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Transcript Meeting
of the
Commission on Health Care
Facilities in the 21st Century

Held on Friday, September 15, 2006
NY Marriott Hotel
525 Lexington Avenue, Stuyvesant Room
Borough of Manhattan

1 Meeting convened at 10:05 a.m.

2

3 P R E S E N T:

4

5 Statewide Members

6 STEPHEN BERGER, Chairman

7 CRAIG A. DUNCAN

8 MARK KISSINGER

9 ROBERT R. HINCKLEY

10 HOWARD T. HOWLETT

11 DARLENE D. KERR

12 RUBEN JOSE KING-SHAW

13 LEO BRIDEAU

14 PETE VELEZ

15 TERESA SANTIAGO

16 BISHOP JOSEPH SULLIVAN

17 PATRICK LEE

18 DR. ALBERT SIMONE

19

20 Commission/DOH Staff

21 DR. DAVID SANDMAN

22 MARK USTIN, ESQ.

23 DENNIS WHALEN

24

25

1 CHAIRMAN BERGER: I have stretched the
2 limits of my ability to waive my basic rules as
3 far as I can. This meeting is called to order.
4 We are going to begin. I am going to ask David
5 Sandman, the executive director, to give us his
6 progress report.

7 DR. SANDMAN: Thank you, Mr. Chairman,
8 and good morning. As we met just three weeks ago,
9 I'll make this a briefer report of activities than
10 I have previously reported. Numerous applications
11 have been received under the Commission's
12 Voluntary Rightsizing Procedures.

13 These come from providers wishing to
14 engage in voluntary talks involving various types
15 of consolidations and collaboration. Staffs of
16 the Commission and the Department of Health do
17 continue to actively supervise and guide those
18 talks throughout the regions of the State, and
19 will continue to do so.

20 Commission staff and RACs also continue
21 to engage in discussions with providers and other
22 stakeholders. Just since our last meeting alone,
23 staff has met with approximately 20 more providers
24 across the state. And at this point we have
25 virtually no nonresponders left in the state,

1 among providers we have reached out to.

2 As always, we remain engaged in active
3 outreach and communications programs with various
4 constituencies. Recent meetings have included the
5 archdiocese of New York, New York City Council,
6 Niagara Health Quality Coalition, the Fire
7 Department of New York, a Coalition of
8 Reproductive Rights Organizations and staff from
9 the state assembly.

10 So in summary, Mr. Chairman, we are
11 making good progress and remain on schedule with
12 our work plan. Thank you.

13 CHAIRMAN BERGER: Thank you, David.
14 Today we are going to begin a discussion on issues
15 relating to reimbursement. While redesigning the
16 reimbursement system is not part of our mandate,
17 as we continue to look at options of restructuring
18 and improving and making an institutional health
19 delivery system both more cost efficient and
20 improving the quality of care, it is clear that
21 ultimately there has to be a change in
22 reimbursement philosophy, strategy and dollar
23 allocation if we want to encourage changes in the
24 patterns of delivery of care.

25 I know when I say this, everyone says

1 "of course," but the next part of it is, the devil
2 will be in the details. And our discussions and
3 the recommendations and guidance we might choose
4 to make will hopefully become a starting point for
5 those who follow us, hopefully, in the near
6 future.

7 I want to put this discussion in
8 context. This commission emerged from the
9 recommendations of the health care reform working
10 group that the Governor established in 2003. One
11 of the reasons for the creation of the working
12 group was the continuous out of control spiraling
13 of both Medicaid and health care expenses.

14 The cost escalation was crippling the
15 ability of state and local governments to invest
16 in the broad range of public services needed to
17 improve the overall quality of life of people.

18 And there was no evidence that spending
19 levels in New York, dramatically higher than in
20 other similar jurisdictions, were achieving better
21 health care. This commission was established to
22 look at part of the working group's
23 recommendations on restructuring and rightsizing
24 the institutionals in the state.

25 Obviously, our efforts and the criteria

1 established, take into account the public good,
2 safety and responsibility of the hospital,
3 improving the quality of care and driving towards
4 centers of excellence.

5 But, ultimately, the state will have to
6 address the rate paradigm, where reimbursement
7 rates are higher for services such as cardiac and
8 vascular surgery and are much more generous than
9 reimbursement for safety net services, emergency
10 services, births, preventative care.

11 Since the people who manage the health
12 care institutions are naturally driven to ensure
13 the survival of their institutions, they are
14 forced to chase the high margin services, whether
15 or not they are truly necessary in their
16 communities.

17 When we look at improving health care
18 what you would make as a recommendation, for
19 example, that a hospital or a community was not in
20 need of a hospital, per se, but what the community
21 needed might be an outpatient clinic or an urgent
22 care facility. While the transitional funding
23 arrangement could be constructed under present
24 reimbursement patterns, the new facility could not
25 be guaranteed long term feasibility.

1 It would be easy to fix this problem by
2 adding more dollars for reimbursement levels of
3 certain services, but the economic reality is that
4 it is not affordable. The long term strategy for
5 moving towards a more efficient and effective
6 health care system has to be based, not only on
7 our recommendations for restructuring, but on a
8 reimbursement strategy that allocates dollars from
9 some services to other services; a taking as well
10 as a giving. That truly reflects public good and
11 public needs.

12 We have to begin that discussion.
13 Dollars have to be freed up and reallocated for
14 reinvestment. Reinvestment, not just for
15 technology, which is what most people believe --
16 where other than a few institutions and perhaps
17 the VA, we are decades behind other industries in
18 the health care arena -- but reinvestment that
19 allows changes to the delivery system that
20 encourages a great deal of what we've heard about
21 during our hearings: Preventative care, primary
22 care and special need services that the state
23 needs.

24 There are not going to be any easy or
25 simple or painless choices. And ultimately, this

1 is going to require the same level of effort
2 subsequent to us, that we put in on the
3 restructuring. But I think what we're going to do
4 today is at least begin to lay out a framework
5 hopefully for that discussion, which can be
6 carried on by those who follow.

7 And I'm going to ask David to begin to
8 lead us through a reimbursement discussion.

9 DR. SANDMAN: Thank you. As our
10 Chairman has noted, the Commission's core mandate
11 to restructure the institutional delivery system
12 does not exist in a vacuum. And, to a large
13 extent, we do get what we pay for.

14 It would be difficult to talk about
15 reforming the health care system without also
16 reforming reimbursement patterns and changing the
17 fiscal incentives.

18 Members of this Commission and members
19 of RACs and numerous speakers at our public
20 hearings have all noted the ways in which
21 financial incentives affect both the supply and
22 demand and the location of health care services.

