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of _____, 2005.

Ellen Sandles, Reporter