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Transcript of the Meeting
of the
Commission on Health Care
Facilities in the 21st Century
Held on
Thursday, June 8, 2006
New York City Conference Center
71 West 23rd Street, 2nd floor
Borough of Manhattan

1 Meeting convened at 10:00 a.m.

2

3 P R E S E N T:

4 Statewide Members

5 STEPHEN BERGER, Chairman

6 LEO P. BRIDEAU

7 CRAIG A. DUNCAN

8 ROBERT J. GAFFNEY

9 DR. ROSA M. GIL

10 ROBERT R. HINCKLEY

11 HOWARD T. HOWLETT

12 DARLENE D. KERR

13 MARK L. KISSINGER

14 PATRICK P. LEE

15 KRISTIN M. PROUD

16 G. NEIL ROBERTS

17 THERESA A. SANTIAGO

18 R. BUFORD SEARS

19 BISHOP JOSEPH SULLIVAN

20 PETE VELEZ

21 Commission/DOH Staff

22 DR. DAVID SANDMAN

23 MARK USTIN, ESQ.

24

25

1 CHAIRMAN BERGER: Good morning. I'd like
2 to call the meeting of the Commission on Health Care
3 Facilities in the 21st Century, our June meeting, to
4 order and welcome all of you here.

5 First of all, thank you very much. We've
6 got a reasonably long day, and what I would like to
7 do is begin by turning the meeting over to
8 David Sandman.

9 David, would you give us a progress
10 report, please?

11 DR. SANDMAN: Yes, of course. Thank you,
12 Mr. Chairman.

13 I am pleased to make this report on
14 progress since our last meeting. Just two weeks ago
15 the Governor announced the availability of
16 \$269 million in new grant funding for hospitals and
17 nursing homes to support restructuring initiatives
18 that are consistent with the goals of the
19 Commission. The funds come from the HEAL New York
20 program, which will ultimately provide up to
21 \$1 billion for this purpose.

22 Under this capital restructuring
23 initiative, applicants may seek funding to support
24 physical reconfiguration of facilities, the
25 downsizing or closure of a facility, consolidation

1 or conversion of providers, programs and acute-care
2 or long-term care beds, and the elimination of
3 duplicative services consistent with community needs
4 for those services.

5 Projects funded under this initiative may
6 include the creation or expansion of critical access
7 hospitals and freestanding emergency rooms with a
8 specified number of medical/surgical beds for
9 inpatient services, as well as projects that advance
10 the areas of diagnostic imaging, ambulatory surgery,
11 outpatient therapy, adult day care, or assisted
12 living.

13 The RFP for this funding initiative has
14 been issued jointly by the Department of Health and
15 DASNY. Specific inquiries related to funding should
16 be directed to those agencies. I would also note
17 that a bidder conference will occur on June 28th in
18 Albany regarding that RFP.

19 The HEAL New York program does have two
20 primary objectives in addition to the capital
21 restructuring initiatives I just described. The
22 HEAL program will also support the development and
23 investment in health information technology projects
24 on a regional level. Thus, the Governor
25 simultaneously announced the award of almost

1 \$53 million in new grant funding to support the
2 expansion of information technology in New York's
3 health care system.

4 The awards are to 26 regional health care
5 networks and they will increase the capability and
6 use of electronic health records among health care
7 providers, reduce medical and prescription drug
8 errors and prevent unnecessary and duplicative
9 medical testing. In addition, the projects will
10 provide patients with greater access to their
11 medical records so that they can participate as
12 informed decision makers in their own care.

13 In addition to these funding
14 initiatives, New York State has also announced the
15 results of the Nursing Home Rightsizing
16 Demonstration Program. Under this program, nursing
17 homes were given the opportunity and the flexibility
18 to voluntarily rightsize and reconfigure their
19 operations to expand into the growing areas of
20 health care, adult day care, and assisted living.

21 The 13 nursing homes chosen to
22 participate in this demonstration project are now
23 permitted to temporarily decertify beds for up to
24 five years or to permanently convert a portion of
25 existing beds. In order to transition into

1 expanding these services, the rightsizing nursing
2 home projects approved will decertify a total of 259
3 unused beds and allow for the conversion of 572
4 existing beds into other long-term care services
5 such as adult day care and assisted living.

