

COMMISSION ON HEALTH CARE FACILITIES  
IN THE 21st CENTURY

New York, New York

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11:00 a.m.

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ROBERT R. HINCKLEY, Vice Chairman  
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CHAIRMAN BERGER: It is now 11:00,  
the time that this meeting was called for, and I  
am calling the meeting to order.

I want to thank you for coming,  
welcome the members of the Commission. We will  
talk a little bit more about the Regional  
Commission members.

If everybody could please take a  
seat, we can get started.

Just I want to check, Al, are you on  
the phone?

MR. SIMONE: Yes, sir, I am, Steve.

CHAIRMAN BERGER: Okay. Just  
checking.

Al Simone, a member of the  
Commission, is on the phone, and he, therefore,  
is a participant.

CHAIRMAN BERGER: Let me begin --

Are the microphones on? No, they  
are actually here for show. And that's serious.  
We don't want anybody to hear what we are saying.

Are they on? Tell me when they are  
on. This is not the pause that refreshes,  
either.

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Can you hear me if I talk without a microphone? Then I will talk like that, because my patience is limited for technology, which is a major subject of this Commission, anyway.

First, what I would like to do is to begin by introducing the senior members --

AUDIENCE MEMBER: Please speak up.

CHAIRMAN BERGER: Who can't hear me?

All over. I need the damn microphones.

MR. SIMONE: Be careful what you say, I can hear you.

CHAIRMAN BERGER: I know. Even at my lowest there are some people in this room that can hear me, so I have to have some moderation.

First let me begin by introducing the senior members of the Commission staff who have joined us since our last meeting.

On my left is David Sandman, who is our Executive Director. David joined us most recently from where he was a Vice President at Harris Interactive, which is a global research consulting firm and he was responsible for their research on health and public affairs issues for

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various nonprofit organizations.

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Prior to that, David was at the Commonwealth Fund, where he was responsible for the projects related to health care coverage, access, health care in New York City, Medicare, and a lot of quality of care issues. Many of the people in the research community know him, people in our sector know him. And we are very pleased to have him with us as Executive Director.

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On my right, almost on my right, is Mark Ustin, who has joined us as General Counsel and Deputy Director. We took Mark from, he was recently Assistant General Counsel to the Governor. He has been responsible to advising the Governor and senior staff on legal issues relating to health and mental hygiene and the aging fields.

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For better or for worse, he was one of the primary authors of the actual legislation establishing this Commission. And we are delighted to have him with us.

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At our last meeting, under the bylaws, I had designated one of the staff people, Hilton Marcus, to be the recipient of all

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2           comments and correspondence. Now, with the  
3           establishment of the senior staff, I am  
4           designating David Sandman as the Executive  
5           Director to be the recipient of all such  
6           information.

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8                           And, by the way, we are still in the  
9           process of building staff. We have a couple more  
10          people.

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13                           But we are now, I would say, fairly  
14          a functional organization.

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16                           What is this, week three?

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18                           DR. SANDMAN: Week two.

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21                           CHAIRMAN BERGER: Week two for David  
22          and we are very pleased with how fast he is  
23          moving.

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26                           Let me now turn to the third item on  
27          the agenda. Just important, and for the record,  
28          to remind people that we have a structure and the  
29          structure and the mandate of this Commission was  
30          built around the notion that we have to be  
31          considerate and sensitive to local needs  
32          throughout our deliberation.

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35                           And the structure of the Commission  
36          mandated the appointment of Regional Commission

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members and their job is to guarantee that

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specific issues of each part of the state is

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fully considered during the deliberations.

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There will be a total of 36 regional

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members: six from each region, two will be

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appointed - two have been appointed by the

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Governor. And two will be appointed by the

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leaders of each of the appropriate legislative

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bodies, the Senate and the Assembly. We are

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still waiting for those appointments and we hope

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to have them very soon.

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The regional members are very

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important for a series of reasons. They vote

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with the Commission on issues pertaining to their

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region. And, therefore, we are very hopeful that

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the rest of the members will be appointed soon

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and so we can get Regional Commissions moving.

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We have with us today several of the

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Commission members and I am just not going to

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spend a lot -- I would just like at least to

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introduce them so people can see them, say one

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line about them. Full bios are presently on the

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Health Department web site.

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We are in the process of

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2 establishing a Commission web site. When it is  
3 up, their bios, bios of the Commission members,  
4 and all the rest of the information will be on  
5 our web site.

6 First, Paul Boylan, who is here from  
7 the Western -- Why don't you either wave or  
8 stand or shout.

9 Paul is Chairman of the Board of  
10 Directors of both Genesee Memorial Hospital and  
11 United Medical Center and we are glad you are  
12 here.

13 I don't know where everybody is  
14 sitting at the moment.

15 Susan Crosset. Susan is Vice  
16 President of public affairs for Niagra-Mohawk and  
17 she is in the Central Region.

18 Is Bob Doar here or is he on the  
19 phone?

20 MS. NOVAL: He will be on the phone.  
21 This is Lorraine Noval.

22 He is testifying at an Assembly  
23 hearing right at this moment, but he will be here  
24 in just a couple of minutes.

25 CHAIRMAN BERGER: On the phone is

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Robert Doar from the Hudson Valley Region. He serves as Commissioner of New York State Office of Temporary and Disability Assistance and he will be a member of the Hudson Valley Region.

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I saw Dick Guardino someplace.

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Richard, there you are.

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He is from the Long Island Region.

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He serves as Vice President for Development at

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Hofstra University and he also served as

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Supervisor of the Town of Hempstead.

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John Haggerty joins us. John is for

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the New York City Region. He is a former court

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examiner of the Appellate Division where he

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specialized in mental hygiene law.

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Dorothy Harris, there is Dorothy.

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Dorothy Harris from the Northern Region. She is

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the Director of State and Local Government

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Relations for the International Code Council and

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was also Deputy Secretary of State for the New

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York Department of State.

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Heidi Nauleau, did I get it?

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MS. NAULEAU: Yes, you got it.

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CHAIRMAN BERGER: From the Western

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Region. She is Chairwoman of RQ Companies, a

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privately owned holding company based in

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Jamestown.

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Dr. Jeffrey Sachs, from the New York

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City Region. Jeffrey is a principal in Sachs

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Consulting. It's a New York based business

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consulting firm and he does a lot of consulting

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for corporations and others specializing in

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health care.

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From the Northern Region, Arthur

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Spiegel. Arthur is Chairman and President of

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Transporter Customs Service, a U.S. customs

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brokerage and international freight forwarding

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firm. He is a former Chairman of the Clinton

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County American Cancer Society and a past Board

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Member of the Adirondack Medical Center.

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Lelia Wood-Smith of the Hudson

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Valley Region is the founder and sole

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practitioner of an environmental law practice

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specializing in land use and zoning.

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And I don't think I missed anybody

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who is here, I hope.

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Now, let me move on, if I may.

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In addition to the Regional Advisory

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Commissions, the legislation established what we

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call RACs, Regional Advisory Committees, and

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these are very important.

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It is the RACs which is sort of the core of the Commission's, the ability to focus on particular needs of a region. Together with the Regional Commission members, they will function as the voice for each particular region.

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They will hold public hearings and discussions; they will solicit input from local stateholder interests and they will develop and their responsibilities are to develop recommendations to us. They are non-binding. But, obviously, there is a point of having them so we can consider them.

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And part of our goal is to get this information and to use it in our decision-making process.

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I circulated to all of you a memo in advance regarding the size of the RACs. And I would like, if it's acceptable, I would like a motion and we would like to authorize them so we can get them started.

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MEMBER: So move.

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MEMBERS: Seconded.

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CHAIRMAN BERGER: Any opposition?

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Thank you.

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I will tell you, and some of you, our goal is - and David will talk a little bit in a moment - to really, we have got to put this process in place and we want to get the regional Commissions established, the RACs established, and a real schedule for local meetings and for community input as soon as possible.

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Two more, getting through the process stuff. I apologize. We got to do some of this stuff.

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Two things which are under Item 6.

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Let me just, the first is confidentiality.

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I just want to say this again in public now. The Commission is here and we have a public audience. We are starting to have regional members.

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We understand - and this is partly a communication to all of the people here - that we do understand that we will be handling very sensitive data and that we understand our requirements and responsibilities under the act

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2 and under common sense in terms of  
3 confidentiality.

4 As we agreed in the bylaws, we will  
5 not disclose or discuss any confidential  
6 information, especially facility-specific  
7 information, with anyone. Those discussions,  
8 when we have them, will take place in Executive  
9 Session.

10 And that is the way we will  
11 function. And that is the way the Regional  
12 Commissions will function.

13 We will ask that - and as part of  
14 that - we will maintain and we will create a  
15 structure for confidentiality regarding  
16 recommendations that will be kept confidential  
17 until the final report.

18 If there are any questions about  
19 what should or should not be confidential and  
20 what material has to be kept confidential, you  
21 can contact me, you can contact David. And  
22 probably, most importantly, you ought to talk to  
23 our General Counsel about this, talk to Mark  
24 Ustin.

25 This is a reminder. I am not going

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2 to have to say this again.

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I am going to have to say it again over the next year and a half. But I want everybody to understand that's the way we will be functioning.

We have also distributed today a guideline. It's an information guideline for observers who are attending the hearing.

Obviously, we function under the Open Meeting Law and we keep moving and hopefully we will get a place that's big enough - I think this one finally probably is - that we can accommodate people.