23 The Commission's enabling statute
24 specifically provides for the Commission to make
25 non-binding recommendations with respect to

1 reimbursements and other broad systemic issues.
2 In doing so, the Commission has an opportunity to
3 establish a blueprint for ongoing discussion and
4 reform.

5 Most of what we'll discuss today
6 reflects themes and issues that have been raised
7 during the public hearings, as well as in numerous
8 private sessions with providers, consumers,
9 organized labor and other stakeholders.

10 And part one will focus on
11 reimbursement issues, in particular Medicaid.
12 Reimbursement is a particularly complex subject.
13 My comments are meant to be a springboard for
14 discussion among our members. I will identify the
15 major issues, and also lay out some potential
16 options to address those issues.

17 And then, if time allows, part two will
18 focus on additional systemic reforms beyond
19 reimbursement. And these will include primary
20 care, work force development, alternative delivery
21 models, as well as information technology.

22 Here in New York State, acute care
23 reimbursement is generally governed by the Health
24 Care Reform Act of 1996 and its subsequent
25 extensions. HCRA aimed to create a market-based,

1 competitive system by deregulating inpatient rates
2 for commercial payers.

3 For the first time, hospitals were
4 required to negotiate with private payers and the
5 managed care plans. And this was a major
6 departure for New York, which previously had a
7 fully regulated system, in which all rates were
8 state-set.

9 Because of the concern about how this
10 new, partially deregulated system would affect
11 various "public goods," HCRA also established
12 pools of supplemental funds for things like bad
13 debt and charity care and graduate medical
14 education.

15 It is important to note that HCRA
16 deregulated only the commercial component of the
17 reimbursement system. The federal government
18 continues to set Medicare inpatient rates.
19 Similarly, New York State continues to set
20 Medicaid fee-for-service rates, although these
21 cover progressively fewer Medicaid beneficiaries,
22 due to the phased implementation of mandatory
23 Medicaid managed care.

24 It would be really tough to overstate
25 the significance of Medicaid. New York State's

1 Medicaid program is the most expensive in the
2 nation, costing approximately \$45 billion a year.

3 Across the nation, our Medicaid program
4 spends the most per recipient, the most per
5 capita, and the most as a percentage of gross
6 state product.

7 State payments for Medicaid, separate
8 from those of the federal or county government,
9 comprise more than 25 percent of all state
10 spending. It is also a huge cost for county
11 governments. In Monroe County, for example, or in
12 Rochester, Medicaid spending accounted for \$831
13 million in 2004, which is more than the total
14 Medicaid spending in eight other states. One
15 county in New York State spends more than other
16 states combined.

17 Given the magnitude of Medicaid, direct
18 state action would be an important first step to
19 reforming the reimbursement system in New York.
20 Medicaid policy has enormous potential to
21 influence the actions of private and federal
22 payers. And at the same time, we should remain
23 cognizant that Medicaid is one payer among many.
24 Its importance and influence varies by individual
25 hospitals and by community, some of which are more

1 or less dependent on Medicaid for their revenues.

2 Discussion about reforming payment for
3 Medicaid and public goods has generally coalesced
4 around the following principal issues:

5 Inpatient rates, what has been called
6 the "rate paradigm," obstetric rates, emergency
7 service rates, and outpatient rates. I am going
8 to address each of these in turn, but stop along
9 the way for discussion among our members, and make
10 this a more sort of digestible and interactive
11 type of discussion.

12 So let me begin by summarizing some of
13 the current methods used to determine Medicaid
14 Fee-for-Service inpatient rates. Every hospital
15 has a base rate per discharge that was originally
16 developed using that hospital's 1981 costs.

17 These base rates have been continually
18 updated with trend factors for inflation, with
19 enhancements to cover unanticipated costs over and
20 above that trend factor, and through various rate
21 appeals.

22 So the hospital base rate for discharge
23 is increased or decreased to account for the fact
24 that different kinds of cases consume different
25 levels of resources. That adjustment is done by

1 assigning each case or each patient to one of many
2 Diagnosis Related Groups, what we call DRGs, each
3 of which then has a "service intensity weight" or
4 an SIW; it's kind of the alphabet soup part of
5 reimbursement. And those SIWs recognize the
6 typical resource consumption of that group of
7 cases.

8 And, in general, service intensity
9 rates are higher for surgical and interventional
10 cases than they are for, of course,
11 straightforward medical cases.

12 So a hospital's final Medicaid
13 reimbursement rate for discharge essentially
14 equals its base rate multiplied by the service
15 intensity rate of the DRG for that specific case.
16 The principal issue for inpatient reimbursement is
17 not the adequacy of payment, even though this
18 method that I very quickly summarized for turning
19 out the rates is actually enormously complex, the
20 rates that emerged are generally considered
21 adequate overall, in the sense that they do cover
22 the aggregate costs of providing inpatient care,
23 even though particular services may be somewhat
24 over or under-reimbursed.

25 The principal issues of concern for

1 inpatient rates instead of the adequacy are as
2 follows: Obviously, the cost base year is 1981.
3 Over time changes in the practice of medicine and
4 the use of technology have increased some hospital
5 costs and decreased others. And those changes may
6 not have been addressed completely enough through
7 the annual adjustments.

8 And while that's a factor of some
9 concern, obviously 1981 was a long time ago, the
10 major focus of reform attention has actually been
11 on service intensity weights. Indeed these were
12 last calculated in 1992, also a pretty long time
13 ago.

14 Changes in the practice of medicine
15 since that time have not been reflected in the
16 weights. So for some DRGs, lengths of stay per
17 case have changed.

18 It's been suggested, for example, that
19 open heart surgery cases may be reimbursed at a
20 higher rate than their costs today would justify,
21 generally patients' stay -- are much more likely
22 to stay for that type of procedure than they would
23 have many years ago, because, of course, our
24 medicine has advanced.

25 But, conversely, other types of cases

1 that involve new and expensive and implantable
2 devices, are grouped into DRGs that may not be
3 weighted heavily enough to capture these new
4 costs. So we have an imbalance in both
5 directions.

6 Next, we confront what the Working
7 Group labeled the "rate paradigm." And this
8 paradigm, as you reminded us, disproportionately
9 rewards high tech and tertiary services, and it
10 disadvantages baseline community hospital
11 services, like obstetrics, medicine, pediatrics
12 and psychiatry.

13 In order to subsidize the lower paying
14 services, institutions, being rational most of the
15 time, will follow the money. They are driven to
16 compete for high margin tertiary and
17 interventional services leading to expensive
18 duplication of investment and a medical arms race.