6 Beyond these initiatives, the
7 Commission's own Voluntary Rightsizing Procedures
8 continue to gain momentum. We have received
9 additional formal applications from providers who
10 wish to engage in voluntary talks involving various
11 types of consolidations and collaborations.
12 Commission and Department of Health staff are
13 actively supervising and guiding those talks in
14 numerous regions and will continue to do so.

15 We have also received a number of
16 additional informal inquiries, and expect that the
17 availability of HEAL funding I just spoke about will
18 provide additional incentives for providers to
19 submit voluntary proposals.

20 As we've explained previously, the
21 antitrust principles addressed by our procedures are
22 identical on both the state and federal levels. Our
23 voluntary procedures were developed in collaboration
24 and with the support of the New York State Attorney
25 General, and we are also engaged in efforts on the

1 federal level.

2 As I previously reported, Chairman
3 Berger, Vice Chairman Hinckley and our counsel met
4 personally with the FTC to explain the Commission,
5 our mission, and our procedures. Similarly, our
6 counsel, Mark Ustin, and I met personally last week
7 with the Department of Justice to brief them on the
8 Commission's procedures, and I am pleased to report
9 that no objections were raised by either the FTC or
10 the Department of Justice.

11 Last week, some new appointments were
12 made to the Regional Advisory Committee. The Senate
13 made 16 new RAC appointments and the Assembly made
14 one. The names of the new RAC members are posted on
15 the Commission's website. All of them have been
16 sent orientation packages and are being integrated
17 into the work of the RACs, all of whom have been
18 engaged in their work for some time now.

19 The RACs continue to hold discussions
20 with providers and other stakeholders in their
21 regions, and the RACs are beginning to share with
22 the Commission the results of their fact-finding
23 efforts thus far and discussing the situations
24 within their regions.

25 In addition to working hand in hand with

1 the RACs, Commission staff also continue to engage
2 in discussions with various providers across the
3 state and to continue modeling and evaluating
4 different scenarios. The staff has also been
5 meeting with various constituencies such as mental
6 health advocacy groups and primary care providers to
7 continue to ensure that those issues are encompassed
8 in the Commissions's deliberations.

9 So, in summary, Mr. Chairman, we are
10 deep into our information gathering and analysis
11 phase, and I am pleased to report that we remain on
12 schedule and continue to make good progress with our
13 work.

14 CHAIRMAN BERGER: Thank you very much,
15 David.

16 Are there any other questions for David?
17 Commission members? Regional members?

18 Thank you.

19 I want to really say that the work of the
20 Commission staff has been terrific. Working with
21 the agencies and the RACs, integrating the new
22 people into the RACs and doing it quickly is going
23 to be important. The voluntary process which David
24 described is now pretty robust. We think it's going
25 to get to be more robust and it is a process which,

1 to meet all the standards of the criteria that we
2 have developed in terms of state immunity, it has to
3 be supervised by the Department and the
4 Commission --

5 DR. SANDMAN: Correct.

6 CHAIRMAN BERGER: -- and will ultimately
7 have to be part of the Commission's report --

8 DR. SANDMAN: That's right.

9 CHAIRMAN BERGER: -- and, I mean, that is
10 the process, and frankly, as we all said from the
11 beginning, as long as it meets our standards, meets
12 our direction, meets the objectives of the
13 Commission, we want to encourage the industry and
14 players to come and to start these conversations.
15 They will clearly have a quality and a depth to them
16 which will help guarantee success for whatever
17 combinations -- configuration changes and all the
18 rest take place, and while it's a burden on
19 everybody, it's a good burden for staff the more
20 that can be done on a voluntary basis.

21 So, I want to congratulate those
22 institutions -- obviously, we are not going to
23 discuss who they are -- those institutions taking
24 the first step and encourage those who have been
25 thinking about it, and we know there are others

1 thinking about it who have talked to us, to come in
2 and begin the process. Good -- good month.

