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MEETING  
OF  
THE COMMISSION ON HEALTH CARE  
FACILITIES IN THE 21st CENTURY

21 West 23rd Street  
2nd Floor  
New York, New York  
Thursday, May 11, 2006  
10:00 a.m.

B E F O R E:     STEPHEN BERGER, Chairman

COMMISSION STAFF:  
DR. DAVID SANDMAN  
MARK USTIN, ESQ.

1                   CHAIRMAN BERGER: Good morning.

2                   The clock on the wall says it is ten  
3 o'clock.

4                   I welcome you to the eighth meeting of  
5 the Commission on Health Care Facilities in the  
6 21st Century.

7                   We have a quorum and this meeting is in  
8 session.

9                   I would like to turn the floor over to  
10 David Sandman to begin with a progress report.

11                   DR. SANDMAN: Thank you, Mr. Chairman.

12                   I appreciate the opportunity to give you  
13 this brief report on progress since our last  
14 Commission meeting.

15                   We are pleased to report the  
16 Commission's voluntary right-sizing procedures have  
17 gained momentum.

18                   To date we have received a number of  
19 formal applications from providers wishing to  
20 engage in voluntary talks involving various types  
21 of consolidations and collaboration.

22                   In accordance with our official  
23 procedures, staff of both the Commission and State  
24 Department of Health are now actively supervising  
25 and guiding those talks in numerous regions and

1 will continue to do so.

2           We have also received quite a number of  
3 informal inquiries on this topic and I do expect  
4 that we will be receiving additional applications  
5 from a number of them.

6           As we explained previously, the  
7 antitrust principles addressed by our procedures  
8 are identical on both the state and federal levels.

9           Our voluntary procedures were developed  
10 in collaboration and with the support of the New  
11 York State Attorney General and we are also engaged  
12 in efforts on the federal level.

13           Since our last meeting, Chairman Berger,  
14 along with our vice chairman, Bob Hinckley, and our  
15 general counsel, Mark Ustin, met personally in  
16 Washington, D.C., with the FTC to explain the  
17 Commission, our mission, as well as our voluntary  
18 procedures. During this briefing no objections  
19 were raised to our procedures.

20           We do have a meeting scheduled with the  
21 federal Department of Justice to also brief them on  
22 the Commission and our voluntary rightsizing  
23 procedures.

24           As always, we do continue to engage in  
25 an active communications program and we hold

1 numerous meetings and presentations and  
2 communications with various constituencies at this  
3 time.

4 I will not list all of them, but recent  
5 meetings and briefings have occurred with the  
6 members and staff of Healthcare Trustees of New  
7 York State, members and staff of the SEIU-1199 data  
8 center, members and staff of the State Senate and  
9 Assembly, United Hospital Fund, College of  
10 Healthcare Executives, the Western New York Health  
11 Care Association, the New York City Commissioner of  
12 Health, New York Association of Health Care  
13 Providers, the Mental Health Association of both  
14 New York City and Westchester, as well a the  
15 Catholic Conference.

16 Since our last meeting, the RACs remain  
17 deeply engaged in their work. All of them are  
18 holding discussions with providers and other  
19 stakeholders within their regions.

20 Many of them are holding meetings every  
21 week and sometimes more than once a week in which  
22 they talk with lots of different parties. They are  
23 holding day-long sessions and some of them are  
24 making site visits to facilities.

25 The staff is continuing to provide the

1 RACs with different types of analysis and support  
2 to model different scenarios and understand the  
3 impact of potential restructuring.

4           We are at the point where the RACs are  
5 beginning to share with the Commission the results  
6 of their fact-finding efforts thus far and  
7 discussing the situations within their regions.

8           At our last meeting, the members did  
9 request various types of information, including  
10 updates on pending CON applications, Medicaid  
11 spending trends, as well as system affiliations,  
12 and all of that information has been compiled by  
13 the staff and we have distributed it to the members  
14 prior to today's meeting.

15           The staff has also continued its work  
16 researching reimbursement issues and other  
17 structural topics that the Commission may wish to  
18 consider as it moves along with its work.

