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Transcript of the Meeting of the  
COMMISSION ON HEALTH CARE FACILITIES  
IN THE 21ST CENTURY  
Held on Thursday, March 9, 2006,  
71 West 23rd Street,  
New York City

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1 Meeting convened at 1:30 p.m.  
2 P R E S E N T:  
3 STATEWIDE MEMBERS:  
4 STEPHEN BERGER - Chair  
5 LEO P. BRIDEAU  
6 ROBERT J. GAFFNEY  
7 DR. ROSA M. GILL  
8 ROBERT HINCKLEY - Vice Chair  
9 HOWARD T. HOWLETT  
10 DARLENE D. KERR  
11 RUBEN JOSE KING-SHAW  
12 MARK L. KISSINGER  
13 KRISTIN M. PROUD  
14 G. NEIL ROBERTS  
15 THERESA A. SANTIAGO  
16 BUFORD R. SEARS  
17 ALBERT SIMONE - (via telephone)  
18 BISHOP JOSEPH SULLIVAN  
19 PETE VELEZ  
20 COMMISSION/DOH STAFF:  
21 DR. DAVID SANDMAN  
22 MARK USTIN, ESQ.  
23 NEIL BENJAMIN - Department of Health  
24 LISA WICKENS - Department of Health  
25

1 REGIONAL MEMBERS:  
2 PATRICIA ACAMPORA  
3 STEPHEN L. ALBERTALLI  
4 PAUL S. BOYLAN, ESQ. - (via telephone)  
5 BERT BRODSKY  
6 PETER CAPOBIANCO  
7 CAROL CASSELL - (via telephone)  
8 SUSAN M. CROSSETT  
9 JEFFERY DAVIS  
10 BONNIE DeVINNEY  
11 ROBERT DOAR  
12 R. ABEL GARRIGAN  
13 RICHARD V. GUARDINO  
14 JOHN F. HAGGERTY  
15 DOROTHY M. HARRIS  
16 KIM KUBASEK  
17 PATRICK MANNION  
18 HERBERT D. MARSHALL  
19 JUDGE JOSEPH MATTINA  
20 WILLIAM MOONEY  
21 HEIDI A. NAULEAU  
22 DONNA O'BRIEN  
23 JOHN/JACK O'CONNELL  
24 DR. JEFFREY SACHS  
25 SISTER MARY ANN SCHIMSCHEINER

1 REGIONAL MEMBERS: (Cont.)  
2 ANDREW SICHENZE  
3 HENRY SLOMA  
4 ARTHUR SPIEGEL  
5 JERRY WEBER  
6 ARTHUR WEINTRAUB  
7 LELIA WOOD-SMITH  
8 LIAISONS:  
9 DR. WILLIAM STRECK  
10 PAUL MACIELAK, ESQ.  
11 LAURA LEFEBVRE  
12 MARY ANN GRIDDLEY  
13 LORA LEFEBVRE - DASNY  
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## 1 P R O C E E D I N G S

2 CHAIRMAN BERGER: I would like to call  
3 the meeting to order. We would like to begin.

4 David, why don't you take us through the  
5 progress report. It's been quite a busy time in the  
6 last month.

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

8 I am pleased to make this report on our  
9 progress since our last meeting.

10 Since last month, several new  
11 appointments have been made to the Commission by  
12 both the Senate and the Assembly. The Senate has  
13 appointed two additional regional members, including  
14 Jerry Weber, for the New York City region, and Herb  
15 Marshall, for the Central region.

16 In addition, the Assembly has also  
17 appointed two new regional members, both of whom  
18 come from the Western region. The first is Carol  
19 Cassell and the second is Sister Mary Ann  
20 Schimscheiner.

21 We are pleased to welcome all of the new  
22 members to the Commission.

23 With respect to our work plan, we are in  
24 the analytic part of phase three. Much of the  
25 focus, as you know, is now on the Regional Advisory

1        Committees and providing them with the materials and  
2        the support that they need to be successful in their  
3        work. The staff is assisting the RACs by attending  
4        their meetings and their hearings, providing  
5        background research, compiling and analyzing  
6        additional data, and providing logistical support to  
7        them as needed. All of the RACs are highly engaged  
8        in their work. They are reviewing data relevant to  
9        their region and holding discussions with providers,  
10       as well as other stakeholders within their regions.

11                Since our last meeting, we have been  
12       engaged in an intensive series of public hearings  
13       across the state sponsored by the RACs. To date, we  
14       have conducted public hearings in locations as  
15       diverse as Niagara County, Buffalo, Binghamton,  
16       Syracuse, Albany, Plattsburg, Westchester, New  
17       Paltz, Middletown, Staten Island, Brooklyn and  
18       Queens. In addition, we do have a number of  
19       additional hearings either scheduled or in the  
20       planning stages and these include Jamestown,  
21       Rochester, Watertown, The Bronx, Manhattan,  
22       Riverhead and Hempstead, Long Island. And by the  
23       time we are done, I expect we will have conducted  
24       approximately 20 hearings across the state.

25                As previously reported to our members, we

1 have been developing a procedure that would  
2 encourage voluntary right-sizing discussions among  
3 providers and address antitrust concerns. Our  
4 Chairman and our Counsel, Mark Ustin, will have more  
5 to say on this subject in detail. But I am pleased  
6 to report that we have successfully developed such a  
7 policy with support from the Department of Health  
8 and the Office of the Attorney General. This  
9 significant development is being promulgated today  
10 by the Commission and Department of Health. Copies  
11 will be sent to all providers in the state and will  
12 also be posted on the Commission website later  
13 today.