I am not going to go through this. Here is basic, you know, the sensible rules of behavior. We ask people to conform to it as we go forward and we will also post these on the web site.

Now, at the last meeting - and we had a discussion and transmitted some data to members of the Commission - there were some questions about the data and I'm going to say something that you will hear from me regularly from now on. But we are trying to get some

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agreement on the baseline of data.

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I am going to turn it over to David and Neil Benjamin to talk about it. And when they are done I want to try to put it in some context so some of us ought to talk about what it means.

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But first, David, you are finally on.

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DR. SANDMAN: Thank you, Mr.

Chairman. Happy to be here and look forward to working with all the members of the Commission.

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We have been working to achieve a baseline agreement on the data that we will use in the Commission to describe the existing health care system. And there is virtually universal agreement that we, of course, want to use the most complete, the most accurate and the most current data that we can get our hands on.

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And while no set of data is flawless, it is important that we do work from a common framework for our deliberations, so that we are all on the same page and speaking the same language as we go forward in this process.

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Since the last meeting we have been

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fortunate to receive some very valuable input

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from some of the trade associations, from some

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other groups. And we are very appreciative of

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their participation in those discussions with us.

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We have listened carefully to what

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they have all had to say and I think it's fair to

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say that we have demonstrated flexibility and a

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willingness to make modifications when

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appropriate.

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In addition, the Department of

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Health has shown flexibility on deadlines. They

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have extended the opportunity to all hospitals in

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the state to update their SPARCS submissions by

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the end of this month as a way to further ensure

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that the data being used by the Commission is as

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accurate and complete as can possibly be.

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At the same time, we all know that

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we are operating under an extremely tight

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timeline. It is quite important that we move

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past this data discussion so that we can get on

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with the substance of our work.

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I think we are in a pretty good

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place right now. Very pleased that we have

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achieved a broad strokes agreement on the sources

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of data on which the Commission will rely, as

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well as what data will be used to address what

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questions.

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And let me just outline quickly what

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that agreement looks like.

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There are two main sources of data

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in New York State. One is called SPARCS, one is

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called ICR or the Institutional Cost Reports.

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And I am going to ask Neil Benjamin,

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in just a minute, to give you a little more

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background about those, let you know what they

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are, where they overlap and what's unique about

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them as well.

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We are going to use ICR for certain

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purposes. We are going to be using SPARCS for

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others. But we are not going to be merging ICR

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or SPARCS.

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We are going to use ICR for

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occupancy data rates as well as financial

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information on hospitals and residential health

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care facilities.

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Just, the CD that is distributed at

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this meeting before you - this is a lot better

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than those huge books of data you got last time,

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I hope - these CDs do contain on them the ICR based facility and regional occupancy rates for the past five years. And we are asking you to replace the SPARCS based occupancy data distributed last time with the information on this disc.

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Having asked for that substitution, you will see, however, that the overall picture doesn't really change all that much. It's really just a few percentage points: a statewide average occupancy of 65 to 67%, versus around 62% that we have seen in the previous data.

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There is a little bit more data coming your way, at our November meeting, that will include the remaining five years of ICR based occupancy. This goes back to the most recent five years and we will add five more years on to that. So you will have ten years of occupancy data.

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We will also be giving you ten years of ICR based financials and we will be giving you ten years of the corrected and verified SPARCS clinical data, once the hospitals finish and submit those corrections that are due to us by

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2 the end of this month.

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So having settled which data sources we are going to use and for what purposes, we are still having some discussions about what I will call the definitional items that are important, such as licensed beds versus staff beds. And I think we will have that resolved for you by the November meeting as well.

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So unless there are any questions at this point, I would like to ask Neil again to just give a little bit of background about SPARCS versus ICR and how you think about the two data sets being used in conjunction.

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CHAIRMAN BERGER: Any mike you like, Neil, is fine.

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MR. BENJAMIN: Preferably one that works.

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Thank you, David, and Mr. Berger and Commission members. Pleased to be here to talk to you a little bit more about data but try to certainly --

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CHAIRMAN BERGER: Is there a living mike on that side?

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We are not getting any juice over

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2 here, guys.

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I want to understand if there is any strong discrimination taking place because we have the man with the data trying to talk.

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Neil, come sit here.

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Can we get, while he is moving his chair, can we try to get that side of the table up and powered?

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MR. BENJAMIN: Mr. Chairman, what David described, there really are again the two basic sources of data.

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David defined ICR as Institutional Cost Report.

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SPARCS, for those of you who may not know, stands for Statewide Patient and Research Cooperative System. And there are some similarities, but many distinctions in these two.

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The reporting timeframe I'll talk about first: annual for ICR and it is monthly for SPARCS.

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The purposes, the main purpose for ICR is to allow the Department to establish and set Medicaid rates and all corresponding adjustments to those rates.

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The purpose of the SPARCS system is much more broad and quite a bit different. It is primarily to accumulate and assess clinical and demographic indicators of public health in New York State.

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Some of those examples are:

everything is reported on a discharge basis by patient diagnosis; there is epidemiological data in there and it can be disseminated many different ways. It can give us trends, for example, both facility-specific and county patient of origin, where people are being treated, what they are being treated for, where they have been treated in the past.

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We also have the ability to

determine in-migration and out-migration trends for services, in-patient services in and out of the county. It's a very useful data set.

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Whereas, the ICR is really two key

areas. One, it's a plethora of fiscal data. It's income statements and balance sheets and all these other types of things, salaries, et cetera.

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And it also contains some

statistical data that is also reported in SPARCS:

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2 discharges, patient days, length of stay, and  
3 et cetera, those types of things.

4 And, again, that's again primarily  
5 used for rate setting.

6 There are, in terms of the volume  
7 that we handle, there are approximately 220  
8 hospitals and they are required to provide one  
9 ICR. Whereas, there are 220 hospitals that are  
10 required to report every month in SPARCS.

11 And they do have an adjustment in  
12 the following month and then there is an annual  
13 deadline for all adjustments. So it's a heavy  
14 load on the system.

15 Two other just quick points.

16 Compliance and accuracy - just to  
17 spend a second on those. The ICR -  
18 coincidentally or not - seems to have a much  
19 higher compliance factor in terms of deadlines  
20 that may or may not have something to do with the  
21 fact that that drives how people get paid.

22 Whereas the SPARCS system, as we  
23 mentioned before - and as David and Mr. Berger  
24 commented on - we are in a major initiative right  
25 now to update, clean up, verify and provide the

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2 most accurate set of SPARCS statistics that we  
3 have ever had.

4 And with the cooperation of all the  
5 providers, I think that's going to give the  
6 Commission a really accurate and solid set of  
7 data to move forward on, especially on the  
8 clinical type of trends.

9 The last thing is that there are  
10 outside attestations and certifications required  
11 for these. The ICR's are required to be  
12 certified by an independent certified public  
13 accountant.

14 And the SPARCS data is required to  
15 be certified as consistent by a certain level of  
16 officer of their own reporting entity.

17 So we will be doing our best and  
18 certainly in November you can be sure that you  
19 will have the data of high quality and accuracy  
20 that was previously described.

21 CHAIRMAN BERGER: Neil, would you do  
22 a -- I think, why don't you do us a favor for  
23 everybody. If you could take what you just did  
24 here, which is the analysis of the two separate  
25 systems, the values in one and the impact, and

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2 just turn your notes into a readable memo - I can  
3 look at these notes. I got to tell you, I can't  
4 read it - into a readable memo and circulate it  
5 to the members of Commission, so that they can  
6 begin to frame the two data sets and get an  
7 understanding of them, as opposed to everybody  
8 having to sort of - those of us who don't know  
9 exactly - making notes as you are talking.

10 So we will circulate this to  
11 everybody.

12 MR. BENJAMIN: Absolutely.

13 MR. KISSINGER: I have a question,  
14 too.

15 On these data sets, the lag that we  
16 are talking about, I mean, when you were talking  
17 about the ICR, which year and what's the period  
18 they have to adjust the data.

19 MR. BENJAMIN: I failed to mention  
20 that.

21 The ICR's are due on, I believe, May  
22 31st of the year following the calendar cost  
23 report year. And there are a couple of  
24 different - there is a provision to extend that  
25 and then there is a period for adjustment.

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And there is - what I think is most important to the industry - is called a hotline appeal period. And during each of those we can process different types of changes to that.

SPARCS is monthly. And there is a period of time the following month for hospitals to, in the first week of the following month, for hospitals to clean up that data.

And then there is, in general, though, an annual deadline for all of it for the previous year and that is June 30th.

CHAIRMAN BERGER: Anything else for Neil?

MR. ROBERTS: Could you just speak about the other levels of care of data. I assume nursing homes would be just ICR, for example.

MR. BENJAMIN: Sure, I would be glad to.

The nursing homes, thankfully, we have one set of data common to this and that's really the nursing home cost report that is filed for reimbursement purposes, for Medicaid reimbursement purposes. That has similar deadlines. It probably has a similar breakdown

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2 in terms of the information - fiscal to  
3 statistical.

4 And there are also actually --

5 Neil, now that you mention it, there  
6 are also other reporting, quarterly reporting by  
7 nursing homes relative to the acuity of care that  
8 they provide. Those are, allow us, we make, the  
9 Department makes adjustments I believe four times  
10 a year to Medicaid rates based on the changes in  
11 acuity.

12 That data has been disseminated  
13 previously to you and I would respectfully ask  
14 that you don't throw that book out, because that  
15 data is fairly consistent.