19           Also, since our last meeting we have  
20 conducted additional public hearings across the  
21 state, and that phase of our work is complete.

22           In total, we have heard from hundreds  
23 of witnesses and collected thousands of pages of  
24 testimony. Both our staff and the RACs have  
25 reviewed the testimony carefully. Many of our

1 members have reviewed the written testimony during  
2 those meetings, particularly for the purpose of  
3 identifying common themes raised during the  
4 hearing.

5                   As a result of that review and the  
6 input received from the hearings, we are  
7 recommending two additions to the framework  
8 criteria that were previously adopted unanimously  
9 by the Commission.

10                   In some areas we heard a lot of  
11 testimony regarding rural providers, specifically  
12 their geographic isolation, travel barriers, and  
13 their role in essential access.

14                   Consequently, we are recommending the  
15 availability of service criteria be amended to give  
16 formal recognition to those hospitals designated as  
17 rural.

18                   Operationally, we will rely upon the  
19 existing Department of Health technical definition  
20 of a rural hospital on issues for Medicaid  
21 reimbursement as well as for eligibility for  
22 participation in the rural health care access  
23 development program.

24                   In addition, in other areas, we have  
25 heard about racial and ethnic disparities and,

1 consequently, we are recommending that the service  
2 to vulnerable populations criteria be amended to  
3 include the percentage of non-white discharges from  
4 a hospital.

5                   This data is available from SPARCS and  
6 it will be broken out by African Americans,  
7 Hispanic and Asian patient categories as it is  
8 reported by the hospital.

9                   We believe that these additions would  
10 enhance the robustness of the measurements set and  
11 formally recognize the importance of various issues  
12 raised during the public hearings that we have  
13 conducted across the state.

14                   So we will ask the membership for a  
15 motion to adopt these proposed additions.

16                   In summary, Mr. Chairman, we are deep  
17 into our information gathering and analysis phase  
18 and we remain on schedule and making good progress  
19 with our work.

20                   CHAIRMAN BERGER: Thank you.

21                   Is there a motion to amend criteria?

22                   MR. DUNCAN: So moved.

23                   CHAIRMAN BERGER: Second?

24                   MR. HOWLETT: Second.

25                   CHAIRMAN BERGER: All in favor say

1 "Aye."

2 (Chorus of "Ayes.")

3 CHAIRMAN BERGER: Thank you very much.

4 Adopted.

5 Thank you, David.

6 For those of you who have not seen it,  
7 the testimony has been voluminous, but it has been  
8 well worth it, and as we plow through different  
9 pieces of it, we have been learning a great deal  
10 and I want to thank not only the regional members  
11 and RAC members, but numerous organizations that  
12 have done so much serious work, and as we do, treat  
13 this whole process seriously. Their participation  
14 is evidence of that and I want to thank all of them  
15 as well as the staff for the work that has been  
16 done.

17 Are you ready.

18 DR. SANDMAN: Yes.

19 Thank you again, Mr. Chairman.

20 This morning I am going to present an  
21 overview of three region, specifically, Long  
22 Island, New York City, and the Northern Region  
23 overviews.

24 The format of the presentation will be  
25 very similar to what we presented in our last

1 meeting where we focused on the central region.  
2 Although that presentation only covered one region,  
3 the point that came through loud and clear was that  
4 the region was geographically large and diverse and  
5 could not be treated as one entity, but rather  
6 focused on specific markets and local communities.

7           Let me begin my remarks this morning by  
8 reiterating that point and, in fact, multiplying it  
9 by three because today I do have the challenge of  
10 weaving together an overview of three regions into  
11 a single presentation of regions which are equally  
12 large, diverse, and complex and, in fact, the  
13 analysis in all of them is being conducted on a  
14 deeper and sub-regional level that reflects the  
15 characteristics of specific communities and  
16 markets.

17           I will describe some of the  
18 characteristics of each region, their demographic  
19 profiles, as well as their hospitals and nursing  
20 homes and other long-term care resources.

21           Just by way of getting ourselves  
22 oriented here, on the map you can see the actual  
23 regions highlighted starts at the bottom in violet.