14 Also, as discussed at our last meeting,  
15 the membership reiterated the need to examine the  
16 reimbursement systems and to make recommendations to  
17 realign the financial incentives to promote a  
18 reconfigured system. To that end, the staff has  
19 begun working on background papers that will be  
20 shared with the Commission members to inform their  
21 deliberations. We do, of course, continue to engage  
22 in an active communications program, both for us to  
23 receive information from the public and interested  
24 organizations and to make information readily  
25 available to the public and our membership.

1                   Some recent meetings and presentations  
2                   with various constituencies have included the New  
3                   York State Health Facilities Association, the  
4                   Greater New York Hospital Association, Central New  
5                   York Health Systems Agency, in Syracuse, the New  
6                   York City Council, Primary Care Development  
7                   Corporation as well as the Community Health Care  
8                   Association of New York State.

9                   So, Mr. Chairman, in summary we remain on  
10                  schedule and making good progress with our work.

11                  CHAIRMAN BERGER: Thank you very much.

12                  David mentioned, and I'm going to ask our  
13                  general counsel to take us through the procedure  
14                  that we're going to promulgate on voluntary  
15                  right-sizing. When this Commission was established,  
16                  it was clear that the task was enormous, but the  
17                  environment was ready for a serious review of  
18                  structure as it existed. The Commission was  
19                  established and exists because there was general  
20                  support through the industry for a good, clean look  
21                  at the institutions as they existed in the future.  
22                  One of the things that has -- that I found very  
23                  positive during the last several months as we've  
24                  been organizing ourselves, working on data, meeting  
25                  with communities, that I found and other members of

1       this Commission have found and members of the  
2       regional commission members have found and members  
3       of RAC have found is that the industry itself has  
4       been thinking about -- somewhat triggered by the  
5       existence of this Commission, but out there in the  
6       environment -- ways in which right-sizing  
7       reconfiguring could take place. But, frankly, every  
8       place we went they said, "well, we really can't sit  
9       down and do this. It's complicated, it's  
10      cumbersome, there is the antitrust issue, there is  
11      the Health Department, there is this, that and the  
12      other."

13                So, today, what we're trying to do is  
14      take care of "this, that and the other" and see if,  
15      in fact, there are opportunities in the system  
16      voluntarily for progress to be made, with the  
17      general goals and directions of this Commission kept  
18      in mind.

19                I am going to ask Mark Ustin, our General  
20      Counsel, who has worked on this, to just outline the  
21      terms and shape of the procedures that we're putting  
22      into place.

23                MR. USTIN: Sure.

24                Just a couple of initial points.

25                First, as many of you already know, the

1 Commission's mandate extends not only to formulating  
2 recommendations for the right-sizing of the hospital  
3 and nursing home systems, but also "fostering  
4 discussions" among stakeholders. So this process is  
5 completely consistent with our mandate under our  
6 enabling statute.

7 Basics on antitrust law. The fears of  
8 some of the providers who are interested in engaging  
9 in some kind of a voluntary initiative are not  
10 unfounded. Federal and state antitrust laws, for  
11 any of you who are not aware, do forbid conduct that  
12 poses an unacceptable danger to competition. Things  
13 that spring to mind are price fixing, market  
14 allocation, certain mergers, that sort of thing.  
15 The laws are enforced by the Federal Department of  
16 Justice, the Federal Trade Commission, the State  
17 Attorney General and even private litigants. And  
18 the consequences can be severe. They can range from  
19 civil remedies, the most obvious being an injunction  
20 forbidding the arrangement, to even criminal  
21 penalties, including both fines and in some cases  
22 even imprisonment. In particular, in New York there  
23 have been some notable cases where deals that seemed  
24 like they were finalized have been undone. However,  
25 not all anticompetitive arrangements do violate

1 antitrust laws.

2           Some are small enough and inoffensive  
3 enough that regulators have indicated they'll ignore  
4 them, specifically if they fall within certain  
5 defined safe harbors. Some are outweighed by  
6 pro-competitive efficiencies that are achieved. A  
7 perfect example being a two-hospital town where the  
8 two hospitals agree to share certain services, to  
9 allocate certain services, in order to keep one from  
10 closing and thus allow them to continue to compete  
11 in other areas.

12           Some are outweighed by other policy  
13 goals. For instance, where market allocation can  
14 result in improved quality of care. The ones that  
15 are most important for us, though, are those  
16 situations where an otherwise problematic  
17 anticompetitive arrangement is protected by the  
18 Constitution.

19           In some cases, where the states enact or  
20 are exempt from antitrust laws based on principles  
21 of federalism; that is, the federal government  
22 cannot dictate policy to a state. And from the  
23 point of view of the state's own laws, its antitrust  
24 laws can confound policies that are expressed in  
25 other statutes.

1                   Another useful one is where  
2                   anticompetitive action involves the petitioning of  
3                   state government. That's actually protected under  
4                   the First Amendment. And that's called the  
5                   Noerr-Pennington Doctrine, named after two seminal  
6                   cases in the area. Both the state action doctrine  
7                   and the Noerr-Pennington Doctrine are clearly  
8                   applicable to the Commission.

9                   The Commission recommendations themselves  
10                  are unlikely to be subject to state antitrust laws.  
11                  In particular, under state action, two things are  
12                  required: A clearly articulated state policy and  
13                  active state supervision of the arrangement. The  
14                  Commission enabling statute clearly sets out the  
15                  Commission's policy in favor of conforming service  
16                  supply to regional needs and the Commission's active  
17                  role in formulating its recommendations and the  
18                  Department of Health's active role in implementing  
19                  them supply the needed active supervision.