19 So those are the main issues within
20 patient rates, but there are various options to
21 address them, which are not mutually exclusive
22 options.

23 The first option would be to
24 recalculate the service intensity weights to more
25 accurately reflect today's costs. In theory, this

1 may allow funds to be shifted from services that
2 are paid too highly to those that are paid too
3 little. And furthermore, a new system could build
4 in the same margin on all services, thereby
5 reducing the incentive to compete for tertiary
6 care business and providing a stable and fair
7 level of support for community hospital services.

8 This type of initiative is already
9 somewhat under way, and the Department of Health
10 is looking at the potential impact of an SIW
11 reweighting. And, incidentally, as many of you
12 probably know, the federal government is also
13 moving in this same general direction, in terms of
14 how they formulate Medicaid reimbursement rates.

15 The impact of such change on an
16 individual institution and on the rate paradigm is
17 not yet known. For individual hospitals, the
18 impact could be substantial. It is reasonable to
19 assume that there would be both winners and losers
20 during SIW reweighting, based on what their
21 current services look like.

22 A change in weight could dramatically
23 change revenue in an individual hospital, and
24 given the unknowns in this initiative, a change in
25 payment based on the reweighting could be phased

1 in gradually, to avoid unnecessary harm and undue
2 disruption to the financial position of the
3 individual institutions.

4 A second approach would more explicitly
5 recognize and support safety net providers and
6 services. Even if the reweighting was successful,
7 it may not entirely solve the rate paradigm
8 problem or meet the needs of all providers. It
9 would if the world were so simple. It would be
10 great, but I am not sure it is.

11 There are essential services that
12 hospitals provide that are, by their nature, very
13 expensive: Emergency services, trauma services,
14 burn care, emergency preparedness and the list
15 goes on.

16 Others, like obstetrics, are expensive
17 because of the disproportionate burden associated
18 with malpractice costs. And there is a subset of
19 hospitals that may always have structural
20 financial problems because of their mix of
21 patients, payers and services.

22 Mechanisms could be devised to insure
23 support for these essential providers and
24 services. One alternative that has been suggested
25 would create an additional adjustment in the rates

1 to provide for greater payment for community and
2 public good services.

3 Prior to HCRA, we did have such an
4 approach in the reimbursement system, so there is
5 a precedent for doing. So with that,
6 Mr. Chairman, I think this might be a great place
7 to open up for discussion and comments.

8 CHAIRMAN BERGER: If we have not
9 confused everybody.

10 MR. KING-SHAW: Could you touch briefly
11 on the state's disproportionate sharing and the
12 government programs that have affected
13 reimbursements? I think this would be a nice
14 inclusion in the rate discussion.

15 MR. WHALEN: (Inaudible.)

16 CHAIRMAN BERGER: Dennis, you can't do
17 that. You have to come up here. This is the
18 classic moment where the person we need is Dennis
19 Whalen, the Deputy Commissioner.

20 MR. WHALEN: What I think we should do
21 on that is provide some information. But this is
22 very much a moving target. Particularly as
23 federal policy is changing in these areas, and
24 folks will have noticed if they are following the
25 press, hearings by Mr. Grassley on various related

1 topics, and federal concern about these particular
2 mechanisms of DSH, our disproportionate share and
3 IGT, intergovernmental transfers, you know,
4 representing inappropriate churning by states or
5 methods to capture the federal dollars
6 inappropriately.

7 It has led to, in New York, an ongoing
8 discussion with the federal government over
9 approval of our state planning, which now, I
10 think, are not unique to New York; but in every
11 state you get a series of questions attached to
12 them asking detailed information about how IGT and
13 DSH works.

14 So my suggestion on this is that we
15 could provide a short paper with some bullets that
16 provide the context for both of those situations,
17 but we have a number of hospitals in the state
18 that are at the DSH cap and that create these
19 financial issues where we can't go above certain
20 levels.

21 So if they are in some of those
22 situations that you talked about on your last
23 point, that is a challenge.

24 DR. SIMONE: This is just a general
25 comment. We are trying to reduce costs, so we

1 describe the models. The first thing is, is it
2 the right model, can you change the model? If
3 it's the right model, you can point out that it's
4 not calibrated properly, so if it is out of date,
5 it's been through changes.

6 So, I guess the emphasis here is on
7 calibrating the existing model. The last
8 suggestion was made in adjusting the model. So
9 are we doing both or are we focusing on one or the
10 other?

11 DR. SANDMAN: They are not necessarily
12 mutually exclusive. The first option, essentially
13 a reallocation of existing services. So if we are
14 overpaying for certain services and underpaying
15 for services, we are trying to address that
16 imbalance and bring the margins for the lower-end
17 services and the margins for the higher-end
18 services to be more alike.

19 DR. SIMONE: Recalibration would do
20 that?

21 DR. SANDMAN: We would hope. In
22 theory, the answer would be "yes." But it is an
23 untested proposition at this point, that would
24 require modeling before implementation.

25 CHAIRMAN BERGER: I think my answer is,

1 I don't know. To be very honest, I don't know at
2 this point. And I think that we as a group
3 wouldn't necessarily have the ability to know
4 this, based on the work that we have done, because
5 we really haven't done the work in this area.

6 My hope was that we send a guidance
7 message for the work, because there has to be
8 follow-up work to the Commission. And by laying
9 out some of these pieces that we already looked
10 at, we can create sort of the first step of a road
11 map for those who are looking at reimbursement
12 issues and can tackle some of these issues.

13 We have heard some very interesting
14 testimony from many different kinds of groups.
15 Now, admittedly, nobody said, "Take away some of
16 our money for other services." All right. We
17 understand that. Nobody bellied up to the bar and
18 offered to buy drinks for everybody in the saloon.

19 On the other hand, what we heard across
20 the board is that there has to be -- there are
21 services which are not receiving the support
22 payment. And across -- and Leo made the point to
23 me beforehand -- and across the total range of
24 spending, that is the total range of what we're
25 spending, we have spent \$45 million a year -- that

1 there has to be a serious effort that goes beyond
2 what we are doing. In fact, that helps implement
3 what we were hoping to recommend, which is the
4 process by which we take apart and rebuild the
5 reimbursement approach, recognizing what I said,
6 what David said, what lots of people said, that we
7 have tapped out -- you know, the taxpayers in this
8 state are really tapped out, and we have got to
9 reach a point where we are working off the total
10 health care spending that we already -- we got to
11 find a better way of doing.