24           It is the Long Island region and New  
25 York City is right next to it and is highlighted in

1 yellow, and the large green area is the Northern  
2 region, a defined by our statute.

3           Just as the picture shows you, the  
4 regions do differ in their size. Long Island is  
5 comprised of just two counties, Nassau and Suffolk  
6 Counties, which together account for only three  
7 percent of the state land area.

8           Of the two, Nassau is the more populous  
9 of the two counties, while Suffolk is larger in a  
10 geographic sense.

11           The New York City region is composed of  
12 the five boroughs or five counties, and New York  
13 City contains only one percent of the state's land  
14 mass.

15           By contrast, the Northern region is  
16 quite large and is made up of sixteen counties and  
17 accounts for almost one-third of the entire state's  
18 land mass geographically.

19           In terms of population, in these  
20 regions the relationship is essentially reversed.  
21 The Long Island region ha almost three million  
22 residents or 15 percent of the entire state's  
23 population.

24           New York City, of course, is  
25 exceptionally dense. It has more than eight

1 million residents or actually 42 percent of the  
2 state's population, although it is only one percent  
3 of the land mass, and the Northern region is made  
4 up of urban and some very rural areas combined for  
5 1,430,000 people or seven percent of the state's  
6 population.

7                   Let's look both backwards and forwards  
8 in terms of population trends.

9                   During the '90s, the population of New  
10 York State as a whole grew by about five percent,  
11 as shown by the red line on the graph. Much of  
12 that growth occurred here in New York City, which  
13 is depicted in green. The city experienced about a  
14 nine percent increase in its population, fueled  
15 largely by an influx of new immigrants into the  
16 city.

17                   Long Island is noted by the light blue  
18 line and almost exactly mirrored the statewide  
19 trend, and during the statewide trend, the Northern  
20 region in yellow remains essentially flat.

21                   Looking forward to the year 2030, it is  
22 projected that New York City will continue to  
23 experience substantial growth in its population  
24 while the state, on a whole, will experience  
25 marginal growth and the population of Long Island

1 and other regions are expected to remain flat.

2                   The patterns across the region also  
3 vary.

4                   Looking at the age distribution, you  
5 can see that the Northern and Long Island regions  
6 have similarly higher proportions than the  
7 statewide average of 12.9 percent. However,  
8 residents sixty-five and older make up 7.9 percent  
9 of the population of New York City, which is also  
10 consistent with having a larger immigrant  
11 population that does tend to be younger at the time  
12 of immigration.

13                   Again, looking up to the year 2030,  
14 statewide the proportion of the elderly population  
15 is going to grow gradually over the next  
16 twenty-five years.

17                   The Northern and Long Island regions  
18 will experience somewhat higher rates of increase  
19 while New York City will experience a rate of  
20 increase in its elderly population that is lower  
21 than the statewide average.

22                   A quick look at the economic condition  
23 in each region.

24                   Statewide, according to the Department  
25 of Labor, the most recent report indicates

1 unemployment rates of 5 1/2 percent.

2                   On the other hand, the average wage in  
3 New York City is much higher than the statewide  
4 average, nearly \$65,000, while the average wage  
5 level in both Long Island and the Northern regions  
6 are considerably lower.

7                   Among all ages, New York City has the  
8 highest rate of uninsured residents of any region  
9 in the state.

10                   Here in the city, nearly one in five  
11 are uninsured versus fourteen percent statewide.  
12 In the other regions, both have uninsured rates  
13 that are half of that of New York City.

14                   As we all know, health care is a large  
15 and important part of the data. On this slide from  
16 the Department of Labor, and it does group together  
17 one sector that provides health care services, as  
18 well as what they call social assistance services,  
19 because it can be difficult sometimes to  
20 distinguish between the boundaries of those  
21 activities.

22                   In combination, 14 percent of workers in  
23 New York State are employed in health care and  
24 social assistance, a rate that is comparable in the  
25 Northern region. It is a bit lower in Long Island

1 and is a bit higher in New York City.