16 We did get, I got a call the other  
17 day from one of the members of one of the nursing  
18 home associations to chat about it, but the  
19 differences were minor. We will be talking about  
20 that.

21 Any material changes we will provide  
22 to you.

23 CHAIRMAN BERGER: If I may, I think  
24 that we are --

25 Is this as far as it goes?

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We spent a lot of time on the acute care data sets because that's where we have had the bigger problems. And it's not that we don't understand that part of our mandate is also dealing with long term care, but that data set is not in the same condition as the acute care.

Thank you, Neil.

And you will distribute that.

MR. BENJAMIN: Yes.

CHAIRMAN BERGER: If we could get a mike? Can we get the mikes fixed on this side or is this just -- Are we going to have to --

Moving chairs is okay. It keeps the audience awake.

MEMBER: And the speakers.

CHAIRMAN BERGER: That still not working?

David, why don't you and I switch and why don't you take us through your, sort of an overview of the workplan and the workplan schedule.

DR. SANDMAN: I would ask the Commission members to turn their attention to the flow chart that we have distributed to you today,

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which does illustrate the workplan and will serve

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as a roadmap for us in the remaining time of the

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Commission's life and give us all a sense of

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where we ought to be at various points and what

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we will be asking of the Commission members at

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various points in time.

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We do only have about 14 1/2 months

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remaining before we must report our

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recommendations to the Governor on December 1st

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of '06. And somehow, despite this very short

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period, we have managed to split it into five

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different conceptual phases.

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The first, as you will see, we have

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labeled the organizational phase which, for many

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reasons, is largely behind us and which we need

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to complete as quickly as possible, not the least

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of which because we have said it was associated

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with summer of '05 and tomorrow is the first

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official day of autumn, so we have got to finish.

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Fortunately, we can put check marks

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next to many of those specific items in the

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boxes.

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The bylaws have been established for

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the Commission. We have made a lot of progress

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2 in building the Commission's infrastructure, just  
3 to make it a real Commission that can function.

4 We are in good part staffed up and  
5 adding a few additional people to our staff as  
6 quickly as we can.

7 We are putting protocols in place in  
8 how to receive information from the community and  
9 various groups, and share that appropriately.

10 And then, just as importantly, how  
11 do we get information out to the world beyond the  
12 Commission. And that will include establishing  
13 our own web site for the Commission, which should  
14 be up also within the next several weeks.

15 I have already spoken about agreeing  
16 upon and obtaining the necessary data. I think  
17 we are in great shape in accomplishing that.

18 And we will be providing significant  
19 support to establish and help the RACs get up and  
20 running, once their members are appointed.

21 So, summer and Organizational Phase  
22 1, fortunately, is largely behind us.

23 BISHOP SULLIVAN: David, is there  
24 any expectation of the Commission to make  
25 recommendations of people to serve on the RACs?

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2

DR. SANDMAN: We would be happy to

3

receive those.

4

One thing we are doing now is

5

compiling lists of people from various regions.

6

And we would invite all members - the Regional

7

members, of course, as well as statewide

8

members - to send names to us of of who you think

9

would be good choices.

10

MR. VELEZ: David, are there any

11

specific guidelines that will be given to the

12

Regional Commission that would define the

13

category, the type of individuals that they

14

should solicit as members?

15

AUDIENCE MEMBER: Can't hear the

16

question.

17

DR. SANDMAN: Well, the members of

18

the RACs will themselves be appointed by the

19

Governor and the Legislature in equal numbers.

20

So it's for the RACs to seek out their own

21

membership.

22

CHAIRMAN BERGER: The appointment

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process is the same appointment process that, in

24

fact, we all went through.

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So the submission of names means,

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2 what we will do is we will take the names and  
3 sort of give them to the three appointing  
4 officers and they will ultimately make the  
5 decisions.

6

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DR. SANDMAN: Are there any other  
questions? Or I'll move on.

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The second phase to be occurring in  
the fall of this year we have labeled Criteria  
Development.

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And I think it's probably one of the  
most difficult and as well as one of the most  
important phases that we will be undertaking,  
because it will lead us through our deliberations  
and decision-making for the balance of the  
Commission's work.

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We are, during this phase, assessing  
what the current capacity of the system looks  
like and, equally importantly, trying to get a  
sense on what the future need for capacity will  
look like in a redesigned system as well as the  
system that accounts for large scale changes,  
such as demographics, pharmacologic advances, IT  
and broad systemic changes that will affect  
health care delivery here in New York, as well as

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nationally.

We are looking, of course, to identify efforts similar to ours from other jurisdictions and evaluate their applicability for New York State. We are seeking not to completely reinvent the wheel, if we can avoid doing so, and learn from other's successes and failures, of course.

Large scale centralized health planning has not been in vogue in this country for the past twenty years. So, in some respects, we are pioneers yet again, and will be creating this process for ourselves.

But we are looking at similar efforts that we can find from other states, from the VA system. None of them, of course, is a perfect template for New York that we can simply load on. But we would like to liberally steal other people's great ideas and use them if we can.

We will, of course, be examining and refining the statutory criteria that the Legislature and the Governor set up for us, identifying any additional criteria as the

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statute, of course, allows and encourages us to

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do.

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And what we hope to come back to you

6

with at our November meeting is really a very  
thoughtful framework for decision-making and a

7

set of criteria by which the Commission will

8

conduct its work and then measure the data we

9

have talked about against those criteria.

10

Finally, we will, of course, be

11

helping the RACs to get set up and develop their

12

own regional work plans that look like a

13

quasi-modified miniature version of what the

14

Commission is doing.

15

Having done that, we expect in the

16

winter of this year and spring of '06, a really

17

deep dive for probably about six months of time

18

into the data, assessing and measuring those

19

against the criteria and the framework to which

20

we have agreed and making at least preliminary

21

findings as to where the Commission may be

22

heading.

23

We will, of course, during that same

24

period, be holding regional public hearings in

25

each of the six regions around the state so that

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all groups, all parties, all voices that wish to

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be heard and participate in this process will

4

have the opportunity to do so.

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And because we want the RACs, of

6

course, to be developing their recommendations in

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a timely fashion that can feed into the overall

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Commission's deliberations, we will look to them

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to develop at least preliminary findings as the

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spring winds down.

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We have allocated the summer, two or

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three months then, for both the RACs, to move

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toward a development of their final

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recommendations and, of course, for this

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Commission to be discussing and refining its own

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preliminary findings on an iterative basis. We

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do, of course, expect several rounds of that as

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we move to a vision which we all can feel good

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about.

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Then in the fall we have allocated

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about two month's time, essentially, for the

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development of the final report, circulation to

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the Commission.

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And, again, that will be an

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iterative process.

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We expect several rounds of revisions and refinements again until we come to a consensus document that the Commission would like to formalize its recommendations in.

And, once again, our report will be due to the Governor on the 1st of December in '06.

Again, I would be happy to take any questions or comments on this roadmap.

CHAIRMAN BERGER: Dr. Gil.

DR. GIL: David, Phase 2, the statement, evaluate system trends, and here I see service delivery.

The health delivery system in New York State include different levels, such as acute care hospitals and nursing homes. But there are other levels in the health care delivery system that are essential for the people that we serve.

Are we including or are you going to provide us with data that is inclusive and comprehensive of all levels of the delivery of health care?

DR. SANDMAN: Dr. Gil makes an

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excellent point and I think it is consistent with

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the overall vision of this Commission, which was

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established specifically for the purpose of

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taking a holistic view on assessment of the state

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health care system. And we are aware of the

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interactive effects, some of which, of course, we

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would like to encourage.

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There are many levels of care.

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For example, on the long term care side, well

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below nursing homes: home health, assisted living

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and so on.

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And so all of those factors will be

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part of that.

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BISHOP SULLIVAN: Will the RACs be

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working off the same criteria and applying, as

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they develop their workplans, and who will

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oversight that to see that there is kind of an

19

equal assessment?

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DR. SANDMAN: Actually, the staff

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now is preparing a set of materials for the RAC

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members, not too dissimilar from the welcome

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packages that you received, with our

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recommendations for how to structure themselves,

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what their work plan should look like.

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It will mimic very closely what this Commission is doing so that we are, again, marching in a coordinated way towards the same end goal. And the staff, in large part - I wouldn't say staffing the RACs, that would be overstating - the best word is probably coordinating and supporting the RACs to ensure that, again, we are coordinated and not going in multiple directions that we cannot pull together at the end.

BISHOP SULLIVAN: But there are a lot of criteria, it seems to me, that are differential in the state, throughout the state, depending on where you are located. So it is going to take a lot of judgment, it seems to me, to apply these things with some discretion and prudence.

CHAIRMAN BERGER: I think, Joe, the whole concept of having Regional Commissions and RACs was a recognition that - and this is part of the difficulty - there are very different areas of the state. We are all aware of this and we want input which relates to those different kinds of jurisdictions, kinds of areas.

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Hopefully, we can come out with a set of criteria and guidelines that work in Manhattan and work in Buffalo and work in Dutchess County and work in the Southern Tier, taking into account the different configurations.

And I think that's part of what we are going to drive the staff to try to work towards, so we can start talking about those specifics in November.

The other piece I want to be clear on is that the RACs don't belong to us. They are appointed to represent the region. And I think, sensibly, we are going to lay out our criteria for them, show them where we are going and, hopefully, they will understand that unless they are able to take the broad criteria and make it work in their region, they are going to be outliers and they are going to be hard for us to communicate.