3 Are you ready?

4 DR. SANDMAN: Sure.

5 CHAIRMAN BERGER: Okay, go ahead.

6 DR. SANDMAN: Hit it?

7 CHAIRMAN BERGER: Yes.

8 DR. SANDMAN: Thank you again,

9 Mr. Chairman.

10 This morning I am going to present an
11 overview of two regions, the Hudson Valley and the
12 Western region. The format will be similar to what
13 we've presented at the previous meetings.

14 In my prior presentation, the point that
15 came through loud and clear was that all of our
16 regions are large, they are diverse, and each of
17 them require a subregional analysis focused on
18 specific local markets and communities. So, let me
19 start my presentation this morning by reiterating
20 that point, which is equally true for the Hudson
21 Valley and for the West.

22 I am going to describe some of the
23 characteristics of each region, their demographic
24 profiles and their supplies of hospitals and nursing
25 homes and other long-term care resources.

1 (Slide.)

2 Just to get ourselves oriented, here on
3 the map you can see the actual regions highlighted.
4 In blue is the Hudson Valley region and in green is
5 the Western region. Just one note on the Western
6 region: I want to point out that Monroe County,
7 which is home to Rochester, technically belongs to
8 the Central region, not to the West where it is
9 sometimes grouped in other planning exercises. I
10 just wanted to make that clarification. Sometimes
11 people are not sure what region they belong to.

12 The two regions are pretty similar in
13 their size. They are both composed of eight
14 counties and they represent 13 and 14 percent
15 respectively of the state's land mass. The Hudson
16 Valley is the more populous of the two regions. It
17 has 2.3 million residents, or 12 percent of the
18 state's population, while the West has 1.5 million
19 residents, or 8 percent of the state's population.

20 (Slide.)

21 In each of the regions, the population is
22 highly concentrated within a single county, and both
23 regions also contain some very rural areas. In the
24 Hudson Valley, Westchester County has nearly 1
25 million residents, or fully 40 percent of the entire

1 region's population. Orange County follows it -- it
2 is the second most populous. But by contrast,
3 counties such as Delaware, Sullivan, and Putnam are
4 really quite rural and sparsely populated.

5 In the Western region there is a similar
6 pattern. Erie County, home to the City of Buffalo,
7 also has about 1 million people, which is 60 percent
8 of the entire region's population. Niagara County,
9 which is immediately to the north, is the second
10 most populous, and here, too, we have some very
11 rural areas with populations of fewer than 50,000
12 people.

13 (Slide.)

14 Let's look backwards and forwards in
15 terms of population trends. During the 1990s, the
16 population of New York State as a whole grew by
17 about 5 percent, as shown by the red line. The
18 Hudson Valley, denoted by the light blue line, did
19 slightly outpace the statewide trend and grew at a
20 faster rate, but by contrast, the population of the
21 Western region actually declined by a few percentage
22 points and defied the statewide trend.

23 (Slide.)

24 Looking forward to the year 2030 and
25 using Census Bureau data, it is expected that the

1 same patterns will continue but also may be
2 amplified. It is projected that the Hudson Valley
3 will continue to experience growth in its population
4 while the state as a whole will experience only
5 marginal growth. Again, by contrast, the population
6 of the Western region is projected to shrink by more
7 than 10 percent.

8 (Slide.)

9 The patterns also vary when looking at
10 the age distributions within the regions. The
11 Western region currently has a somewhat higher
12 proportion of elderly residents than the statewide
13 average of 12.9 percent, while the Hudson Valley
14 looks pretty much identical to the state as a whole.

15 (Slide.)

16 And then, again, looking out to the year
17 2030, statewide, the proportion of the elderly
18 population is going to grow gradually over the next
19 25 years. The Hudson Valley looks almost exactly
20 like the statewide trend -- you really can't see it
21 because the two lines are right on top of each other
22 like a perfect mirror image. The Western region,
23 however, is expected to experience a higher rate of
24 increase so that more than 20 percent of its
25 population will be aged 65 or older by the year

1 2030.

2 (Slide.)