2                   It is worth noting, too, that within  
3 those regions there can be a lot of variations from  
4 county to county, specifically when looking at very  
5 large counties such as Manhattan, or very small and  
6 rural counties, where a large hospital may in fact  
7 be the single largest employer in the county and  
8 could account for a larger percentage of FTEs.

9                   Moving to the supply of hospitals,  
10 there are 24 acute care hospitals on Long Island  
11 which collectively have almost 8,000 licensed beds  
12 and those hospitals have 7,377 available.  
13 Collectively they had about 3080 discharges and  
14 they employ 4,200 full-time employees.

15                   New York City has more than twice that  
16 number. They have more than twice as many  
17 hospitals as Long Island or 59 to be exact.  
18 Together they have 28,000 licensed beds and they  
19 report staffing 25,000 of them.

20                   In combination, they discharge 1.2  
21 million patients and employ around 1,750 FTEs.

22                   The Northern region has 25 acute-care  
23 hospitals with 4,500 licensed beds and they ha  
24 about 180,000 discharges in 2005 and actively  
25 support 23,000 full-time employees.

1                   At our last meeting, a question was  
2 raised about systems and affiliations within the  
3 regions, so in the packages distributed to members  
4 prior to the meeting, there is more detailed  
5 information about the specific system affiliations,  
6 but at a summary level.

7                   These slides do indicate the larger  
8 systems for each of the regions in New York City.

9                   There are five major systems. The New  
10 York City Health and Hospitals Corporation, which  
11 operates our public hospitals, has 13 hospitals,  
12 followed by New York Presbyterian, Continuum Health  
13 Partners, St. Vincent's Catholic Medical Centers,  
14 as well as North Shore-Long Island Jewish, which  
15 has a presence both in New York City as well as on  
16 Long Island.

17                   As I mentioned in the segue, North  
18 Shore-LIJ is the largest system on Long Island with  
19 eight hospitals, followed by the Catholic Health  
20 Services with five.

21                   In the Northern region, the main system  
22 is Northeast Health with three hospitals.

23                   There are also what we might consider  
24 mini that each have two hospitals or two campuses  
25 within them.

1                   There is Maspeth with two hospitals,  
2 Adirondack Medical Center has two and Albany  
3 Medical Center which also has two campuses. So we  
4 coined the phrase "micro system" for them.

5                   Looking at occupancy rates based on  
6 licensed beds, statewide average is 65.3 percent.  
7 Long Island looks relatively better with a rate of  
8 73 percent.

9                   New York City is very close to the  
10 state average and the Northern region has an  
11 occupancy rate below the state as a whole.

12                   The picture does change a bit if you  
13 look at the available beds, and then it climbs to  
14 77 percent. Both Long Island and New York City  
15 have occupancy rates of 83 percent and the Northern  
16 region still lags behind with 68 percent.

17                   The regions also differ in the physical  
18 condition of the hospitals that were examined.

19                   The operating margin of hospitals in  
20 HANYS, the New York City and Long Island region  
21 exactly match how they are defined for the  
22 Commission. What they call the Northeastern region  
23 exactly match how they are defined for the  
24 Commission. What they call the Northeastern region  
25 is a very close, but not perfect match to the

1 definition of our Northern region. You can see  
2 that while the statewide operating margin was  
3 negative, the hospitals on Long Island had a  
4 positive .7 percent compared to those in New York  
5 City, which had a negative margin of 1.3 percent,  
6 and the northern region enjoyed a prosperous margin  
7 of 2 percent.

8                   Lastly, looking back over the past  
9 decade, New York City has had a number of hospitals  
10 closed. Those that are closed are listed here.

11                   There have been four closed in Long  
12 Island. Brunswick Hospital remains, but recently  
13 closed its medical center.

14                   Massapequa and St. John's Episcopal  
15 have closed, as well as Mary McClellan Hospital and  
16 Leonard Hospitals.

17                   Turning to long-term care, statewide  
18 Long Island has 78 licensed nursing homes with  
19 almost 17,000 licensed beds.

20                   Nursing home occupancy is higher in  
21 Long Island; the average topping the statewide  
22 average rate. 1,745 are classified as low acuity  
23 residents, meaning that they are coded as either  
24 PAs or PBs.