12 And whether you calibrate or change the
13 model, whether you make some hard decisions about
14 determining what we'll fund and not fund, we are
15 trying to put on the table of the Commission that
16 this is the next stage of this discussion.

17 And the state can take the lead, and,
18 frankly, they will have Medicare coming in behind
19 them on this. And I think ultimately we'll bring
20 all private insurers into the same ballpark,
21 because you have got Medicare and Medicaid
22 involved, you have enough where I think you can
23 get the whole system to focus on reallocating
24 dollars to the priorities.

25 MR. VELEZ: The issue of inadequate

1 reimbursement has been in the agenda for as long
2 as I can remember. I am not quite sure how we can
3 begin to define what the paradigm shift is going
4 to be, unless, you know, because that problem --

5 (Inaudible, background noise.)

6 CHAIRMAN BERGER: You have a very
7 powerful, energetic, full of energy persona.

8 (Laughter.)

9 MR. VELEZ: -- unless you begin to
10 define specific principals, are going to hopefully
11 recommend some kind of guide, a new strategy to
12 re-evaluate taking in the patients who have not
13 moved forward.

14 I think -- it begins to identify those
15 two elements. My concern is, how do we get the
16 people who are going to make the difference begin
17 to focus on what the priorities should be?

18 You know, we know that in the last
19 decade or something, chronic diseases have become
20 a major epidemic, depending on what chronic
21 diseases you talk about. We know that the
22 inability of the system to be able to manage those
23 conditions effectively, continues to escalate the
24 cost of health care.

25 So if you're able to define specific

1 priorities that would achieve several -- one,
2 hopefully, to improve, you know, a better outcome,
3 maybe a reallocating of resources. And
4 substantiate that in the long run, maybe not
5 immediately, but in the long run, we can benefit
6 financially from making those decisions. I am not
7 quite sure.

8 We can speculate, you know, what is in
9 the system, and who is responsible for moving the
10 agenda forward, and who is protecting the current
11 agenda, and why that current agenda is being
12 protected.

13 And I think you highlighted some issues
14 earlier, Stephen, is that parochial interests is
15 able to hold on, you know, to what is past,
16 because financially 50 other agencies or 50 other
17 institutions continue to provide, you know,
18 tertiary care services, even though they are
19 somewhat duplicative; I think that other
20 facilities may be doing the same thing.

21 But I think we have to begin -- and I
22 am glad we began the discussion. You know, what
23 is the true meaning of health care? How do we
24 change health care for the 21st Century? What is
25 it that we want to achieve in the process?

1 Maybe through these discussions, we may
2 be able to evolve, and can recognize it for future
3 consideration.

4 MR. BRIDEAU: First of all, I want to
5 comment to David for really a superb paper on a
6 very complicated topic. This was very, very
7 helpful. As you read it, you can't help but be
8 impressed by the complexity of the financing
9 system for Medicaid, for acute care, for long-term
10 care, for primary care.

11 And as you look across the state, as
12 we've done, you also can't help but be impressed
13 at the fragility of the acute care system, long
14 term care system and the primary care system for
15 the care of the poor in particular.

16 And the issue, the concern that I have
17 is, while I think it is appropriate for us to
18 offer a broad guidance on this very, very complex
19 topic, it is really easy to propose changes the
20 past intended not to process without really
21 getting underneath this and understanding it as
22 deeply as it needs to be understood.

23 That is not a plea for the status quo,
24 and I don't believe the status quo is tenable over
25 the long term. I think one of the messages that I

1 hope this Commission sends, is that it's not
2 tenable over the long term. The amount of money
3 that New York spends on Medicaid is very
4 impressive.

5 The question of why are we spending so
6 much, is it going to the right places, are we
7 promising too much on the investors side, for
8 example?

9 The kinds of tough questions that
10 nobody likes to deal with that I think, given that
11 we don't have to deal with it, we should encourage
12 others to deal with it. But I do think that we do
13 need a statement around a need to address this, in
14 the context of our work.

15 MR. DUNCAN: You make the Medicaid
16 reimbursement system almost rational. Thank you.
17 It is fascinating to me that 1981 is a quarter of
18 a century ago. It's a little bit of a different
19 world.

20 Steve, one of the things that's
21 interesting to me, and I'm not quite sure how to
22 articulate this; we are looking at the hospitals
23 by region, coming from the collage, if you will,
24 of services and reimbursements, private pay,
25 Medicaid and Medicare. And we are concerned about

1 the public good of the hospital.

2 And one of the things that was not
3 commented on is the migration of services that are
4 going from acute care to private physician groups
5 now, which I believe has a dual impact: One is
6 that it does erode viability of these hospitals,
7 particularly when you are looking at the Medicare
8 fixed reimbursement rates.

9 And the other is, in a peculiar way, we
10 are subsidizing through Medicaid, the differences,
11 for the for-profit initiatives, so it is an
12 inappropriate transfer of dollars, if you will.

13 And I just think it is so profound and
14 so large now, and pervasive now that state is
15 telling you that you should not, perhaps, fix with
16 this group, but comment on it.

17 CHAIRMAN BERGER: By the way, in the
18 task force and the working group, we did comment
19 on it. This is a clear part of what is happening.
20 And also, part of the reason that I think the
21 comments everybody said, we are going to try and
22 work them into the paper.

23 But, the intensity of what you have to
24 do to really try to grapple with this, I repeat,
25 it is the same intensity that we have. I think we

1 can lay out some guidelines and say these are
2 directional things.

3 But this is going to require a year and
4 a half of work that is totally focused on this.
5 The same way we focused on the institutional
6 structure. Bishop Sullivan.

7 BISHOP SULLIVAN: One of the things I
8 think is interesting about this, even though it is
9 not within our mandate, is that it conceptualizes
10 the issue. Because, to me, we're going to be
11 looking at certain institutions, their very
12 condition in some way. "Is it affected and is it
13 majorly affected by the reimbursement system?"

14 Others are by location, the mix they
15 offer the community, the uninsured that they
16 serve. So I think we have to try to discern what
17 institutions or even the conditions by which the
18 reimbursement has been a major factor in their
19 decline and then their marginality, in terms of,
20 you know, describing discipline.

21 The other thing, it seems to me, that
22 we can't move the imposition, make judgments
23 solely on the fact that, you know, the issue is
24 what condition this institution is in at the
25 present time. Because, it is possible that with

1 the reimbursement change, that institution is not
2 inviable, but is necessary for other reasons,
3 other than the financing.

4 So I think this is helpful to us and
5 contextual to us, the importance, but the relative
6 importance of the decisions we have to make.