I think it will work out fine. But it's not a perfect system.

They don't work for us and people have to understand that.

Anything else?

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MR. HINCKLEY: David, I think this is a great start for the work that you have to accomplish and we have to accomplish. And one of my concerns is that we have a tremendous amount of work to do here over the next fourteen months or so, as do you.

And what I would like to do with each subsequent meeting of this Commission is perhaps devote ten minutes to see where we are in the work plan, both to hold our feet to the fire and hold your feet to the fire a little bit. Because I want to ensure that we are making progress as we go along and don't get to the summer or the fall of 2006 and have to jam everything into a few months.

DR. SANDMAN: This is a living document and we do expect to be adding tasks to it as we move along. And we tried to put time periods that were specific enough and fungible enough to make adjustments as we need to.

CHAIRMAN BERGER: Kristin.

MS. PROUD: At the first meeting of the Commission there was a provision in the bylaws, I believe, for the appointment of

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subcommittees as part of this state-wide body.

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And I am wondering if there has been, in the formation of the work plan today, any contemplation of establishing subcommittees?

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CHAIRMAN BERGER: The answer is it's in the bylaws. We have not thought about it yet, honestly. Frankly, we want to get a staff on board. But it's a good point and we will come back.

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If we do establish subcommittees, they will also, obviously, be subject to the same freedom of information. I am just saying the obvious.

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If we do, we will have, they will be public meetings and all this.

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But let us think about whether that works and whether it works now, whether it becomes more important as we move maybe six months in.

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Maybe the first thing to do is to get a report back in November on sort of the first cut at the criteria and then see if that triggers and leads us to the need to establish subcommittees.

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Craig.

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MR. DUNCAN: David, it's encouraging to see the work plan laid out and there is a big job ahead of us.

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Something that would be very helpful is if between meetings, if you could distribute information to us and give us a chance to really work this through and come in prepared to do the task at hand.

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MR. ROBERTS: A follow-up on that.

I can see lots of ways where this could bog down and in fourteen months we would have nothing, one of which, with something as broad as the criteria, if we were to see that first time in November and be expected act on it, that would be potentially difficult.

18

It may not be, but --

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CHAIRMAN BERGER: We will have to, in order to have a serious meeting in November, we have got to get some material out to you before so we can begin talking about it. I understand that. I think David understands that.

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And, in fact, to some extent I think it is fair to say that you could argue that the

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entire process is sort of a crunch.

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But the first big crunch is getting that Phase 2 piece done and then the final crunch will also be a crunch.

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But the first one is a very pressured effort in trying to get us - and I wanted to talk some more about that a little later - but to get us into a position to begin to look at the system intelligently.

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It doesn't work. We got to talk loud. Technology has abandoned us.

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MR. SEARS: I would like to suggest, from a format standpoint, that we take this work plan, which I think is an excellent start, and put it in a Gant (ph) chart format so that we can follow things meeting by meeting and have deadlines that I think will be a little easier to follow.

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CHAIRMAN BERGER: That technology is probably do-able.

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MR. SEARS: Right.

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CHAIRMAN BERGER: Should we move on?

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Would I like my seat back? I don't know, why not. It's good for my knees and my

25

1

2 hips to move. It's a health therapy issue.

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Let me move to Point 9 on the agenda.

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I am going to turn this over to Bob Hinckley, who is vice chairman, to talk about this.

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We have, the state has at the moment, in round numbers, about \$3 billion in capital programs before - under the Certificate of Need process. About half is acute care, about half is long term care.

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And the State Department of Health has its responsibilities and its requirement. We are separate from them.

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19

But we are engaged in a process over the next, we will be engaged in a process over the next year and a half and we will be talking about reshaping the system.

20

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22

And, at the same time, the Department is sitting there with very large requests for capital.

23

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The question, and Bob who has sat on - some of us have - on all sides of this issue, has been thinking about it.

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And do you want to raise this and

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talk a little bit about it?

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MR. HINCKLEY: Yes.

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CHAIRMAN BERGER: It's a substantive

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issue that at least ought to be talked about.

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MR. HINCKLEY: Thanks, Steve.

8

This issue has been getting a lot of

9

concern in a number of areas over the past few

10

months since this Commission was formed, whether

11

that be from members of the State Hospital Review

12

and Planning Council, we see it in the media, we

13

hear it from the industry.

14

Steve's right, there is about

15

\$3 billion worth of projects somewhere along the

16

pipeline for the Department of Health and State

17

Hospital Review and Planning Council. And I felt

18

that it was important that we have a discussion

19

about it and at least provide some sense of the

20

Commission as guidance to the Department of

21

Health and SHRPC.

22

Our work is going to take us

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fourteen months to do and we have to recognize

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that the hospitals and the nursing homes have

25

work to do as well and they have projects that

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they have been planning for significant amount of

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time and have invested resources in. So I think

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we have to weigh that.

5

I would like to believe that all

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\$3 billion worth of projects were designed to

7

make the system more efficient. In that case,

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maybe our work would be done. But I don't think

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that's quite the truth.

10

However, we have to recognize, we

11

can't just say that we can't allow any projects,

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the Department of Health and SHRPC shouldn't

13

allow any projects to go through until we report.

14

There is work that has to be done by the

15

hospitals and nursing homes.

16

They have patient safety issues;

17

they have plans that will right-size or make

18

their systems more efficient.

19

So I think we need to look at maybe

20

some criteria to provide to the Department of

21

Health and SHRPC going forward, while we do our

22

work. I think we would be abrogating our

23

responsibility if over the next fourteen months

24

these next \$3 billion worth of projects went

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through without any comment or guidance from us.

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And I know the Department of Health has done some thinking about this. Clearly, I would believe that any project that's consistent with the goals and objectives of this Commission - to make the system more effective, more efficient, to downsize it, if they feel - if the hospital or nursing home - feel that's the right thing to do - that type of project should go through.

Any type of project that really is designed to improve patient safety would be something that we should certainly lend our support to.

But I'd really like to get a sense from the rest of the members of the Commission what their feelings are on this.

There is a lot of money at stake here, not only for the hospitals, but Medicaid is a major payer. They will be paying part of the freight for all these projects going through.

MS. PROUD: Is there a way that the Health Department can give us some sense within all of those Certificate of Need applications that are pending of how many of them are for

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2

downsizing related purposes versus increasing capacity versus patient safety and some of the other categories that you mentioned?

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8

And also regional breakouts: are the bulk of the patient safety requests in a particular part of the state or are they scattered?

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10

That kind of information might be helpful.

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CHAIRMAN BERGER: I want to come back to that comment.

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Craig, go ahead.

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MR. DUNCAN: Having lived in that environment for many years, both with the Hospital Review and Planning Council and as a provider, the concerns that I would have with this - and I think we have got to review this, I don't think there is a question - is that we clarify the criteria enough so everybody has an understanding.

22

23

24

25

You expect, when you put an application in, it's going to be fourteen to sixteen months in the process. If we are doing something now that is catching somebody that is

1

2 twelve months into it, we may really be impacting  
3 the system in a very negative way.

4

I just think we really have to  
5 publish this and have an opportunity to wrestle  
6 with this, talk about it and then support it.

7

CHAIRMAN BERGER: I think, if I may,  
8 I think the point Kristin made is important.

9

The Department of Health does not  
10 work for this Commission. And I want to be very  
11 clear that they have their separate  
12 responsibilities and we have ours.

13

They are working with us on a lot of  
14 projects, but they are independent and they will  
15 stay independent.

16

I think what Bob was suggesting, and  
17 I think would be useful, what Bob was suggesting  
18 that what we say to the Commission at the  
19 moment - maybe more specifically in November,  
20 Craig, but at least at the moment - the  
21 Commission exists. It is going to be looking at  
22 rightsizing; it's going to be looking at making  
23 changes.

24

You have in front of you \$3 billion  
25 worth of projects. We would like to know how

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many are them are for safety; how many of them

3

are expansion; how many of them are for

4

downsizing and all the rest.

5

We would like to sort of know that.

6

We, as a Commission, would like to know that now.

7

We would like to understand the nature of the

8

project.

9

By the way, and that is information

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that once you guys tell us, that helps us

11

understand where the hospital systems think they

12

are going, which is information.

13

But by beginning to flesh it out for

14

the Department and the Council, as to putting

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them in those buckets and those criterias, if

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nothing else in the next month, begins to change

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the shape of the dialogue. I think that's part

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of what you want to do here at this point.

19

And as we get more specific criteria

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which we agree upon, assuming we get there in

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November, we can go back to the Department and

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say, you have your responsibilities, and the

23

Council, but here is what we think you ought to

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consider.

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We understand the issues of patient

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safety, we understand some of the issues that have to be dealt with immediately. But when you have got \$3 billion worth of projects sitting out there, that is a lot of capital.

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11

And we are talking about projects, and I will just say that every director of every long term care and acute care institution that has got a project manager called me on the phone saying stay away from this. They have been much nicer.

12

13

I mean, I am a simple kid from the Lower East Side, so I translate.

14

15

MR. HINCKLEY: That is why you gave it for me to do.

16

17

18

CHAIRMAN BERGER: That's why I gave it for you to do because you have more elegance and more grace than I have.

19

But did I leave you out there alone.

20

MR. HINCKLEY: Yes, yes.