20                  Now, it's also arguable that the  
21                  existence of the Commission may provide some level  
22                  of state action protection to voluntary initiatives.  
23                  The problem there, though, is the active supervision  
24                  component. Unless some state agency, whether it's  
25                  the Commission or DOH, has a role in the development

1 of such initiatives, its arguable that the degree of  
2 state supervision will not be sufficient to meet  
3 that threshold.

4 So, this procedure that we're announcing  
5 today is an attempt to supply that level of active  
6 supervision not only just to meet the legal  
7 threshold, but also to ensure that any voluntary  
8 right-sizing activities undertaken prior to the  
9 issuance of the Commission's recommendations are  
10 consistent with the Commission's mandate.

11 The procedure provides the following:  
12 Facilities that want to pursue such discussions are  
13 required to first contact our executive director and  
14 express that intent in writing. The executive  
15 director will then arrange a discussion among those  
16 facilities, Commission staff and/or members and DOH  
17 staff. After such discussion, the Commission and  
18 DOH participants will determine whether the  
19 contemplated activities are consistent with their  
20 policy objectives. And if so, the facilities will  
21 be authorized to continue such discussions, provided  
22 they update the Commission and DOH on such  
23 discussions on a regular basis.

24 If at any point the Commission or DOH  
25 determines that the contemplated right-sizing

1 activities are not consistent with policy  
2 objectives, the procedure terminates and the  
3 participating facilities are on their own at that  
4 point.

5 The final objective of these discussions  
6 is either to develop a plan that can be implemented  
7 prior to Commission recommendations or more likely  
8 incorporated into such recommendations.

9 Now, as David mentioned, this procedure  
10 has been developed in conjunction with the  
11 Department of Health and it's also received verbal  
12 support from the Attorney General's Office. I can  
13 tell you on the staff level we had a very productive  
14 meeting with their health care and antitrust staff  
15 and they expressed full support for it and indicated  
16 they will continue to do so.

17 Further details about the procedure are  
18 going to be posted on our website after this meeting  
19 and transmitted to all facilities via the Health  
20 Provider Network.

21 If there are any other questions,  
22 certainly feel free to contact us. And if there are  
23 any questions from Commission members now, we'll  
24 take them.

25 CHAIRMAN BERGER: Just as a final piece,

1 the staff, our staff, Department of Health staff and  
2 Attorney General's staff have worked on this given  
3 the incredible sensitivity that exists in the health  
4 community on this subject area. I spoke directly  
5 with the Attorney General himself who was very  
6 supportive. He was totally briefed, he knew exactly  
7 why I was calling, he knew exactly about the issue,  
8 he had worked with his staff and he personally told  
9 me he is very supportive. And I said, "Well, I'm  
10 going to say that in public." He said, "I'm very  
11 supportive and you can say it in public." So, I am.  
12 So, we're hopeful that this will become a part of  
13 one of the tools we can use as we move forward.

14 Now, we've had some people come on to the  
15 phone since we began the meeting. Could I sort of  
16 get a roll call of who is on the phone?

17 MS. CASSELL: This is Carol Cassell.

18 CHAIRMAN BERGER: Carol, welcome to your  
19 first Commission meeting.

20 MS. CASSELL: Yes. Pleased to be here.

21 DR. SIMONE: Al Simone.

22 CHAIRMAN BERGER: Welcome.

23 DR. SIMONE: Thank you.

24 MR. BOYLAN: Paul Boylan. I'm still  
25 here.

1                   CHAIRMAN BERGER: Okay, Paul. Thank you  
2 very much.

3                   Are there any questions on the procedure?  
4 Kristin.

5                   MS. PROUD: Given, Mark, as you said  
6 earlier in your presentation, that the U.S.  
7 Department of Justice, as well as the Federal Trade  
8 Commission do also look at these issues, even though  
9 we have the full support at the state level of all  
10 of the involved bodies, the Attorney General's  
11 Office, the Department of Health, where does that  
12 leave the facilities that may enter into these  
13 conversations with respect to potential review or  
14 action by the federal agencies?

15                   MR. USTIN: Certainly the federal  
16 agencies are at liberty to act, you know, as is any  
17 regulator. However, the legal analysis is the same  
18 on both levels and in particular the Attorney  
19 General's support of the process, as well as the  
20 Department of Health's support of the process, I  
21 think provides a substantial level of protection,  
22 certainly more than they have absent a procedure  
23 like this.

24                   CHAIRMAN BERGER: As a non-lawyer I asked  
25 the same question and got that answer.

1           I think that at some point having the  
2           full support of the state -- sort of the entire  
3           state's position, we are going -- we'll have some  
4           conversations with Washington, if they think we have  
5           to. But we thought it was very important having all  
6           the state apparatus lined up as the basis for us to  
7           proceed.

8           MS. PROUD: I just would hate to see the  
9           hospitals and nursing homes still be reluctant to  
10          participate because they would then be nervous that  
11          when they were afraid at the state level, now  
12          they're fearful at the federal level.

13          CHAIRMAN BERGER: We have got to try and  
14          find out if we get some nods some place.

15          MR. BRIDEAU: Related to that, have we  
16          gotten an indication from the Attorney General that  
17          this rises to the level of state action immunity?  
18          Is it that level of protection or is it simply some  
19          useful facts?

20          MR. USTIN: They have said that they deem  
21          it to be sufficient.

22          CHAIRMAN BERGER: Right.

23          And I want to thank both our staff, the  
24          staff of the Health Department and the Attorney  
25          General's staff, all of whom worked together on this

1 smoothly and clearly and it was terrific seeing the  
2 three organizations pull this off.

3 Anything else? Okay.

4 I would like to take a minute and sort of  
5 outline a little bit of where we're going in the  
6 future and have my colleagues comment if they wish.