7 CHAIRMAN BERGER: I think that is why
8 we thought we had to begin to take it on. I think
9 you are absolutely right. David, do want to take
10 a crack at the next piece?

11 DR. SANDMAN: Sure. Let's talk about
12 one particular element of care : Obstetrics
13 services are obviously very important, but often a
14 money-losing losing service.

15 The method is -- actually, just if I
16 could state, the Medicaid reimbursement for
17 inpatient OB care is the same as the payments that
18 I have described.

19 But in response to increasing
20 malpractice costs, in large part, access to
21 obstetric services is declining in many areas of
22 this state.

23 Increasingly, OB/GYN reports they have
24 stopped or decreased the amounts or nature of
25 obstetrical care they have performed because of

1 the fear of malpractice exposure. Hospitals also
2 report that they have limited or eliminated their
3 obstetrics program.

4 Such decreased access
5 disproportionately affects patients with Medicaid
6 and the uninsured. Due to Medicaid's low
7 reimbursement for physician services and the lack
8 of reimbursement for physician services to the
9 uninsured, OBs in private practice are reluctant
10 to treat Medicaid and uninsured patients who must
11 rely on hospital providers for their care.

12 Some hospitals do fill this gap by
13 hiring obstetricians as employees of the hospital,
14 and also paying their malpractice insurance. But
15 the additional costs that they incur employing OBs
16 are not included in the Medicaid inpatient payment
17 rate.

18 This problem, you know, if we are
19 lucky, might be possibly resolved during the
20 comprehensive reweighting of the DRGs, as we just
21 discussed. But if it's not handled adequately
22 with a reweighting, one option might be the
23 additional cost burden could be reimbursed with a
24 special add-on to the base rate.

25 Under the previous reimbursement

1 system, these kinds of extraordinary costs were
2 typically covered with various add-ons to the
3 overall rate. A special add-on to the rate would
4 help preserve OB services and do so particularly
5 in hospitals with higher mixes of Medicaid and
6 uninsured patients. And it would be a relatively
7 easy thing to calculate and to administer.

8 But, you know, none of these are easy
9 solutions and there are factors that would also
10 argue against this approach. Obviously, special
11 add-ons cost money. And, as our Chairman has
12 said, we are dealing with what we think possibly
13 are the costs, but in reality --

14 It could also be seen as another way to
15 avoid more contentious issues of tort reform.
16 Furthermore, there are other clinical specialties,
17 beyond just OB, that also carry disproportionately
18 high malpractice costs, and these too could then
19 be justifiably reimbursed as some type of special
20 add-on, since you are closing the door to
21 potentially very high expenses.

22 Further, only a portion of the high
23 malpractice costs are linked to service to
24 Medicaid patients; the rest are linked to patients
25 with commercial coverage. So you can basically

1 almost see a version of a free ride or effect,
2 where, in fact, Medicaid ends up shouldering the
3 burden, when other types of payers should also be
4 shouldering that burden.

5 And, last, we could have evolved from
6 this the potential option or comprehensive tort
7 reform at the state level. And tort reform may in
8 fact be the least expensive of all of these
9 approaches, but tort reform, you know, in itself,
10 is beyond the immediate scope of both the work
11 group and the Commission. And I would suggest
12 that that issue would also need to be addressed as
13 part of a more comprehensive policy effort. So,
14 again, back to Mr. Chairman.

15 CHAIRMAN BERGER: Certainly one could
16 argue that, I think, we are stretching beyond the
17 purview of this Commission by talking about tort
18 reform, etcetera. I've got to tell you, of course
19 we are. Of course we are.

20 On the other hand, you know, there are
21 portions of this state where OB/GYN services are
22 hard to get. So I will take the blame, you've got
23 to understand the stretch. And if people don't
24 like it, they will --

25 Discussion on this point? I mean, by

1 the way, David is very careful. The solutions
2 that ultimately we have to come up with, and
3 others will come up with, have to be cost neutral
4 solutions. We have to find a way -- we can't just
5 say "Let's add another high cost piece of this and
6 worry about fixing that later on."

7 We have to do both at this time. When
8 we do these packages, they have to be both at this
9 time.

10 DR. SANDMAN: Let's move on to Medicaid
11 emergency department rates. Medicaid
12 reimbursement rates for hospital emergency
13 services consists of two components, both
14 operating costs and capital costs. Capital is
15 reimbursed on a pass-through basis, without a cap.

16 Until recently, the operating cost
17 component had been capped at \$95 per visit, and
18 that was since 1991. However, the final version
19 of the 2006-07 state budget does for the first
20 time since then, phase in higher reimbursement for
21 emergency services, gradually lifting the \$95
22 visit rate up to \$150 per visit in, say, 2009, for
23 the gradual stepped up increase.

24 The issue here is the adequacy of the
25 rate. Even with the recent agreements to adjust

1 ED rates upward, payment is still often considered
2 inadequate to cover the actual cost of an ED
3 visit, which is estimated to be \$400 on average.

4 A secondary issue is that the Medicaid
5 rate fails to take into account the additional
6 costs incurred by hospitals that are dedicated
7 trauma centers. Trauma centers are governed by
8 strict standards: They stipulate specialist
9 availability 24-7, they stipulate minimum RN
10 ratios, and they stipulate the availability of
11 certain types of specialized equipment.

12 Those hospitals that are not designated
13 trauma centers, do not necessarily incur the same
14 costs. Nevertheless, Medicaid pays the same per
15 visit rate to designated trauma centers as opposed
16 to those hospitals that do not have such
17 designations.

18 Once again, the most direct and obvious
19 approach would be to continue to raise ED rates,
20 as I saw in this year's budget. And while this
21 could obviously help, it's just as obvious that
22 the impact of this increase on the state budget
23 could be quite substantial additional spending, of
24 course raising the broader questions about what
25 portion of New York State revenues should be

1 dedicated to health care as opposed to other
2 important public goods.

3 Raising the rates is just not always
4 simple and not necessarily the right answer.

5 Another way to reform the ED payment
6 system would be basically to follow Medicare's
7 leads of implementing a system of tiered payments
8 for low, medium and high intensity cases, with
9 ancillary costs being billed separately.

10 The advantage would be that we have a
11 uniform payment method and the level of payment
12 would be calibrated to reflect the intensity of
13 care as actually provided. You know, a child with
14 sniffles who doesn't have appropriate access and
15 goes to the ED is far less intensive than a
16 gunshot.

17 The disadvantage from the provider's
18 perspective is that tiered rates are more complex
19 to administer, although I will go out on a limb,
20 they do very good for Medicare. There is also
21 concern among them that payers might use enhanced
22 utilization reviews in order to minimize their
23 payments for those services.