3 This is a quick look at the economic
4 conditions in each region. Statewide, according to
5 the Department of Labor, the most recent estimates
6 indicate an unemployment rate of 5 percent. The
7 Hudson Valley enjoys a lower rate of 4.1 percent
8 while the unemployment rate in the West is estimated
9 at 5.6 percent.

10 (Slide.)

11 In addition, the average wage in the West
12 is considerably lower than the statewide average,
13 \$33,000 versus almost \$50,000 statewide.

14 (Slide.)

15 Among all ages, both the Western and the
16 Hudson Valley regions do have lower rates of
17 uninsured residents than the statewide average. In
18 the case of the West, that may be a result of its
19 older population and the nearly universal Medicare
20 coverage among those ages 65 and older, and as I
21 said, the larger than average proportion of elderly
22 residents in the Western region.

23 (Slide.)

24 As we all know, health care is a large
25 and very important part of the state's economy. The

1 data on this slide is from the Department of Labor,
2 and it groups together, as one sector, individuals
3 who are employed in facilities that provide health
4 care services as well as what they call social
5 assistance services, because it is sometimes
6 difficult to distinguish between the boundaries of
7 those two activities.

8 In combination, 14 percent of all workers
9 in New York State are employed in health care and
10 social assistance. That is a rate that is pretty
11 comparable in the Hudson Valley and a bit lower in
12 the West. It is worth noting that within these
13 regions there can be a lot of variation from county
14 to county, especially when looking at either very
15 large counties as well as those counties that are
16 much smaller and more rural.

17 You might, for example, look at a very
18 rural county where, in fact, the hospital could be
19 the largest employer in that area. So, this is
20 another excellent example of how the Commission's
21 approach is always based as a subregional level and
22 is sensitive to what the actual local market
23 conditions may be, because sometimes these averages
24 can mask important differences.

25 (Slide.)

1 Moving on to the supply of hospitals,
2 there are 34 acute-care hospitals in the Hudson
3 Valley, which collectively have around 7,000
4 licensed beds, and the hospitals report staffing
5 6,000 of those. Collectively, they had around a
6 quarter of a million discharges in '04, and they
7 employed almost 30,000 full-time employees.

8 (Slide.)

9 The supply is a bit smaller in the West,
10 which has 28 acute care hospitals, 5,000 licensed
11 beds, and they report staffing most of them, 4,250.
12 In combination, the Western hospitals discharged
13 almost 175,000 patients in '04 and they employed
14 almost 24,000 full-time employees.

15 (Slide.)

16 This slide shows the distribution of
17 hospitals within each region by county, and it is no
18 surprise that the hospitals tend to cluster where
19 the people are, so the population centers of each
20 region -- namely Westchester and Erie counties --
21 also have the bulk of the hospitals. Similarly,
22 there are quite a few rural counties with only one
23 or two hospitals within them.

24 (Slide.)

25 At a previous meeting, a question was

1 raised about estimates and affiliations within the
2 regions, so this slide indicates the larger systems
3 for each.

4 In the Hudson Valley there are two major
5 systems, Pinnacle Healthcare, which is currently
6 comprised of six hospitals, and the Stellaris
7 system, which is currently comprised of four, at the
8 most.

9 In the Western region there are also two
10 large systems, specifically, the Kaleida Health
11 system which has five hospitals, and the Catholic
12 Health System, which has four.

13 (Slide.)

14 Looking at occupancy rates based on
15 licensed beds, the statewide average is 65 percent
16 and the Hudson Valley looks fairly similar with a
17 rate of 62 percent; however, the Western region is
18 substantially lower at 56 percent.

19 (Slide.)

20 The picture changes a bit if you look at
21 it on the basis of staffed or available beds. The
22 statewide average would then climb to 77 percent and
23 both the Hudson Valley and the West would lag behind
24 at 67 and 68 percent, respectively.

25 (Slide.)

1 The regions also differ in the fiscal
2 condition of their hospitals. These are the results
3 of a HANYS analysis that examines the operating
4 margins of hospitals.

5 The Western region, as defined by HANYS,
6 exactly matches how the Commission defines the
7 region. What they call the Northern Metropolitan
8 region is an extremely close match to how we define
9 the Hudson Valley region.