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CHAIRMAN BERGER: But the answer is, that I do think, I mean, I do think that this is going to be a substantive issue for the state going forward and that I think we ought to at least indicate, the Commission ought to indicate

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2 to the Health Department, that they have to take  
3 into account what's going on here. And we will  
4 be more specific with them certainly in the next  
5 month.

6

BISHOP SULLIVAN: One of the things  
7 that I would be concerned about is criteria, is  
8 those who are going to develop plans, to get  
9 market share, that their goal really is to  
10 upgrade the opportunity for the different DRGs in  
11 order to get more resources.

12

I mean, we have inherited a system  
13 that really locks us in a lot of ways from doing  
14 some things. Right?

15

That to me is part of the problem  
16 and I would hope that would be part of the  
17 criteria.

18

MR. VELEZ: I think there is a  
19 general understanding that the dollars allocated  
20 have not been focused primarily on the front end  
21 of health care.

22

When we talk about the different  
23 level of care that the Commission is going to  
24 look at, we talk about the hospitals, we talk  
25 about the skilled nursing facilities and we talk

1

2 about sub-levels of care in skilled nursing.

3

4 But we do not talk about how do we  
5 begin to look at the requests that are being made  
6 for capital funding for the front end of the  
7 system that we have to strengthen considerably.

8

9 So I think consideration should be  
10 given when you go through a process, what is in  
11 the pipeline, so those do not get bogged down in  
12 the evaluation process.

13

14 CHAIRMAN BERGER: The Health  
15 Department, do we have a sense of the Commission  
16 without --

17

18 This is one of those where, you guys  
19 know, we got a lot of stuff happening here. We  
20 are going to move on changes.

21

22 We can't just go forward on a  
23 standard basis as you are looking at these  
24 applications.

25

Is that the shorthand version of  
what we are talking about?

MEMBERS: Yes.

CHAIRMAN BERGER: We will come back

to you in November as we focus on our criteria to  
encourage you - you can't, remember - to

1

2 encourage you to take what we are doing into  
3 account.

4

5 We can't direct them; we can  
6 encourage them.

7

8 MR. SEARS: May I add two additional  
9 criteria. Number one would be enhanced access.  
10 And number two would be to enhance worker  
11 productivity by leveraging technology.

12

13 CHAIRMAN BERGER: Fine. You won't  
14 get any arguments, I don't think.

15

16 Let me, if I may now, I would like  
17 to sort of shift the discussion a little bit.

18

19 I want to, there is an item, it  
20 says, we started talking about the principles for  
21 future reform. We started that discussion today  
22 and that's sort of going to be the criteria and  
23 principles discussion that we are going to be  
24 having over the next, I think, all the way  
25 through, but certainly in the next six months.

26

27 I'd like, let me begin the  
28 discussion, if I may, by going back a minute in  
29 terms of the processes and sort of how we got  
30 here.

31

32 Because we are now in David's Phase

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2

2. We got to David Sandman's Phase 2 on the work

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chart after what has really been about a three

4

year process which began with the establishment

5

of the Governor's Task Force on Health Care

6

Reform three years ago.

7

We started with sort of two basic

8

issues in front of us. One was cost and the

9

other was quality of care - and they were always

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there - and the structure of the institutional

11

networks.

12

And part of the way that legislation

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is carved here is structure of the institutional

14

networks, with Dr. Gil and people who have raised

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the issue, we all want to talk about it.

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We have got to go beyond that.

17

But that was the core and that is

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the core because that is where the bulk of the

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dollars is spent. This Commission has got to be

20

concerned about the future.

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Bishop Sullivan's point is, we have

22

got to be concerned about where we go; we have

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got to be concerned about costs; we have got to

24

be concerned about changing demographics; we have

25

got to look at changes in the pattern of the

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2 health care delivery. And we know what a lot of  
3 that is and we don't know what some of it is  
4 going to be.

5 We know that you have got services  
6 that have out-migrated from the hospital. You  
7 know you got new technology. You got, quote,  
8 information systems; you got telemedicine; we  
9 have got drug therapeutic breakthroughs which  
10 change what you need to do inside institutional  
11 care and we need to care for people in  
12 non-institutional settings.

13 We have safety net issues, which we  
14 ought to talked a little about. We have got 24/7  
15 issues; we have got public health issues,  
16 forgotten. They are now back on the front page.  
17 We have to be cognizant of that.

18 The world is changing. Somebody was  
19 talking about it before, the world is changing  
20 and the marketplace is driving it. Some  
21 contractions and some changes. And we can't stop  
22 that, although some of them may be good ones and  
23 some of them may not be good ones. And that's  
24 part of the facts of life.

25 What David Sandman and the staff,

1

2

working with us, has to do in the next five

3

months, what I call is to create a decision -

4

develop a decision tree - a process, a model, a

5

framework - that will allow us to make judgments

6

that are both economically, mathematically, data

7

base sound, but are fundamentally and

8

qualitatively intelligent.

9

And that's going to be the

10

responsibility, to step from the data to making

11

qualitative judgments.

12

How do we attack the issue of the

13

rightsizing the system? What are we thinking the

14

hospital of the future is going to look like?

15

Not trying to predict it, but we

16

know a lot of things are taking place.

17

What will long term care network

18

look like? What will the institutions look like?

19

What will the non-institutions look like? How

20

will they come together?

21

Because we are spending a lot of

22

money and we have got to figure out where that

23

ought to go.

24

How do we guarantee the safety net?

25

And then, as we go through these and

1

2 other questions that I think we will all start  
3 putting on the table, how should reimbursement  
4 patterns change to reflect the system we are  
5 driving to create, as opposed to the system that  
6 now exists?

7 And if you talk about opening a can  
8 of worms, that is a can of worms that we are  
9 going to have a responsibility for opening and  
10 attacking.

11 Now, the earlier discussion, we have  
12 had a very serious set of discussions between the  
13 Commission, the Department of Health and the  
14 acute care institutions, on solidifying the data  
15 base. That will only tell us where we are.

16 And it does not tell us where we are  
17 going, necessarily, or where we want to be. And  
18 I think that we have got to focus on the future  
19 and not get trapped in the past. That is sort of  
20 my framework.

21 What I would like to do, there are a  
22 couple of points I think we ought to talk about  
23 and put on the table today.

24 And one of them, and I asked - we  
25 didn't give a microphone, I don't know if

1

2           that's --

3

4

                          I asked Ruben King Shaw, who has  
been the Deputy Director of CMS --

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6

7

                          What is that called? Deputy  
Administrator. Sorry. I get these Washington  
titles messed up easily these days.

8

9

                          -- to do a little bit about what he  
sees as the financial future.

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                          We started this Commission and this  
task force focusing on the cost issues in the  
state. But outside of that, you have got the  
bulk, half the dollars come from the federal  
government. The government has expanded the  
Medicare program. And I think it is important  
because I see this as a train coming down the  
road.

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19

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21

                          Ruben, I would like you to kick it  
off. We have other issues, but would you start a  
little bit and try to begin this a little bit,  
give us some sense of the future.

22

23

                          MR. SHAW: Sure. I am happy to,  
Mr. Chairman.

24

25

                          First let me say that what I am  
about to do here is describe what I would term as

1

2

the policy directions that Washington is

3

currently focusing on. It's a function of what

4

the Administrative branch, HHS and Congress,

5

actually, have been pursuing.

6

And in each one of them - and there

7

are seven different categories or directions - I

8

would characterize each one of them as either

9

aggressive or permissive - something that they

10

are actually advocating for and something that

11

they are agnostic - but what permits states to do

12

in the name of Medicaid reform, should the state

13

want to do it, but not strategic objectives.

14

And then also, for each one, I would

15

like to share some sense, at least in my view,

16

whether this is a new money opportunity where the

17

policy would be to invest capital in these

18

things, or a saver opportunity, where the

19

government is looking to limit the growth of

20

expenses or actually recoup savings from them.

21

And just one more word of preamble,

22

I did spend time in the current administration at

23

CMS and the Department of the Treasury.

24

And so this is in part, I think, a

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communication of what has been, at least for the

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last several years, the policy direction.

I do not mean to offer it. It will always be the policy direction in Washington.

But first I think there is the obvious \$10 billion reduction in the Medicaid program that Congress has to figure out what to do with.

And so that number - 10 billion - is a real number. And, whereas, Congress may give states some guidance on how to do that, I think it will generally be permissive in terms of how states would want to do that.

I would characterize it as clearly an aggressive strategy to save \$10 billion in Medicaid, in a saver, not a new money strategy.

The implications are, I think, that the big states with the big Medicaid programs will be the most affected by this.

A lot of the states with the highest federal participation rate are generally lower income states in the Deep South. And post-Katrina, I don't think they are going to get a lot of money out of that part of the country.

So the big Medicaid program, such as

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here in New York, I think would generally have more to think about in terms of its share of that reduction than would, let's say, a Mississippi or an Alabama.

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I also think that the ways that this is likely to play out here in New York and around the country, will be looking at cost-sharing opportunities, both between the state and the Feds, between the beneficiaries and the Medicaid program, between providers and patients.

12

13

14

I think that there is clearly going to be a drive to rethink eligibility requirements for Medicaid program.

15

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20

When you look at Medicaid there are only so many ways you can manage your finances. You could look at your underwriting - which is essentially the people you choose to serve. There is a host of optional categories that will likely come up for review there.

21

22

23

You can look at the coverage - what you are going to offer the people you choose to serve and how much you are going to pay for them.

24

25

So I do think there will to be some cost-sharing and eligibility discussions that

1

2

will be driven by the need to meet the spending

3

reduction targets that will be a part of the

4

program.