25                   By contrast, New York City has 180

1 nursing homes with almost 45,000 beds.

2                   Occupancy is also high in this region  
3 at almost 96 percent and almost 6,000 low acuity  
4 residents.

5                   Moving on to the Northern region, there  
6 are 7s nursing homes with almost 10,000 beds.

7                   Occupancy here is also on the high end  
8 and already about 800 low acuity residents ae in  
9 nursing homes.

10                   Looking beyond nursing homes, this  
11 slide depicts the supply of non-institutional  
12 services in regions.

13                   These resources include health care  
14 slots, long-term home health slots, managed  
15 long-term care and supportive housing units.

16                   The red bar shows the New York State  
17 average supply per capita among adults of 65 and  
18 older.

19                   You can see that New York City has a  
20 relatively well developed supply of such resources,  
21 although there is still a gap between supply and  
22 estimated need. This in part reflects the density  
23 of New York City, which makes the economics of  
24 something like home care more feasible.

25                   By contrast, you have less well

1 developed supplies of such resources.

2                   There are gaps and there are challenges  
3 to developing alternatives to nursing homes in all  
4 of the regions.

5                   Finally, just a quick summary of  
6 closures that have occurred in the three regions  
7 combined.

8                   At this point, Mr. Chairman, I will be  
9 happy to answer any questions or to defer to our  
10 regional members.

11                   Thank you.

12                   CHAIRMAN BERGER: Thank you, David.

13                   Are there any questions? We have all  
14 had this material to look at.

15                   Leo?

16                   MR. BRIDEAU: Leo Brideau.

17                   On the relatively prosperous regions,  
18 you need about four percent margin, so the most  
19 prosperous region produces about half.

20                   CHAIRMAN BERGER: Bishop Sullivan?

21                   BISHOP SULLIVAN: Are you considering  
22 other ratios like FTEs and discharges?

23                   It would seem to me the number of beds,  
24 as well as FTEs, is important because there seem to  
25 be some real disparities in some areas between the

1 FTEs and the number of beds and number of  
2 discharges.

3 DR. SANDMAN: Do you mean staffing  
4 ratio, which is obviously more relative?

5 BISHOP SULLIVAN: Yes. I mean that is  
6 one of the many types of measures of efficiency.

7 It strikes me -- I mean, I know that  
8 does not solve any problems it just gives you  
9 another insight, but the reality is it tells where  
10 inefficiencies may exist.

11 CHAIRMAN BERGER: You have to see the  
12 nature of the hospital and what level of care it is  
13 providing as well.

14 BISHOP SULLIVAN: The two percent  
15 margin in the Northern area, would that reflect the  
16 labor force and what they are paid?

17 They are not unionized.

18 CHAIRMAN BERGER: No, they are.

19 MR. HINCKLEY: There are some unions.

20 CHAIRMAN BERGER: Some are and some are  
21 not.

22 That's a fair question and we will try  
23 to get you an answer and break it down.

24 Any other questions?

25 I'm sorry, we don't take questions from

1 the audience.

2 Members, regional members?

3 For the record, our next meeting will  
4 be on June 8th. It will be at ten o'clock and it  
5 will be here.

6 MR. HINCKLEY: Mr. Chairman, I would  
7 like to move that we move into executive session to  
8 discuss specific medical and financial details of  
9 the facilities in the regions.

10 CHAIRMAN BERGER: Second?

11 MR. SEARS: Second.

12 CHAIRMAN BERGER: Any objection?

13 (No response.)

14 CHAIRMAN BERGER: Thank you.

15 We will now adjourn the public meeting  
16 and we will move into executive session.

17 (Whereupon, the meeting continued in an  
18 executive session.)

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

I, ANNETTE SALVIATTI, a Shorthand Reporter and Notary Public, within and for the State of New York, do hereby certify that I reported the proceedings in the within-entitled matter, on Thursday, May 11, 2006 at NYC Seminar & Conference Center, 71 West 23rd Street, New York, and that this is an accurate transcription of these proceedings.

IN WITNESS WHEREOF, I have hereunto set my hand this            day of            , 2006.

ANNETTE SALVIATTI