7 During this last period of time, as  
8 David, as our executive director, David Sandman, has  
9 pointed out, we have begun a very extensive process  
10 with the Regional Advisory Committees throughout the  
11 state. And this process is continuing on and will  
12 continue through the next month. And what's  
13 happening is exactly what we asked to happen. There  
14 are public hearings in which people are coming and  
15 testifying. There are private meetings. There are  
16 conversations going on. There is a gathering of  
17 information that's taking place.

18 The next stage is for us, as the  
19 Commission, and that means the full Commission as  
20 well as regional members from each area, to begin to  
21 take in some of that information so we can begin to  
22 discuss it in the framework that we will create with  
23 data and other information. But what we said from  
24 the beginning, the data is only one small piece of  
25 the deliberation process. A big part of it is what

1 we learn from the field and it's getting time to  
2 begin to hear from the field.

3 Our intention is to begin having  
4 preliminary reports from the RACs. And I am very  
5 careful. I said "preliminary reports" because  
6 they'll continue to develop information and continue  
7 to feed to us. But to sit down and have preliminary  
8 reports from each RAC. And have them discuss with  
9 us what they are finding, what information they are  
10 gathering, information about need, information about  
11 institutions, information, much of which, some of  
12 which is gathered from the public, but a great deal  
13 gathered in private. We have tried as a Commission  
14 to be very transparent and talk about exactly how  
15 we're operating. That information, first by sanity  
16 and second by statute, is not information which  
17 we're prepared and should not be discussed in public  
18 until this Commission has an opportunity to review  
19 it, digest it and ultimately make decisions at the  
20 end of the year. The one thing we do not want to do  
21 is in any shape or form impair institutions just  
22 merely because their name gets mentioned sitting  
23 around a table in an early discussion. We are not  
24 going to do that. That's not our mandate, that's  
25 not our job. So, we are going to have the

1 discussions -- we're going to ask for the  
2 preliminary reports from the RACs to take place in  
3 executive session, which is allowed under our  
4 charter. After a public meeting we will go into  
5 executive session and we will have preliminary  
6 reports from the regions beginning at the next  
7 meeting.

8           At those sessions, we'll ask the RACs to  
9 report both on what they've discovered, what their  
10 analysis is and that will give the Commission  
11 members and the regional Commission members an  
12 opportunity to begin to incorporate those reports  
13 with the information and data that we have from each  
14 region. This will be, I will tell you, it will be  
15 an interactive process and will go on over a period  
16 of time. Our hope is we will begin it at the April  
17 meeting with one RAC reporting, the first one that's  
18 ready. The May meeting we'll probably have three  
19 RAC reports. The June meeting two RAC reports.  
20 Then probably going forward we'll go back to the  
21 RACs, go back to the people. This will be an  
22 interactive process going through the summer as we  
23 try to sort through all the data.

24           I just wanted people to understand what  
25 the process is going to be because that is, we

1 believe, the correct way to talk and to try to  
2 digest the information. I've obviously warned my  
3 fellow Commissioners that as we start adding to  
4 this, that those meetings may be long. And the  
5 rules require that if at any point we do make a  
6 decision in executive session that we come back into  
7 public session and report that. But the intention  
8 over the next several months is not a decision  
9 making process, it is an information gathering  
10 process from regional people who have now been out  
11 meeting and doing what they're supposed to be doing.

12 So, that's the way I expect the shape of  
13 the next three meetings in particular to be, where  
14 we'll begin gathering the information from the  
15 people, from the field people who have been out  
16 there gathering it for us.

17 We have a procedure which will be  
18 circulated which governs going into executive  
19 session. It's publically posted?

20 MR. USTIN: Yes.

21 CHAIRMAN BERGER: It's publically posted  
22 so everybody will know what we're doing. But if we  
23 ever make a decision in executive session, the law  
24 requires that we come back out into the public  
25 meeting and report it.

1                   The next few months we're just going to  
2                   be gathering information about what's been found out  
3                   there.

4                   Any comments from any of my colleagues?

5                   MR. SEARS: Steve, for the benefit of the  
6                   folks on the phone, you may want to mention that --  
7                   I think we talked about it -- once we go into  
8                   executive session, participation by phone is no  
9                   longer allowed.

10                  CHAIRMAN BERGER: Yeah. I've talked to  
11                  my colleagues and while the statute allows for  
12                  participation by phone for our meetings, I am very  
13                  uncomfortable -- and I think most people share that  
14                  -- with having executive sessions and people on the  
15                  phone. When we're all in the room we sort of all  
16                  know who is there and we have confidentiality and  
17                  protection, not that anybody, any member of this  
18                  Commission, would violate that, but accidents do  
19                  happen. And we just think we're dealing with -- we  
20                  have a responsibility to the institutions. So for  
21                  executive sessions, we have all agreed that we're  
22                  going to do this in person. I think that's right.  
23                  And I think it's only fair to the people we're  
24                  talking about. And I apologize, but I think that's  
25                  the way it's got to be.

1                   Any other --

2                   BISHOP SULLIVAN: Did you want to mention  
3                   that fostering discussion includes voluntary  
4                   initiatives at the local level to come to a  
5                   consensus on recommendations?

6                   CHAIRMAN BERGER: I think that's the  
7                   point of the previous discussion, the voluntary  
8                   right-sizing procedures, is in fact to encourage any  
9                   -- many people of have said to us we have great  
10                  ideas, we understand what your mandate is and we're  
11                  ready to go, but we don't think we're allowed to.  
12                  Well, come talk to us about it. We have to sit in  
13                  the room. But if you're on the right track, we're  
14                  going to help you.