5

And then, of course, the last two we

6

have heard a lot about - you have yet to resolve

7

them - these clawback provisions, that tends to

8

be a very difficult discussion but eventually it

9

does have to be finalized. And this, for those

10

people who do not know, when Medicare picks up

11

the prescription drug costs of Medicaid

12

eligibles, the state will have to give back some

13

of the money that it used to get to pay for those

14

drug expenses.

15

That will have a clear financing

16

effect on the state's ability to serve the

17

population that remains.

18

I do think also in this 10

19

billion bucket is a continued stress on

20

inter-governmental transfers of repayment limit,

21

disproportionate share programs. I lump all

22

those in possible ways that this \$10 billion

23

reduction is going to play out in state Medicaid

24

programs.

25

And I think all of that has or could

1

2 have implications on our discussions here about  
3 the facilities and organizing the health care  
4 delivery system going forward.

5

6 The next one which I would also  
7 categorize as aggressive, but is in combination a  
8 new money and save money strategy, would be the  
9 home and community based programs.

10

11 Clearly in Washington there is a  
12 renewed focus on these home community based  
13 programs and they are sought to address a number  
14 of sectors.

15

16 We have not spoken a lot, at least  
17 not this morning, about community health centers,  
18 critical access hospitals, the qualified health  
19 centers. These are clearly line items in the  
20 Washington budget that are getting money and  
21 getting funded.

22

23 So as we think about the facilities  
24 and right-sizing and the delivery system, I think  
25 it should be apparent that this is one area where  
26 federal funds, a least I think in the near  
27 horizon, will continue to float.

28

29 Cash and carry types of programs,  
30 where programs - Medicaid programs, federal

31

1

2

programs - that put cash in the hands of

3

beneficiaries for self-directed care type

4

initiatives, is a financing vehicle that I think

5

will continue to get some priority out of

6

Washington.

7

Focus on the developmentally

8

disabled I think will continue to develop.

9

I think that there will be continued

10

interest in what is commonly called nursing home

11

diversion program. These are programs that

12

traditionally have been billed as ways to

13

redirect from the nursing home path individuals

14

who can be cared for in a home or community based

15

setting.

16

There are some questions as to

17

whether you are just delaying that admission, if

18

you are truly reducing the capacity or the demand

19

for nursing homes. But they are programs that,

20

nonetheless, do have some strong support in

21

Washington and around the country. I don't see

22

that diminishing.

23

And then I think you do have some

24

issues around home health where current budgets

25

actually reduce reimbursement to home health

1

2 organizations.

3

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However, if you were to look at the overall strategy of home and community based programs without a robust home health delivery system, I think you have got some problems that will eventually have to be adjusted.

8

9

So that I would regard as the second policy direction.

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11

The third would be managed care, disease management and other types of waivers.

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And whereas I think they are generally permissive, states will be allowed to do things. I don't regard that Washington, in general, is particularly endorsing them. But when a state truly has an agenda to do these things, my sense is that CMS will be largely receptive to them. And they tend to play out in a couple of ways.

20

21

22

23

24

Clearly the pricing tensions between managed care organizations and hospitals is one that I think we will have to address. I think that's a part of the cost sharing discussion that gets played out in a certain way.

25

But, clearly, I think the whole

1

2 managed care strategy is one that CMS is not  
3 going to discharge.

4

5 The population based disease  
6 specific initiatives, particularly when tied to  
7 the home and community based care model, is one  
8 that they will continue to encourage,  
9 particularly those that will address longstanding  
10 disparities in health care.

11

12 And so as we are having our  
13 discussions around our delivery system - what it  
14 ought to look like - when you overlay the ethnic  
15 populations and gender populations across the  
16 State of New York, if we were to take decisions  
17 that would hinder the state's ability to correct  
18 historical disparities among those populations -  
19 because we are limiting access or rearranging  
20 funding or addressing those particular providers  
21 of care to those affected populations - I think  
22 we are running in a counterdirection of where I  
23 think Washington policy would like to go.

24

25 I would say the same thing about  
26 specialty networks among physicians.

27

28 Of course the next thing that  
29 everybody knows about would be health care

1

2 information technology. This also I think is an  
3 aggressive technology and a new money strategy.

4 There are all kinds of waivers -  
5 grants, scholarships, demonstration programs that  
6 CMS and the Feds, other departments - ARC,  
7 et cetera - are encouraging. And there is a  
8 regional health information organization -  
9 electronic health records - these registries  
10 share decision-making platforms.

11 One of the things that might be  
12 informative to this group is if we could get an  
13 accounting or an assessment or update on programs  
14 underway in the State of New York that have  
15 already received federal funds for these  
16 initiatives. We might want to keep that in our  
17 thinking so we are not making decisions absent a  
18 strategy which has already been funded or  
19 endorsed by federal policy.

20 CHAIRMAN BERGER: We can do that.

21 MR. SHAW: The last three are very  
22 quick, because I think most people know about  
23 them.

24 The pay-for-performance is a policy  
25 direction that has a; lot of aggressive support

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2

in Washington. These are generally seen as new money in the short term, because you are getting superior, if you will, reimbursement for a specific performance.

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7

8

The hope over the long term, however, is that that new money will lead to overall systems cost savings.

9

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So I think that, again, should there be pay-for-performance demonstrations that have been approved for the State of New York, we should know who they are so that we could keep that in mind.

14

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18

Fraud, waste and abuse is always an aggressive agenda item in Washington. It is clearly seen as a cost saver. I know that every state Medicaid budget factors in so much from fraud, waste and abuse for coverage.

19

20

21

I am not sure what that number is here today, but it is something that I would imagine we want to keep in mind.

22

23

And then the last is this notion of competitive pricing and contracting.

24

25

If you look at Medicare policy and a series of the recent Medicaid waivers, there is a

1

2 general sense that when state payers actually  
3 render either competitive contracting for  
4 delivery of services - albeit the ancillary  
5 services are network rightsizing, even  
6 prescription drugs now - that there is a sense  
7 that there are savings to be had there.

8 The whole Medicare contractor reform  
9 initiative is a series of incentive-based  
10 contracts to rework the administrative structure  
11 of Medicare. There are a series of state waivers  
12 that are demonstration projects that include this  
13 competitive price and competitive bidding  
14 strategy.

15 Washington generally is permissive  
16 and encouraging of them. They can, of course, be  
17 dangerous if not done appropriately.

18 And I guess my last statement would  
19 be, if at some point it would make sense to have  
20 the regional office of CMS - folks we would all  
21 know - I think, present their policy initiatives  
22 for the State of New York and how that may play  
23 in, I think that would be fine.

24 Or having Dennis Smith or someone  
25 from Washington attend the Committee to again lay

1

2

out in more specific ways what the Medicaid

3

policy directions are, I would imagine, knowing

4

the parties involved, that they would be happy to

5

do so.

6

I hope that was helpful in what you

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wanted.

8

MR. HINCKLEY: I want to ask Ruben

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two questions. One might be getting beyond your

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realm of experience.

11

But first, in light of just

12

yesterday or maybe the day before, you had John

13

McCain talking about delaying Part D to help pay

14

for Katrina and Iraq and other federal

15

initiatives, you know, which was I think pretty

16

soundly rejected.

17

But, do you think that will cause,

18

those forces will cause an increase in the

19

\$10 billion Congressional target?

20

And then my second question is

21

unrelated, but it's something I think we have to

22

wrestle with here, is, the Department of Justice

23

view, anti-trust view in health care delivery

24

system, because there has been attempts - at

25

least in the hospital systems - to join together

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2 to make results more efficient on anti-trust  
3 issues.

4

MR. SHAW: I think the first one -  
5 and these are from limited conversations that I  
6 have had with folks, friends, as opposed to any  
7 official policy briefing. So please don't go  
8 back and say Ruben said, because he didn't.

9

But I will say that I do not think  
10 that a delay in the \$10 billion is likely. I  
11 also don't think it's likely to grow. I think  
12 the 10 billion number is a steep hurdle and most  
13 folks understand that.

14

I think to go back and say, well,  
15 now it has to be twelve or fifteen is a really  
16 tough sell and really bad politics. So I can't  
17 imagine them doing that this term.

18

I do think that there will be future  
19 rounds and the patterns - and that those future  
20 rounds will add on to the amount they want to  
21 take out of the Medicaid program.

22

And that I think the exchange for  
23 that, though, would be that Congress over time  
24 will get more prescriptive in how it's done.

25

If Congress is going to ask or the

1

2 Commission is going to ask the Medicaid stage to  
3 absorb more expenses and cut these funds, then  
4 they've got to do more than just lay out a  
5 benchmark and say go hit it guys and run for  
6 cover, which is essentially where we are.

7 They will have to come out with  
8 something I think a lot more insightful, model  
9 waivers and those kind of things, that would lead  
10 states to how they, Congress or CMS would like to  
11 see them get there.

12 I do know, from a general  
13 perspective on your second point, that the  
14 Department of Justice and the Inspector General  
15 are increasingly concerned about anti-trust  
16 issues. But I don't know if they have come up  
17 with a strategy on how they will address it or  
18 what they will do with that.

19 There are health care systems and  
20 there are integrated delivery systems. And if  
21 you call into question the ability of health care  
22 providers to link up and provide integrated care,  
23 then you are calling all kinds of other health  
24 care models into question. I'm not sure where  
25 they would draw the box or draw the line.