24 And, from the state perspective, just
25 as in the "raise the rates" option, there is a

1 question of what the total overall budgetary
2 impact of this change would be.

3 On the trauma rate issue, there are
4 precedents from other states. Other states have
5 established separate reimbursement rates for their
6 trauma centers, but, again, that raises total
7 spending. So, generally, you know, solutions
8 don't tend to come cheap.

9 What I think we can all agree on, is
10 that the very best option of all would be to
11 reduce inappropriate utilization of hospital
12 emergency rooms, which are, of course, one of the
13 most expensive venues in which to receive
14 treatment.

15 Doing so would have myriad benefits.
16 It would improve patient care, and clearly public
17 health, and it would also generate savings to the
18 health care system. It had been hoped that New
19 York's Medicaid Managed Care program would succeed
20 in reducing inappropriate utilization by providing
21 all of its enrollees with a primary care home.

22 And, unfortunately, there really are
23 several bullets in this light; this has not worked
24 as planned, and ED utilization does continue to
25 increase in New York State, as it does nationally.

1 But there are hopeful sides, a number of
2 strategies have been successfully employed to
3 reduce inappropriate utilization. New York State
4 could clearly study these programs, learn from
5 them and attempt to replicate the more successful
6 ones on a demonstration basis. So I'll turn it
7 back to you again, Mr. Chairman.

8 CHAIRMAN BERGER: Any comments?

9 DR. SIMONE: This is a general comment.
10 A friendly clarification comment. You are
11 bringing up issues that are not directly on line,
12 as you pointed out, with our charge, and the
13 charge was, I guess, to determine the optimal
14 capacity configuration for a health care facility.

15 And then what you are pointing out
16 though is that there are these other issues that
17 are clearly an action of correlation with the
18 charge. So it's going down a line.

19 It seems that we really have to make a
20 clear-cut case that these are connected. We said
21 it, but maybe we need to establish it firmly. And
22 if we do, then it is proper, then the second
23 question is, how can we complete our charge if we
24 are saying that the answer to the optimal
25 configuration depends on these things, but we

1 don't know what the resolution of these things are
2 yet, because they are so complex?

3 So how are we going to focus? You can
4 say, "Well, we didn't complete the charge in
5 trying to solve all of the issues appropriately."

6 DR. SANDMAN: I prefer to go back to
7 our enabling statute, which is really provided to
8 give sort of general instructions to us. There is
9 a "shall do" section or "must do," which is do the
10 institutional facility specific work, that of
11 course we have been largely engaged in, and where
12 our specific authority is granted to the
13 Commission.

14 In recognition of the interrelatedness
15 of the issue, our enabling statute does in fact
16 give us a major section -- and specifically gives
17 permission, the latitude to address, on an
18 advisory basis, more systemic issues, such as
19 reimbursement.

20 That's my analogy, but I think it works
21 so well, that someone said to me, "You know, when
22 you give the facility specific stuff, you are
23 addressing the symptoms of very a sick and
24 troubled system, and you absolutely must address
25 the symptoms. Actually you will start from,

1 there, but you don't want to stop there. You also
2 want to then address the root causes in the system
3 that made those institutions so ill to begin
4 with."

5 So if you think of it as symptoms that
6 cause -- that is a more comprehensive effort to
7 change and improve the delivery system, and will
8 encompass that.

9 DR. SIMONE: If I could, I guess what I
10 am thinking is if we were to recommend, for
11 example, that a particular facility should be
12 downsized or merged or consolidated in a certain
13 way, but we have already established the fact that
14 rates or certain kinds of services are critical to
15 the effectiveness for our system.

16 You know, you are going to cut us in
17 half, you are going to revise us in some way, but
18 it may be when you get the answers to those other
19 things, you know, it was premature or precipitous
20 -- I want to make sure we are on solid ground. We
21 make a recommendation that makes you feel good
22 about it.

23 MR. HINCKLEY: On the same hand, I
24 don't think we can say that the fulfillment of our
25 mission depends on solving reimbursement issues.

1 In fact, I believe that making clear, very
2 thoughtful recommendations on our part, in terms
3 of rightsizing the system -- is it a necessary
4 prerequisite to solve reimbursement down the road?

5 I think if we start that discussion,
6 obviously we will have to leave it to a future
7 group of people to solve the reimbursement issue,
8 that will support what we recommend.

9 DR. SIMONE: That is an interesting
10 point. The causes and effect will solve both
11 points.

12 MR. KING-SHAW: Two quick points. The
13 first is, it is way too cold in here.

14 CHAIRMAN BERGER: He is sitting there
15 wearing his hat.

16 MR. KING-SHAW: When you have no hair
17 you got to do something.

18 (Laughter.)

19 MR. KING-SHAW: And a more serious
20 point would be that, for me this information is
21 extremely valuable. As we go through the profiles
22 of the facility, we are looking at, in part, their
23 service mix, and what services they provide. And
24 their payment mix.

25 And so that, if there is a facility

1 which we have to review and analyze, can
2 understand that we are providing, for example,
3 obstetric services in an area, and, largely,
4 financing that through Medicaid reimbursement.
5 That is an important thing for us to understand
6 when we're looking at the health or the prospects
7 or the future of that institution or the root
8 cause of what may be going on in there.

9 So I think if you were to have a long
10 debate on how we're going to reform the
11 reimbursement system for the State of New York,
12 that would be, I think, way outside of our
13 purview.

14 Understanding the trends, position and
15 conditions of the individual profiles for later on
16 today and the rest of the process, I think it is
17 very much relevant.

18 CHAIRMAN BERGER: Thank you. You have
19 to stand up so she can hear you.

20 MR. O'CONNELL: Jack, O'Connell.
21 Emergency room increase, we have been doing a lot
22 of work signing up cases. Have you guys
23 attributed any reason why there's a wide increase
24 and continued increase in emergency room visits?

25 DR. SANDMAN: Well, there are many

1 reasons for it. And one of the more recent
2 national studies that just came out, it is growing
3 across board; it actually says that for many
4 patients it is an affirmative choice. That they
5 know if they go to the ED they probably are going
6 to have to wait, but they will be seen that day.
7 Whereas, oftentimes if they try to see a doctor,
8 if there's a doctor they have, or a facility, they
9 will have to wait two or three weeks for that --

10 CHAIRMAN BERGER: And they will see a
11 doctor --

12 DR. SANDMAN: -- they will get the same
13 day treatment at the emergency room.

14 MR. O'CONNELL: So it's not certainly
15 behavioral modification, in terms of level of
16 service?

17 CHAIRMAN BERGER: It is a rational
18 behavior. There are some clinics throughout the
19 country where they have adopted a managed care,
20 say, model, in which they book two hours a day of
21 no appointments for their client base. So that
22 you know between two and four in the afternoon
23 there are no appointments so you can walk in,
24 they're walk-in time. But that is not done
25 everywhere.