15                  At the last meeting we had to out off --  
16                  we actually -- I guess we sort of got delightfully  
17                  wrapped up in the report that you folks were doing  
18                  on the hospitals of the future. We cut you off  
19                  because we said we did not have enough time to talk  
20                  about the nursing homes. Now you guys have a real  
21                  problem because your last act was real good. So,  
22                  you got a postponement to do act two, so you just  
23                  got to be as good as the last one. And we said to  
24                  Neil Benjamin and Lisa Wickens, come back, we don't  
25                  want to cut you off, do the nursing homes at the

1 next meeting. And we're now going to take a look.

2 Are you guys going to take it over?

3 MS. WICKENS: Yes.

4 MR. BENJAMIN: Thank you.

5 We're going to pick up where we left off  
6 last time. Unfortunately Tom Jung, who took a large  
7 part of the lead last time, is down in St. Croix.  
8 He wasn't able to convince me it was a business  
9 trip, even though he said he was going to check out  
10 their nursing home structures.

11 But seriously, be that as it may, I just  
12 wanted to start off by giving you a real quick snap  
13 shot. I know this is in your data books, et cetera,  
14 and most of it is out there, but it will be real  
15 quick.

16 Right now in the state there are 679  
17 nursing homes that are in operation. About  
18 two-thirds of them, as with hospitals, are  
19 concentrated in the New York City region. But there  
20 are quite a bit in rural areas, and we'll talk about  
21 that later. The age of plant, we haven't really  
22 been able to calculate the average age of plant, but  
23 I think what is important for this discussion is 80  
24 percent of the nursing homes that are currently in  
25 operation were originally built before 1980. And

1       you'll see the importance of that also later on as  
2       we talk about the construct of some of those and the  
3       challenges that they face. Occupancy, just again to  
4       remind everyone, occupancy steadily declined  
5       beginning in 1998 in the high 98 percent to our  
6       latest numbers for 2004, which show about 93.6  
7       percent occupancy statewide. That translates into  
8       eight to 9,000 excess beds depending upon the day  
9       and the closure situations that we have in front of  
10      us. Between 20 and 25 nursing homes have closed  
11      over the past five years. And we have a couple of  
12      plans in front of us right now. And I only mention  
13      that because you'll see the importance of it later.  
14      Nursing homes, the vast majority of the ones I  
15      mentioned were built basically as cookie cutter  
16      models to serve the traditional geriatric nursing  
17      home population. That's why they were built. They  
18      probably served their purpose for the generic  
19      programs that were provided, but we all know right  
20      now that the programs provided in nursing homes  
21      today bear no resemblance to the programs of the  
22      '60s, '70s or even early '80s. A large catalyst of  
23      that was Medicare and moving into paying for  
24      rehabilitation services in nursing homes. That  
25      program began in the early 1990s.

1                   And lastly, you have all talked and it's  
2                   been in some of our correspondence and it actually  
3                   goes all the way back to the work group report, but  
4                   we talked about it a lot in the hospital context and  
5                   that's the competition for patients to generate  
6                   revenues. And there are many reasons for that. And  
7                   also the rate paradigm issue that Mr. Berger has  
8                   mentioned many times. Hospitals possibly attempting  
9                   new services that they shouldn't be in solely for  
10                  the dollars. Well, that same concept is creeping  
11                  into nursing homes; competition for residents given  
12                  the specialty services that are being provided just  
13                  about everywhere, as well as education and awareness  
14                  of the consumer, is driving an intense competition  
15                  for occupants of the beds. You know, there are  
16                  different dynamics at play there, but nevertheless  
17                  we struggle all the time with, well, should simply  
18                  looking at it, should we get rid of all the physical  
19                  As and Bs or attempt to change the planning process  
20                  so those beds are assumed not to be available? And  
21                  what we're finding and what we did in the nursing  
22                  home bed need formula that we updated, we're finding  
23                  that even though they are like care and even though  
24                  there may be other settings, nursing homes have not  
25                  stopped competing for those residents because they

1 do contribute towards overhead. And in an era of  
2 declining occupancy, that's a business strategy that  
3 they continue to pursue.

4 So, that's just a little background. I  
5 am going to turn it over to Lisa. We'll be handing  
6 it back and forth as we did last time. But for the  
7 next section it's all yours.

8 MS. WICKENS: Thank you, Neil.

9 As we had started our last presentation,  
10 we wanted to identify the factors that are driving  
11 the need for change as we did for hospitals for  
12 nursing homes, the availability of alternatives that  
13 Neil just mentioned. Right now, consumers are  
14 making the decisions that they do want different  
15 types of services and we have adult homes, we have  
16 assisted living, we have the new ALR, or the  
17 assisted living residence model, we have the  
18 community services. So there are lots of different  
19 options right now.

20 Technology, which I'll go into a little  
21 later, is also important in nursing homes. It's  
22 not, obviously, as far along as it is in hospitals,  
23 but right now the nursing homes are competing for  
24 staffing, they have lots of different care levels  
25 that they are dealing with right now. So, they need

1       technology to, one, help them with the safety and  
2       management of the residence that they're dealing  
3       with; two, help the staff to be able to do their job  
4       quicker and more efficiently; and three, be able to  
5       identify and gather all of the assessment data  
6       that's required under Medicare and Medicaid just to  
7       make sure that people and the staff have more time  
8       at the bedside versus in the charts trying to do  
9       MDS's.

10                   Consumers preferences and awareness.  
11       Neil just mentioned this, but the consumers and the  
12       family members of the consumers that are going into  
13       long-term care alternatives and nursing homes right  
14       now are more educated. They know what they want,  
15       they know how they want it and they know where they  
16       want it. So, that is actually something that  
17       nursing homes are adapting to. They are trying to  
18       adapt to those needs.