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They may figure out where and then go after that sweet spot. I just don't believe they have done that yet.

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CHAIRMAN BERGER: What you are saying - I think it's important - what you are saying, in listening to this, the 10 billion is real and we are going to get hit.

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The next stage, and it's not the end, there will be more. And as bad as the 10 billion is, it is probably a set of changes that we will have the option of making on our own if we meet the dollar bogey.

14

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The next round they may be changing our system.

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MR. SHAW: The true answer would be yes. There is a general commitment to what would be called transition grants or transition waivers and the bean counters and policy folks in Washington are most concerned about agreeing to a waiver that would give investment capital, if you will, up front money to transition the system, in hopes that there will be long term savings and efficiencies and improvement of quality that never materialized, so that you are back asking

1

2 for more money.

3 That's the biggest fear they have.

4 But presuming there is a rational  
5 case, they said over the long term we are going  
6 to restructure this thing, then you don't have to  
7 worry.

8 CHAIRMAN BERGER: Which is the case  
9 New York has made, which is the case New York has  
10 presently made.

11 And we believe -- And that's part  
12 of our job.

13 Our job is, we have got a billion  
14 and a half dollars which we better invest in ways  
15 that produce savings and produce a better system.  
16 That's part of it.

17 Other issues?

18 Craig.

19 MR. DUNCAN: Thank you and I enjoyed  
20 your presentation.

21 MR. SHAW: Thank you.

22 MR. DUNCAN: Very informative.

23 Just as a word of comment, perhaps  
24 caution, the discussion of the principles and the  
25 framework and the criteria, all being based on

1

2 data, is good, coming up with a common framework  
3 for us to work from.

4 Just as a caution though, sometimes  
5 perfect is the enemy of good.

6 And if you look over our shoulders  
7 too much at data and really at a market driven in  
8 a very different environment with all we face,  
9 even the last three or four years, considering  
10 some of the out-migration issues, we have to be  
11 very cautious in coming to some concensus with  
12 those that we need to, including ourselves, but  
13 really not get dragged down too much at ground  
14 level with this.

15 MR. HINCKLEY: I agree 100 percent.

16 I think the data will show us where  
17 we are today. I don't know how much it is going  
18 to show us what the system is going to look like  
19 ten years from now.

20 It might show us a trend in which  
21 way it's going. But we have got to use our own  
22 minds to get around that.

23 CHAIRMAN BERGER: It's part of, I  
24 think, our responsibility and I agree.

25 Dr. Gil.

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DR. GIL: I think that in terms of the criteria, which I think is essential to proceed with the work here - and I enjoyed Ruben's presentation and he was reminding me of the issues that we are confronted with safety net issues in New York City and New York State and the whole issue of health care disparities that need to be taken into account as we build a criteria here.

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And I am reminded, for example, even with the data that I saw from the previous meeting, and I think that we have known this for a while, that, for example, pediatric in-patient, the census has been low and low and low and low.

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And the question is, is that trend - because with the system has reconfigured itself in creating more primary care services that have prevented admissions in hospitals.

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Same concern I had for the opposite side of the data that I have seen, which is behavior health care is overwhelming hospitals with a capacity of about 100 percent where they are using psychiatry or substance abuse services.

25

And I certainly hope that we are not

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going to sit here and repeat the process of  
de-institutionalization that happened in the '50s  
as we emptied out the state psychiatric  
hospitals, because I think that then the great  
City of New York, Fifth Avenue, will be really -  
we will have those roaming on the street that  
really belong in a safety environment where care  
is being provided.

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So my early comment today in terms  
of the clarification of the different levels of  
care has to do, which is in a way in consensus  
with some of the principles that you have  
enumerated, which is, to achieve this goal to  
reconfigure the system, it can just not only be  
using a data on two levels of the system, but it  
behooves us to think beyond that and create  
community based services that can sustain the  
community, and whenever needed, and then go for  
acute care services.

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23

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So I hope that the struggle here in  
creating the criteria, that it has to be  
consistent. And I think that the word demography  
only speaks about those that we serve.

25

And I hope that we are going to be

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considering here, as safety net issues, the

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problems of the uninsured and the City of New

4

York and the state and who are the facilities

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that treat them, and who are the facilities that

6

do not treat the underserved.

7

And by doing so, what we do is we

8

increase the health disparities.

9

So as we struggle with that issue of

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the criteria, I think that we need to put these

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elements on the table.

12

CHAIRMAN BERGER: Pete.

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MR. VELEZ: David, my question is,

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in reference to Phase 2, as you begin to evaluate

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trends, historical trends, to hopefully get a

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projection of trends going forward, my

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recommendation would be, rather than waiting to

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finalize this trends and coming up with a

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potential recommendation, I think it is critical

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that we begin to be transparent in the process,

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share that information with as many people

22

outside of this entity as possible, so that we

23

can get the right feedback to see whether what we

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have decided of the potential trends, as we

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define health care going forward, that we share

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2 that information so we can make better decisions  
3 going forward.

4

CHAIRMAN BERGER: I saw a hand.

5

MR. SHAW: Right here.

6

7 I went through the factors book when  
8 it was first sent to me. I hope everybody else  
9 did.

10

11 And Factor Number 8 I think is one  
12 that, just as what Dr. Gil and others have been  
13 talking about this morning, and it very clearly  
14 says that we are to consider services that are  
15 serving Medicaid recipients, the uninsured and  
16 underserved communities.

17

18 Now, to me, underserved communities  
19 would include issues of health care disparities  
20 in ethnic populations, regional underserved  
21 geographies in the State of New York, as well as  
22 certain medical conditions.

23

24 And I think the mentally disabled  
25 and the developmentally disabled would be in that  
26 category.

27

28 So if we are looking for additional  
29 criteria to use, then my suggestion would be that  
30 we make sure that they are not already addressed

1

2 in the current nine factors that were given to  
3 us, and then average whichever ones we don't.

4

5 If we need to mine these down to  
6 specifics to make them more clear, I am okay with  
7 that.

8

9 But if we are coming up with a new  
10 list of criteria that have no connection with  
11 these factors, it is not going to be why we would  
12 want to do that, given the time that we have to  
13 do this whole thing.

14

15 CHAIRMAN BERGER: The factors are  
16 pretty broad. We just about have everything.  
17 You have the ability to use them to make  
18 judgments.

19

20 I think the difficulty will be --  
21 My private thought in an open  
22 meeting is the difficulty will be that we start  
23 with an embedded infrastructure serving  
24 populations in this state which has grown up over  
25 a long period of time. And the difficulty for us  
is, as we come together and try to come up with  
criteria, we will see the shape of - not the  
totality, but the shape of - very different  
patterns, which those institutions are very

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2 important, but very different patterns of patient  
3 care and health care.

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And we have to make our judgments in  
the face of imbedded infrastructure and the  
change that we are talking about has got to be  
environmental, it has got to be incremental, it's  
got to be evolutionary and it's got to be real,  
so we can have an impact on the system.

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And that is not going to be easy for  
this group and for our colleagues on the region.

But I think if you look at the  
factors, a lot of that stuff is covered in there.  
But we have to try to figure out how to deal with  
them.

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MR. SIMONE: (via speakerphone)

Steve, I have a comment when you have an opening.

CHAIRMAN BERGER: Sure.

MR. SIMONE: Opening now?

CHAIRMAN BERGER: Yes, go ahead.

MR. SIMONE: Just real quick, you  
started out by saying that we had 65 percent  
capacity utilization. That means some parts of  
the state are going to be 100 percent and some  
are going to be 35 percent and we are talking

1

2 about criteria.

3

4 It's just a thought, we might need -  
it might be different categories of the criteria.

5

6 You might need a set of criteria of  
hospitals that fall in one capacity category and  
7 criteria of those that fall in another. There  
8 might be reasons why one is 35 and one is 100.

9

10 And we ought to be able to  
accommodate those reasons and maybe the criteria  
11 that we base decisions on.

12

13 CHAIRMAN BERGER: I agree. Although  
I think we will find that there are very few that  
14 are 100. And there is a spread. I mean, there  
15 is obviously a spread in every region.

16

But we will get you some of the --

17

18 As you look at the information by  
hospital, you will be surprised at some of the  
19 occupancy rates, even at hospitals you didn't  
20 expect; you would think would be higher.

21

22 But I agree, there are some that  
have greater utilization.

23

Anything else?

24

25 MR. ROBERTS: Occupancy rates and  
things like that, this Commission has some

1

2 diversity in its knowledge base.

3

4

5

I, for one, could use an education  
on what desired occupancy rates at hospitals  
would be.

6

I can tell you about nursing homes.

7

CHAIRMAN BERGER: 100 percent.

8

MR. ROBERTS: 100 percent.

9

10

11

But I don't know -- There was some  
discussion at the last meeting about that, which  
was an eye-opener for me.

12

13

14

15

So there is an educational component  
that I hope David accepts, to make sure that we  
are all relatively on the same footing. We will  
never be on the same.

16

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18

CHAIRMAN BERGER: We ought to do  
that and we will do that. And that is part of  
what the discussions on the data have been.

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I would only like to point out - to  
pick up on things that other people have said -  
is that today's occupancy rates, based on today's  
medical system and today's institution and  
today's patterns of care - and they may not be  
tomorrow's occupancy rates - or not tomorrow,  
next month or ten years - are based on different

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2 patterns of care.

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And that was part of the reason, I think, that Bob, for example, raised the issue, that we are investing billions of dollars in patterns of care that are present patterns of care and they may be changing dramatically.