1 DR. SANDMAN: Not everywhere, but there
2 have been similarly, you know, cool things in New
3 York. Like PCP -- the City has been
4 experimenting with a lot, so it's in early stages,
5 but we see some motion in that direction.

6 CHAIRMAN BERGER: Long way to go.
7 Pete, did you have any --

8 MR. VELEZ: As I go through a document
9 -- I was wondering is this leading somewhere?
10 Ultimately, we begin high -- before we consider
11 very serious recommendations, how we are going to
12 realign the system?

13 Certainly we have to pay attention to a
14 lot of issues here. There are, in fact,
15 negatively -- because of a lack of appropriate
16 funds in the program and et cetera -- you know, we
17 started the discussion, we literally reduced
18 dependents in the system or reduce as much as
19 possible the system and created this.

20 So we begin to go back and look at what
21 the position is, and you have discussed a lot of
22 them very eloquently. How do we develop or
23 sustain an appropriate structure of primary care,
24 preventive services to allow us to achieve, you
25 know, greater health outcomes?

1 You know access can become another
2 major, major issue. If we don't provide
3 appropriate access, we will continue to see the
4 over utilization of emergency services.

5 I remember looking back in one of my
6 facilities I was -- we really had some data and
7 looking at emergency service repeat applications
8 and we were able to substantiate that over 85
9 percent of patients that were using our emergency
10 department were for non-emergency services. Why?

11 I think if you don't have immediate
12 access, where are you going to go? Because they
13 want to see a doctor. So how do we begin to
14 redefine the system? You look at those facilities
15 to further enhance accessibility to reduce, you
16 know, disparity in health care, that is creating a
17 major, major problem.

18 So I think, David, I'm not quite sure
19 where this is going to -- sort of working, the
20 process and the direction -- when we are
21 deliberating and making a recommendation about how
22 we want to -- a lot of these elements are taking
23 place.

24 DR. SANDMAN: Let me use that, your
25 excellent point, to make a segue specifically into

1 some of the other system issues that you have
2 already alluded to; namely primary care.

3 We all know that primary care is an
4 essential component of a health care delivery
5 system. Patients and society as a whole derive
6 substantial benefits when patients have regular
7 and continuous access to care in the least
8 intensive, least expensive venue appropriate to
9 the patient's care need.

10 But as, Pete, you know as well as
11 anybody, many patients, such as in low income
12 communities, face difficulties accessing primary
13 care, other than in a hospital, except there are
14 not enough primary care providers in indigent
15 neighborhoods.

16 For example, in nine low-income
17 minority communities in New York City, for
18 example, only 28 primary care physicians with
19 hospital privileges, and they were fully
20 accessible to 1.7 million residents. That is a
21 lot of patients to 28 docs, potentially.

22 A private physician's office may refuse
23 or limit care they provide to Medicaid patients.
24 And government funded clinics may have
25 unacceptably long waiting lists, or may be

1 inconveniently located.

2 So hospitals often fill a crucial need
3 by providing the primary care health patient
4 services, but hospitals, and especially a
5 fragmented ED model are not optimally suited for
6 providing primary care.

7 Primary care reform could include the
8 following elements: Ensuring that all of New
9 Yorkers do have a primary care home. Stemming the
10 erosion of primary care capacity. We need to
11 invest in primary care infrastructure, including
12 investment in facilities and in equipment and
13 information technology. Ensuring adequate
14 financial support to the primary care safety net,
15 and investing in the development of an appropriate
16 work force as well.

17 So you set me up perfectly to do the
18 primary care aspect. So, thanks.

19 If there are no other comments, I
20 will just talk a little bit then about work force.

21 MR. BRIDEAU: I would like to comment
22 on the dialogue. I think the last piece puts it
23 in context. As your walk through acute care,
24 primary care versus base rates and so on, there is
25 no aspect of the health care system we talked

1 about where we say "So we need to invest more in
2 this area."

3 There is none of these areas we say
4 "Now we do that less than this," so that we can
5 shift it over. So we can talk about shifting, but
6 there ain't no great places to shift from, is what
7 we are facing.

8 And if we are heading down the
9 direction that says, "Look, New York State can't
10 afford to spend any more on the Medicaid program,
11 but we need to address these issues."

12 And I think we need to be equally clear
13 that we've got some goals, that need to be
14 achieved; rules, some basic rules. Pete, your
15 comment on making sure that we don't do anything
16 that erodes access to primary care is absolutely
17 critical.

18 Recognizing that every aspect of the
19 system is fragile and that our recommendations can
20 make things worse; we have the ability to do that.

21 And, third, we haven't talked about it
22 yet, but preserving the public good. It's a
23 critically important part -- the free market isn't
24 going to do that. But those are -- there's an
25 obligation of the government to respond to them.

1 So it means that if, in fact, there is
2 going to be some reform, that in addition to
3 dealing with some of the underlying drivers of
4 utilization, because I believe patients do think
5 rationally in seeking care -- where they seek
6 care.

7 That in addition to that we have
8 addressed some of the uncomfortables in the
9 program. And that is, we have to look at the
10 benefits package and recognize that we promised
11 this package that is richer than anybody else in
12 this room has, but we haven't funded it. And so
13 it's an unfunded mandate.

14 Secondly, the Medicaid program was not
15 initially designed to be a long-term care program
16 for the middle class. That's what it's become, at
17 a very, very high expense.

18 Those are topics that are really
19 uncomfortable and nasty to talk about. But I'm
20 uncomfortable with a recommendation that says
21 there is a ground rule that says you don't spend
22 any more money, unless there is a corollary that
23 says that these are very important objectives that
24 have been placed -- but there are parts of this
25 program that nobody is willing to really tackle,

1 but I got you to tackle.

2 CHAIRMAN BERGER: In the task force
3 group, we took those issues on and we think you
4 are right. There are parts of the system today
5 that were never intended to be part of the
6 Medicaid system, but they are.

7 I think we have to talk about revenue,
8 but there is a political consensus spoken as
9 opposed to unspoken that says we have expanded
10 this mandate and are going to continue to front
11 the standard mandate and, therefore, the people of
12 the State of New York are going to spend 25
13 percent of the world dollars or 50 percent or 90
14 percent.