19                   The acuity. We have a lot of vacancies  
20       in nursing homes and I actually started watching  
21       this happen in the mid '90s when the acuity level  
22       was such that residents either came into the nursing  
23       home older and much more frail because they had a  
24       certain network or support system at home so they  
25       could age in place, so when they did come to the

1 nursing home they had so many co-morbidities and  
2 were so ill they didn't live as long or we had the  
3 types of patients that came in for the short-term  
4 rehab. And they also didn't stay long. So, length  
5 of stay has really changed in nursing homes.

6 Neil.

7 MR. BENJAMIN: The fiscal pressures, we  
8 don't need to spend a lot of time on that. I mean,  
9 suffice it to say that nursing homes are under a bit  
10 of pressure for just about every reason that Lisa  
11 and I just mentioned. The providers are under  
12 pressure. Payors certainly are always attempting to  
13 match up the most appropriate rate for needed  
14 services in the most appropriate setting. And we  
15 have -- we mentioned employers here, and that ties  
16 into the staffing issues, the next point.

17 It's difficult and it's becoming more  
18 difficult for nursing homes to compete with  
19 hospitals for a lot of their direct care staff due  
20 to the fiscal pressures that they're facing. Yet  
21 they do need a lot of the same type of support  
22 staff. And when you combine that with sporadic  
23 shortages around the state, nursing homes right  
24 now -- and again we're trying to tie all this into  
25 what the building of the future may look like -- a

1 lot of them are really constrained right now with  
2 squeezing efficiencies out of their building.  
3 Because, as we said, buildings just are not  
4 constructed to produce efficiencies for the types of  
5 programs that are there now.

6 MS. WICKENS: Difficulty navigating the  
7 convoluted system. What that basically means is  
8 consumers now have so many options and the  
9 availability that I mentioned before, they're asking  
10 and demanding some assistance in trying to identify  
11 what the right services are and how do they get  
12 them. And daily I get phone calls helping people  
13 navigate the system.

14 The factors specific to long-term care.  
15 Consumers preferences for independence, least  
16 restrictive setting. Olmstead decision, basically  
17 people that are old or young and disabled have the  
18 opportunity to make their own decisions and to help  
19 decide where they want to be. And they have the  
20 right to get those services in the least restrictive  
21 setting. If they do have to be in a congregate care  
22 level setting in a nursing home, they still want to  
23 remain as part of the community. That is one of the  
24 preferences that consumers say is one of the most  
25 important things they want when they age and they

1 actually are maybe now widowed or by themselves and  
2 now need more services, they still want to remain as  
3 part of the community.

4           The adaptability for different acuity and  
5 individual needs. The nursing home that is in place  
6 right now is not the nursing home that was in the  
7 1980s or 1990s, or in the 1970s for that matter.  
8 You don't have your garden variety cookie cutter  
9 nursing home. You don't have your -- no disrespect  
10 meant to anyone -- but everyone isn't in a pink  
11 sweater, in a wheelchair, with white hair and  
12 glasses. We're actually taking care of people in  
13 nursing homes that have lots of different needs and  
14 specialty services. You need to be able to not only  
15 adapt in regards to your staffing and your  
16 programming, but the building has to be able to  
17 adapt so your staff can be able to get to all of  
18 those levels of care.

19           The specialty services. Specialty  
20 services are continuing to pop up. When consumers  
21 now live longer, they have more co-morbidities. And  
22 those consumers are not just the older geriatric or  
23 just the young, there is also the pediatric  
24 population that may need long-term care that before,  
25 20 years ago, might not have survived. That's just

1 one area of specialty services that we're seeing  
2 that needs to be cared for in a nursing home.

3 Skilled nursing homes offering  
4 non-institutional alternatives. Again, this is a  
5 factor that consumers are requesting. If they are  
6 going to make a decision to be in a long-term care  
7 setting, they want to have different alternatives  
8 right on-site. They want to be able to be part of  
9 the community, but they want to have different  
10 options. They want to have the continuum right  
11 there. They don't want to have to go from one place  
12 where they've actually been very comfortable and go  
13 to another building so that they can get a different  
14 type of service.

15 And the urban versus rural distinction.  
16 One of the things that we've identified and we've  
17 seen is in the urban areas, we have higher  
18 concentrations of nursing homes and there are many  
19 more options for individuals. There is more  
20 competition and there is more of a network or a  
21 continuum right within the community. So, they  
22 actually have more options than in an urban area.  
23 And they have much more specialty services. You go  
24 to a rural area, you see several nursing homes that  
25 have very low case mix indexes. The reason, some of

1 the things that we've identified, is that you don't  
2 have the continuity and the networking in place in  
3 the community. Therefore, people that are aging and  
4 do need some services, maybe not all of the services  
5 offered by a nursing home, now go into a nursing  
6 home. Therefore, there are less options and there  
7 is less specialty.

8 The nursing home facilities. The picture  
9 on the left is the garden variety that we've seen  
10 and a lot of people still have in their minds as  
11 what is happening in nursing homes. Versus on the  
12 right, where we see someone that's younger, is  
13 actually going through some rehab. That's just one  
14 area that we're seeing some growth in nursing homes.

15 Going back to the physical plant. I can  
16 walk into any nursing home and tell you when it was  
17 built. This is a typical 1960/1980 physical plant  
18 model. This is the most nurse intensive, CNA  
19 intensive model and it's the most common that we  
20 have. It makes it very difficult to be dealing with  
21 different levels of acuity when you've got to run  
22 120 feet. That's how long those halls are. In  
23 addition to that, you think of an evacuation, you  
24 think of fire, you think of other things, this is  
25 also very difficult. This model was built just like

1 a hospital and it does not work for long-term care.  
2 It doesn't work, especially now with all those  
3 factors that I've mentioned, when you have limited  
4 staffing, you can't put technology -- and having to  
5 have someone with a vent, traumatic brain injury and  
6 dementia in this type of unit doesn't work.