10 You can see that the picture is really
11 not particularly pretty anywhere. Statewide, as
12 well as in both regions, the average operating
13 margins are in negative territory.

14 (Slide.)

15 Lastly, looking back over the past
16 decade, the Hudson Valley has had a number of
17 hospitals close. Most recently there was New York
18 United in 2005 as well as St. Agnes in 2003.

19 (Slide.)

20 There have also been four closures in the
21 Western region. Most recently, in 2001, Olean
22 Hospital consolidated what had been two campuses
23 into one -- there is still an Olean General
24 Hospital, but it's one campus, not two. Olean did
25 not go away completely, and then there were three

1 other closures that occurred in the late 1990s.

2 (Slide.)

3 I am going to turn to long-term care.

4 In the Hudson Valley, there are 95
5 licensed nursing homes with 15,000 beds. Nursing
6 home occupancy is relatively low in the Hudson
7 Valley, averaging 91.5 percent, although there is a
8 huge variation across facilities from a high of over
9 99 percent to a low of 47 percent. So, again,
10 averages are important but don't tell us the whole
11 story.

12 Among current nursing home residents in
13 the Hudson Valley almost 2,000 of them are
14 classified as low acuity residents, meaning that
15 they are scored as either a PA or a PB.

16 (Slide.)

17 The Western region has 85 nursing homes
18 with 12,000 beds. Occupancy is higher in this
19 region, it's almost 95 percent, and here, too,
20 occupancy varies widely across the individual
21 facilities, and there are about 1,600 low acuity
22 residents currently in Western nursing homes.

23 (Slide.)

24 This slide, just like the hospitals,
25 shows the nursing homes by county. They, too, as

1 you would expect, cluster where most of the people
2 and the hospitals are; they tend to form sort of
3 organic ecosystem systems with the hospitals, so
4 that almost half of them are located in the
5 population centers of Westchester county and Erie
6 county.

7 (Slide.)

8 Looking beyond nursing homes, this slide
9 depicts the supply of non-institutional long-term
10 care resources in each region. Those types of
11 resources would include adult day health care slots,
12 long-term home health slots, managed long-term care,
13 and other types of supportive housing units.

14 The red bar shows the New York State
15 average supply per capita among adults ages 65 and
16 older. In comparison, both the Hudson Valley and
17 the Western regions have less well developed
18 supplies of such resources available to their
19 elderly residents.

20 So, there are gaps and challenges in both
21 regions to developing alternative placements to
22 nursing homes.

23 (Slide.)

24 Finally, this is a very quick summary of
25 nursing home closures in recent years. The Hudson

1 Valley has had only three, as shown on this slide --

2 (Slide.)

3 -- while the West has had many more --
4 it is actually going to take me two slides to show
5 you all of them -- there have been ten to be exact,
6 as shown on both this slide as well as this one.

7 So, at this point, I would be happy to
8 answer any questions or to defer to our regional
9 members who can offer us additional insights and
10 understanding of these two regions.

11 Thank you very much.

12 CHAIRMAN BERGER: Are there any
13 questions?

14 Yes?

15 MR. BRIDEAU: My question is to whether
16 we have any insights as to why there are so many
17 more nursing home closures in the Western region
18 than the Hudson Valley?

19 DR. SANDMAN: I don't know if I can tell
20 you why. I would ask some of the Western folks, but
21 you may or may not be able to make the link that
22 given that they are more closures in the West, the
23 nursing homes that are there now do enjoy a
24 substantially higher occupancy rate than those of
25 the Hudson Valley.

1 CHAIRMAN BERGER: Are there any other
2 comments?

3 BISHOP SULLIVAN: I was just wondering
4 why there were a smaller number of non-institutional
5 services in both Western and in Hudson Valley?

6 DR. SANDMAN: That is a pattern that is
7 generally true upstate as opposed to downstate. New
8 York City enjoys a relatively good supply of those
9 types of services in part due to the density of the
10 city, which makes the economics of those types of
11 services such as home care more viable.