And that's part of the reason why we raised the Certificate of Needs issue and that's what's the difficulty: balancing data and occupancy rates of today against both needs and changes in patterns of care as we go forward, because we want to invest in the change.

I think that's part of what our mandate is.

MR. VELEZ: If we don't deal with the reimbursement issue, that pattern of change will be very, very difficult to accomplish.

CHAIRMAN BERGER: I got to tell -- Absolute.

DR. GIL: Absolute.

CHAIRMAN BERGER: And I think that when we come to deal with that, which will be near the end, as we start to figure out where we want to go, just everybody understand, every

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2

person you ever met anywhere in the health care

3

industry will be visiting you on your lawn and in

4

your apartment building and in your elevator.

5

MR. VELEZ: It's already started.

6

CHAIRMAN BERGER: Because everybody

7

who has a public -- I am going to speak about

8

the Medicaid.

9

Everybody who has a public Medicaid

10

dollar today believes in their heart that they

11

own it and it should really be \$1.10.

12

MEMBER: No, \$1.40

13

CHAIRMAN BERGER: And I agree. I

14

have said that before. We have got to deal with

15

reimbursement, I absolutely agree.

16

Any other comments?

17

We have created a mission and a

18

charge for our staff to start getting back to us

19

and to start thinking.

20

I also encourage the following: I

21

encourage members of the Commission to

22

communicate directly, obviously, with the

23

Executive Director of the staff, to talk to them,

24

to give them ideas, to go back and forth.

25

They have the ability. That

1

2 technology works. They will communicate to us,  
3 the rest of us, on ideas that any of you generate  
4 and we can communicate by e-mail and talk ideas  
5 back and forth and we will do so.

6

And I think that is important so  
7 that we can have some of this going back and  
8 forth before the next meeting.

9

Business - organizational business.  
10 The next meeting will be November 10th. It will  
11 be from one to three p.m.

12

Do I know where? Here.

13

And the mikes will work.

14

Second, for your records for next  
15 year, so we can get it on everybody's schedule,  
16 please hold the second Thursday of each month.

17

And if you ask me about August, I  
18 will give you the same answer the staff gave me -  
19 hold all the months, second Thursday of each  
20 month for meetings.

21

And by the next meeting, Kristin, I  
22 will be able to respond to the judgment about  
23 subcommittees and we are going to --

24

I encourage everybody who is here at  
25 the Commission - the regional members, and our

1

2

friends in the audience - to encourage the

3

appointment of the remaining Regional Commission

4

members and the RAC members.

5

Any of you who have friends in the

6

Legislature, I encourage you to reach out to

7

them, because we want to get this process started

8

and we need the rest of the Regional Commission

9

members appointed to begin scheduling the public

10

meetings.

11

Is there anything else?

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Kristin.

13

MS. PROUD: I have a point to raise

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that I think carries over from last meeting and

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from some of the discussion that we had today

16

about the data, and that is with respect to the

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nursing home data.

18

Prior to the first meeting we

19

received data about hospital closures in the last

20

five or ten years and what, if anything, has

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happened with those facilities in terms of the

22

actual infrastructure.

23

And there has been a request for

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similar data, if it exists or if it can be

25

compiled, with respect to nursing homes.

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DR. SANDMAN: It has been compiled  
and we will get that out to you.

3

4

CHAIRMAN BERGER: We got it; we'll  
get it to you.

5

6

MS. PROUD: Just looking ahead,  
since we are talking about scheduling of 2006,  
the Phase 3 of the work plan as currently drafted  
calls for regional hearings to be held as  
required under the statute.

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I was wondering what would be an  
appropriate rule, if any, or what the thinking is  
with respect to attendance by or participation of  
the state-wide Commission members in the various  
regions across the state, because we all  
obviously are representing or at least coming  
from different regions of the state.

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CHAIRMAN BERGER: I asked Kristin  
to -- Kristin raised this with me and we started  
talking about this before.

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25

I'll give you my reaction. Mark,  
I'd like hear what your sense is.

My reaction is that as a gathering  
of knowledge, if there is a regional meeting and  
you want to attend, I think as a knowledge-

1

2 gathering feel and touch for what's happening,  
3 it's fine.

4 But they are separate activities.  
5 And they are separate meetings and there are  
6 meetings for both the RACs and the regional  
7 people and we shouldn't participate.

8 We can be there be as an informed  
9 audience, got to duck answering questions about  
10 whether did my institution convince you today  
11 that it's, you know, whatever, as we all know.

12 But my sense is, for information  
13 it's fine. But it's not your meeting; it is not  
14 our meeting. And we ought to leave it to the --

15 It's the regional people's meeting.

16 Isn't that the way sort of the --

17 MR. KISSINGER: Yes, that's my  
18 sense, too. That's the interpretation or the  
19 intent going into the statute, that there would  
20 be a regional structure operating separately.

21 CHAIRMAN BERGER: Joe.

22 BISHOP SULLIVAN: Is mental health  
23 part of our responsibility?

24 MR. KISSINGER: We were just talking  
25 about that.

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DR. GIL: Joe, in most acute care facilities in New York City - I don't know the rest of the state - there are in-patient psychiatric units. And this is the concerns that I --

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8

BISHOP SULLIVAN: Because there is a lot that is not there.

9

10

DR. GIL: There is a lot that is not there, absolutely.

11

12

And I think that perhaps we need some data in this particular --

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14

15

The same thing with the developmentally disabled, that I think it would help us to look at this medical perspective.

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18

MR. KISSINGER: I mean, the Commissioner of Mental Health has also approached me about that exact question.

19

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22

I talked to her a lot about a role for her or her staff on this endeavor. So I think it's inevitable, in a way, but I don't want to be swallowed up in there.

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24

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MR. HINCKLEY: I think it's a difficult task to take, because if you are going to do it right, you have to start dealing with

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2 the state psychiatric institutions and that's a  
3 whole different --

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MR. SHAW: If I can make a  
statement.

I can understand why we and many  
other people, as a group, may want to say it's  
just too complicated, we have enough to do, let's  
not do it.

And that's the traditional approach  
to mental health issues, particularly with  
facilities.

I do think that if you have a  
Commission on health care facilities for the 21st  
Century, and you don't deal with the fact that  
many of the facilities and the delivery systems  
that we are talking about have an important role  
to play for these populations of the  
developmentally disabled and the mentally  
retarded, then I think it's a disingenuous  
report in the end.

And so we can screen it out now and  
be very clear about what it is and what it's not.  
But I think it begins to slant our findings with  
a bias that we define up front.

1

2

There is some risk in that, in my

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opinion.

4

CHAIRMAN BERGER: Could I make a

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suggestion, because when I was initially asked

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before the Commission legislation sort of finally

7

passed, what do you think - because it's going to

8

be a base closing commission - I said no,

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whatever the Commission legislation mandate is,

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once you step into this field, and no matter how

11

narrow - and this statute is not narrow by the

12

way - no matter how narrow it is, it will open up

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on day one, because all of these issues will

14

suddenly appear in front of you and you are going

15

to have to deal with that.

16

I think what we have to do, so as

17

not to get swallowed by any piece of this --

18

By the way, we could get swallowed

19

and it doesn't have to be mental hygiene issues -

20

it could be the acute care; it could be the long

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term care; it could be the at home care; it could

22

be just any one of these issues; it could be

23

reimbursement issues - we have to try to keep

24

ourselves so that what we create is not the

25

perfect answer and the total solution that nails

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2 every - dots every 'i' and crosses every 't'.

3

4 And I think if our approach is we  
5 want to create a process, a framework, a  
6 decision-making framework and make the first of a  
7 series of decisions, we will be okay and we can  
8 keep the wide perspective.

8

9 We just cannot solve each and every  
10 part of the system's problems in the next fifteen  
11 months.

11

12 But we can lay out where we think it  
13 ought to go and take the first steps. I mean, we  
14 do have to take the first steps.

14

15 If it was just a theoretical  
16 Commission, then you put the books on the shelf  
17 and it would go away.

17

18 So we have got to get ourselves far  
19 enough along. And, I agree, we have got to keep  
20 a wide perspective so we at least know what's  
21 going on.

21

22 But at some point we are going to  
23 have to make some focused decisions.

23

24 BISHOP SULLIVAN: Because it strikes  
25 me that there is a fair amount of change in  
26 mental health and there is, to a large extent,

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2           it's an ambulatory care system, not all that well  
3           put together. And it's a housing system as well.

4                         CHAIRMAN BERGER: Or lack thereof.

5                         BISHOP SULLIVAN: Yes. So it just  
6           strikes me, if you talk about health delivery,  
7           this is a major issue.

8                         CHAIRMAN BERGER: Still want the  
9           job?

10                        DR. GIL: Come on, David. You have  
11           big shoulders.

12                        CHAIRMAN BERGER: Youth, large  
13           shoulders and he has got to go to the gym to keep  
14           his strength up.

15                        Anything else? We covered a lot.

16                        I want to thank you all for your  
17           participation and we look forward to seeing you  
18           in November.

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21                                 (Time noted 12:35 p.m.)

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C E R T I F I C A T E

I, ELLEN REACH, a Shorthand Reporter and  
Notary Public within and for the State of New  
York, do hereby certify that I reported the  
within-entitled proceedings on Wednesday,  
September 21, 2005, and that this is an accurate  
transcription of what transpired at that time and  
place.

\_\_\_\_\_

ELLEN REACH,  
Shorthand Reporter