7 So, in the 1990s, nursing homes started  
8 to say, well, we've got to make this a little bit  
9 more user friendly, we've got to start to think  
10 about those nurses and those CNAs that have to run  
11 up and down those halls and we have got to think  
12 about the consumers that are coming in. So, they  
13 came up with these, like, satellite programs.  
14 You'll hear them as pods they'll be referred to.  
15 People have tried to bring in more services into  
16 this area, but also to make it more home like so it  
17 doesn't look like the institutional model. It's  
18 helpful. It's made improvements. I can tell you  
19 it's not one of the best models that's out there  
20 because it's still difficult, especially when you  
21 have different levels of specialty areas.

22 So, nursing homes in the future. I don't  
23 know if everyone here has heard about  
24 resident-centered. OBRA '87 basically said people  
25 have the right to receive the care that's based on

1 the residents, it's based on what they need, it's  
2 resident outcome. The survey process became  
3 resident outcome based. And culture change is now  
4 something that CMS is focusing on in nursing homes.  
5 They have the right to make the choice of what they  
6 want, when they want to get up. And that also is  
7 very difficult in the old physical plants because  
8 you may have 40 different individuals wanting to get  
9 up at different times and it makes it very difficult  
10 to actually be able to provide those services if  
11 everyone wants to get up at a different time. It  
12 just doesn't work.

13           Innovative approaches. Nursing homes in  
14 some areas of the state have already begun this  
15 where they not only are looking at different  
16 programming, but they are actually inviting the  
17 community in to the home of these residents. For  
18 instance, they've had pools that are actually in  
19 some of the nursing homes or gyms where the  
20 community actually comes in and actually utilizes  
21 those services with the other members of the  
22 community, the residents in this nursing home. And  
23 in areas where there is a continuity of services or  
24 there is a lesser level of care in assisted living,  
25 that's been beneficial for them, too. They utilize

1 the same services. So, the community is integrated.

2 Another innovative approach is you have  
3 day care right on the same site as nursing homes.  
4 That's becoming more and more popular as well.

5 Household models. This is a picture of  
6 an actual nursing home in, I believe, Pennsylvania.  
7 This actually, for those of you who have been at the  
8 Desmond, in Albany, that's what it reminds us of.  
9 It's a really nice hotel in Albany. But this is a  
10 nursing home and it's a community. It was based on  
11 what do people want. They still want to feel like  
12 they're in a community. They want to have types of  
13 services and they want to have a place where, when  
14 people come in to see them, they have a place to go  
15 and show and say this is where I live. So, they  
16 have everything from the barber shop, they have  
17 stores, they have actual stores that would normally  
18 be on the street corner, probably a Starbucks right  
19 within the nursing home.

20 The household model is actually again  
21 going back to efficiencies and staff time. The  
22 staff are actual parts of the household. Nurses and  
23 CNAs don't just do those types of tasks, they help  
24 with the cooking, they help with all the other  
25 pieces and include the residents in that.

1           Technology, again we'll talk about that  
2           and I have some pictures to explain, technology is  
3           not maybe where it could be in nursing homes, but  
4           it's starting and it's starting to become more and  
5           more efficient. Again, I think it's being really  
6           driven by staff shortages and the specialty of  
7           services that are being delivered.

8           Emphasis on hospitality is obvious from  
9           this picture.

10           Adaptable construction. This is very  
11           important and it's also very expensive. We know  
12           that construction costs are going up, but we also  
13           know that people want different options and they are  
14           demanding those different options. Tom had  
15           mentioned this during the hospital presentation  
16           regarding the one-bedded rooms and the two-bedded  
17           room. Many people believe that residents, geriatric  
18           residents or younger residents, want to just be by  
19           themselves, they don't want a roommate. Well, when  
20           you talk to different consumers, that might not  
21           always be the case. Some consumers do want to be  
22           with their spouse -- sometimes not -- but there  
23           should be that chance to actually be adaptable with  
24           moveable walls, moveable partitions. That's where  
25           this is really important.

1                   Also in a time when we have MRSA and we  
2                   have VRE and we have these types of bacteria that we  
3                   have within homes and within hospitals and  
4                   institutions, it's also important to have the  
5                   adaptability that you need to be able to move those  
6                   partitions, move the walls and adapt to the needs of  
7                   the residents.

8                   Patient safety. Besides just having  
9                   technology, one of the important factors for nursing  
10                  homes is actually to help attain or maintain  
11                  someone's level of functioning. To do that, those  
12                  long corridors, they really don't work. People who  
13                  are actually on rehab, after a traumatic brain  
14                  injury, after a serious car accident, they're  
15                  starting to want to get up and try to walk. Looking  
16                  down a 120 foot hall and someone on either side of  
17                  you is very overwhelming. Again, it's important and  
18                  this is part of the construction that needs to be in  
19                  place in the future for the nursing homes.