12 That is not to say that home care isn't
13 possible in rural areas, I mean, there are many,
14 many quality --

15 BISHOP SULLIVAN: But distance and
16 transportation --

17 DR. SANDMAN: Transportation is a factor.
18 Workforce issues, as well, can be a major constraint
19 in some regions to having those types of services
20 available.

21 MR. VELEZ: David, as you began to focus
22 on the data for the voluntary action that has been
23 taken by some of the hospitals in the systems, do
24 you see any implications in the Hudson Valley for
25 the reduction of beds, taking into consideration

1 that five or six hospitals have already closed?

2 DR. SANDMAN: Well, among the voluntary
3 proposals they do span, I believe, across every
4 region now, from -- we have some from each of the
5 six regions.

6 CHAIRMAN BERGER: I think that we will
7 take -- obviously, as we are working with the
8 voluntaries, we are looking at the total picture. I
9 think it would be inappropriate at this point to
10 talk about that in public settings since we are
11 dealing with specific hospitals, and the last thing
12 we want to do is have people start guessing as to
13 what's happening because that would be terrible for
14 hospitals in the system.

15 MR. SEARS: I have one observation in
16 answer to Leo's question about the disproportionate
17 closure of facilities in the Western region.

18 I think the operators in the Western
19 region would answer by saying that the methodology
20 of reimbursement for Medicaid patients is based on a
21 1983 base year, which unfairly disadvantages Western
22 New York because at that point in time the economy
23 was even worse than it is now, relatively speaking.
24 It was just beginning to, sort of, change from a
25 pure goods-based economy to a more service-based

1 economy. Wages were at rock-bottom lows, et cetera.

2 So, they feel they are somewhat
3 disadvantaged as compared to other regions of the
4 state as we just trend that agency's base year
5 forward.

6 CHAIRMAN BERGER: Okay.

7 Sister?

8 SISTER SCHIMSCHEINER: Also, if you take
9 a look, St. Luke's Manor and St. Clare Manor were
10 very small nursing homes, very inefficient, not
11 in -- they were not in compliance, and the Catholic
12 Health System closed those. Also, Mt. Saint Mary's
13 Long-Term Care Facility closed and a brand new
14 nursing home was also closed. So, I can speak for
15 the Catholic Health System.

16 CHAIRMAN BERGER: Thank you, Sister
17 Schimscheiner.

18 Are there any other comments?

19 BISHOP SULLIVAN: Just one.

20 CHAIRMAN BERGER: Yes, sir.

21 BISHOP SULLIVAN: The low acuity, is that
22 disproportionate to some of the other regions?

23 DR. SANDMAN: I don't believe -- well, I
24 think the number of low-acuity residents in those
25 regions relative to how many nursing home residents

1 they have is pretty consistent, but I am kind of
2 going from memory. Let me get back to you about
3 that.

4 CHAIRMAN BERGER: We'll lay it out --
5 actually we'll ultimately have a chart which deals
6 with that as we look through all the regions.

7 Okay, thank you, David.

8 That's the baseline and that's some of
9 the basic information about the two regions.

10 Let me just remind everybody about the
11 future meeting schedule that we agreed upon at the
12 last session. The next meeting will be July 20th,
13 here, then August 10th and September 14th -- next
14 three meetings.

15 MR. ROBERTS: All here?

16 CHAIRMAN BERGER: All here, yes. We sort
17 of had an interesting vote last time, and I think
18 the end of it was that transportation, in the end,
19 makes it better here.

20 MS. KERR: September 14th?

21 CHAIRMAN BERGER: September 14th, yes.

22 Are there any other questions, pieces of
23 business?

24 Mr. Kissinger?

25 MR. KISSINGER: Chairman Berger, I move

1 that we end our executive session to address in
2 detail the medical, financial and credit histories
3 of typical general hospitals and nursing homes in
4 the Western and Hudson Valley regions.

5 CHAIRMAN BERGER: Is there a second?

6 MEMBERS: Second.

7 CHAIRMAN BERGER: Any objection?

8 Thank you very much. This meeting is
9 adjourned.

10 (Time Noted: 10:30 a.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 a Notary Public, do hereby certify that the
foregoing is a true and accurate transcription of my
stenographic notes.

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

ELLEN SANDLES