15 If that is political consensus -- I
16 don't believe it is political consensus of the
17 state. I think the other part though, of saying
18 that, yes, we should add here -- but at that point
19 -- I think the part that Bob made, the point that
20 Bob made before, is important of why we are
21 around. One of the things that we believe we will
22 try to do with the system, is that one piece of
23 what we have is too much of some things.

24 We have excess institutions, excess
25 beds and duplications of services. And I think

1 that is part of what we can deal with as well as
2 the second stage of people taking on the
3 rebalancing costs and reimbursement issue.

4 DR. SANDMAN: The other piece I would
5 like to talk about is restructuring through
6 alternate models, actually bringing together a
7 reform mandate and specific recommendations on
8 refinancing issues.

9 Most communities assume that hospitals
10 should provide a broad array of services, but, in
11 fact, some traditional features of the hospital
12 are no longer needed. Benefits could be derived
13 by restructuring health care delivery to provide
14 only the services that a community actually needs.

15 Benefits would include hospital
16 enhanced access to services, less duplication and
17 the amelioration of the economic impact of a
18 potential old hospital closure. This has been one
19 of the most common and frustrating elements
20 identified by Commission and by the RACs in this
21 process.

22 The Commission has identified instances
23 across the state in which the community needs more
24 than an ambulatory care center and less than a
25 full hospital. That is, some combination,

1 typically, of an emergency department, holding
2 beds to backup ED, ambulatory care and often
3 imaging services and perhaps ambulatory surgery.

4 Unfortunately, that tends to be a
5 pretty spectacularly unprofitable combination of
6 services. So that may be the exact combination
7 that each community needs. There really is no
8 financially viable model for that kind of hybrid
9 institution, other than perhaps a critical access
10 hospital, which is a federal designation that
11 really is designed much more for rural areas than
12 suburban or urban settings, and would not apply
13 broadly enough to be useful in all instances.

14 What Steve often has said is, you know,
15 you got, I don't know, a five-story hospital and
16 you really need the first and second floor
17 services they provide, you don't necessarily need
18 floors three, four and five, but you have to have
19 them, because they are cross-subsidizing floors
20 one and two.

21 CHAIRMAN BERGER: Actually, what I said
22 -- he is being nice. What I say is -- and you
23 wouldn't want some of your worst enemies to be
24 upstairs on floors three, four and five, in a
25 major facility.

1 DR. SANDMAN: So this lack of a viable
2 alternative model has led to situations in which
3 whole hospitals must and should be maintained in
4 order to deliver smaller subsets of community
5 services in communities, of which in fact could be
6 provided and probably provided better by a more
7 focused facility.

8 These hospitals have a lot of
9 structural financial challenges, as you know. In
10 response they tend to pursue unnecessary capital
11 investments in order to expand their revenue base
12 and stay alive.

13 It has been suggested that the state
14 investigate alternative models, furthering the
15 work they have done via the licensure of a
16 free-standing emergency room.

17 The models could include a new
18 definition, a different term than a critical
19 access hospital, but something that could foster
20 those kinds of institutions in a rural setting,
21 for example.

22 I thought this was a good place to
23 maybe stop, because it really binds together our
24 facility work with the financing issues with what
25 we have been talking about.

1 MR. KING-SHAW: Just a point. There is
2 a model called a specialty hospital that describes
3 what you are talking about. It is controversial.
4 There are your older, full service community
5 hospitals don't like that for obvious reasons, but
6 there is a model that is a hospital, and it's less
7 than a full service community hospital, that does
8 provide a faster service, what the community
9 needs. I don't want debate in any way, but I do
10 want to point out that they're there.

11 They are here in New York State, and
12 Medicare has taken a rather diagnostic view. I
13 would not want them to be overlooked as part of
14 this.

15 MR. BRIDEAU: Just on that point, the
16 only comment I would have is -- I speak as the
17 owner of one of those -- part owner of one -- they
18 tend to be only in profitable service lines and
19 great payer mix areas. You don't see such models
20 opening up in poor urban areas.

21 But I do think that there is a kind of
22 model that you described. If you look at what's
23 happening, again, with payer mixes, the notion of
24 a big box -- hospital without beds, that is a
25 pretty common model now that is being developed

1 across the country and is very profitable, but,
2 again, because they are picking where they put it.
3 Whether it can survive in some of the areas we are
4 talking about is an open question.

5 CHAIRMAN BERGER: We have once again
6 raised a few more questions than we necessarily
7 have an answer to. But I think this is a piece of
8 the framework we thought was important for us to
9 have and to lay out.

10 At our next meeting we will spend some
11 time on the long term care and reimbursement side
12 and talk a little bit about financing and funding
13 on that side. So we will all have an opportunity
14 to talk about the financing, state spending and
15 state funding, where it goes.

16 Present viewpoint is correct. We have
17 to look at the entire package.

18 MR. VELEZ: In this exercise, do we
19 have the flexibility to do much more thorough
20 analysis, if you make a shift in government
21 sources? In two, three, four, five years from now
22 this could be the outcome in terms of economy of
23 scales?

24 CHAIRMAN BERGER: My guess is, if we
25 can't do it in our time frame -- I think that one

1 of the recommendations -- I believe -- I mean, my
2 sense is, that to begin to do this will take --
3 well, it would probably take -- and I want to talk
4 to DOH to see what they know, but my sense is,
5 you'd have to set-up a group to work on this. It
6 would take them nine months, a year or so to do
7 something like this.

8 Dennis, what do you think? I think
9 what we can do is set people off to work, but I
10 think there is a lot of work that has to take
11 place, a lot of work.

12 Okay. Any other questions?

13 The next meeting of the Commission will
14 take place in this room -- am I correct? I just
15 have to check with the staff. You talk about
16 nomads, I mean, nobody's got a record better than
17 us -- on October 12th, next meeting, October 12,
18 at 10 a.m. in this room?

19 DR. SANDMAN: Yes, sir.

20 CHAIRMAN BERGER: That will be the next
21 meeting. It is a two-day meeting; October 12th
22 and October 13th. Mr. Hinckley?

23 MR. HINCKLEY: Mr. Chairman, I move
24 that we enter executive session to address in
25 detail the medical, financial and credit history

1 of particular general hospitals, and nursing homes
2 that may be subject to Commission recommendations
3 for restructuring resizing, closing, consolidation
4 or conversion.

5 CHAIRMAN BERGER: Do I have a second?

6 All in favor say "I." Any opposed?

7 We're adjourned. Thank you very much.

8 Thank you, David, and thank the staff for putting
9 together an excellent presentation.

10 (Time Noted: 11:15 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