20                  And community integration I've beat to  
21                  death.

22                  Technology in nursing homes. Here you  
23                  see actually the neon lights. Again, we're not  
24                  where we would like to be in nursing home  
25                  technology, but this is a start. For safety issues,

1       also for staff, for people that actually are  
2       sleeping but staff need to go into the room, this is  
3       a nursing home in our capitol district area, in  
4       upstate New York, and they actually have lights  
5       around the sink in the bathroom, along the floors  
6       and along the doors for safety for the residents,  
7       but also for safety of the staff.  These other  
8       models you're just seeing pictures of screens.  
9       There are a few different nursing homes in the state  
10      that have begun to try to assist their staff to be  
11      able to complete all of the paperwork that you'll  
12      hear people complain about in a nursing home to be  
13      done takes a lot of fact gathering and it's  
14      something called minimum data set, or the MDS.  In  
15      order to make that fact gathering and the data  
16      easier to obtain, they've actually put PDAs into the  
17      nursing homes for the direct care staff to be able  
18      to collect some of that information.  That  
19      information automatically will go into a central  
20      system where the clinicians, the doctors and the  
21      interdisciplinary care team can review it at the  
22      same time and come up with a care plan.  That saves  
23      time.  It also improves the efficiency and it has  
24      also helped with cutting down on medication errors  
25      because this is also being utilized for medication

1 administration and for treatments. So, it's really  
2 starting to make change.

3           There is also another product that's come  
4 out that we've just had our first -- we've just had  
5 a presentation by a group that's helping consumers  
6 before they have even made a decision on where  
7 they're going to actually start to identify what  
8 types of homes, what types of places, services are  
9 offered in their community. And then, instead of  
10 having to go through the convoluted system by  
11 calling, by trying to view and tour, it's actually  
12 happening through this system that's just being  
13 built for consumers. I think this is critical in  
14 trying to help people identify where they want to be  
15 and how they want to get their services.

16           Program initiatives. Short-term rehab  
17 through occupancy and length of stay obviously are  
18 down and resources are up. I've already explained  
19 why. The average age of residents in the nursing  
20 home in the early 1980s or mid 1980s was probably  
21 very few male and the average age was between 75,  
22 80. It would not be unusual to see someone even in  
23 their late 60s. Now the average age has gone up,  
24 you have more males, as they start to catch up with  
25 the women. They're living almost as long.

1                   And the special care units. Traumatic  
2                   brain injury, behavioral intervention -- I'm going  
3                   to just speak very quickly on this. Behavioral  
4                   intervention is something that is very important in  
5                   regards to the physical plant. We have more and  
6                   more members in our communities that have the  
7                   history of either mental illness and some  
8                   disabilities and there are more people that are  
9                   aging and that do need skilled nursing care and need  
10                  a level of care delivery in a nursing home. It's  
11                  very important that there are smaller, home-like,  
12                  safe environments and not, again, the long units.  
13                  It's very difficult to have a behavioral unit with  
14                  everyone spread out. That's also important in  
15                  regards to the adaptability of the units.

16                  The bariatric, this is becoming -- I  
17                  don't want to say a bigger issue, no pun intended --  
18                  it's becoming something that we're seeing the need  
19                  for more bariatric units. It's very expensive  
20                  because you have to have wider halls or wider  
21                  doorways, you have to have more equipment. A lot of  
22                  the equipment that's actually being put in place is  
23                  equipment that's built into the unit. So, it's  
24                  becoming more and more expensive, but there is more  
25                  of a need for that.

1                   Dementia related, dialysis, ventilator  
2                   dependant and the pediatric ventilator dependant.  
3                   We're seeing more requests for these types of  
4                   services. I can tell you right now we don't have a  
5                   pediatric ventilator unit in downstate New York and  
6                   it's something that the consumers in the communities  
7                   need. As children before would have not lived as  
8                   long as they can now with new technology, we need  
9                   these types of services.

10                   Program initiatives. Again, the  
11                   continuum -- the institutional versus the  
12                   non-institutional. People making their own choices  
13                   where they want to be.

14                   The base line infrastructure development  
15                   and considerations. As nursing homes close in the  
16                   state, one of the biggest problems and actually  
17                   we've talked to a lot of different providers and  
18                   associations that have come in to talk to us, the  
19                   problem isn't necessarily just nursing homes  
20                   closing, it's having housing. We can't allow all  
21                   nursing homes to close because then we don't have  
22                   the housing for the individuals and we don't have  
23                   the networks of services in the communities built in  
24                   that we need. So there is definitely a need for  
25                   more physical houses and congregate levels of

1 services.

2 Age sensitive considerations. Again,  
3 because we have so many different specialty areas  
4 we're dealing with.

5 Activity programs and safety in  
6 day-to-day activities. Again, there are more and  
7 more issues coming that nursing homes are dealing  
8 with in regards to not only the behaviors that I  
9 mentioned, but nursing homes are trying to deal with  
10 the resident elopements. We're having more and more  
11 residents that are having resident-to-resident  
12 altercations. Another reason for having smaller  
13 units and more ability for staff to be able to be  
14 right there with the residents.

15 The Eden Alternative and the Greenhouse  
16 Project. I'll start with the Greenhouse Project.

17 This is something that more -- it's  
18 actually in Tupelo, Mississippi. This is a picture  
19 of one of the facilities in Tupelo, Mississippi.  
20 But this goes back to the household model. This  
21 goes back to building nursing homes that are more  
22 home like, that are smaller units. So, instead of  
23 having a unit of 40 on one long corridor, you have a  
24 small house for six to ten people, with a kitchen,  
25 with the staff that stays within that house and

1       cares for all those residents no matter what their  
2       needs are. So, it means adaptability is critical.  
3       But it's expensive. You still have to have the  
4       people to be able to get to all the other small  
5       houses. And it probably works a lot easier when  
6       there is not snow on the ground between the houses.

7                   And the Eden Alternative, although there  
8       have been several different projects that have  
9       started in New York State for the Eden Alternative,  
10      it's not just about plants and animals. It's also  
11      about having staff go off site for staff meetings.  
12      It means a lot of other pieces where the residents,  
13      their home, is separate from the real business  
14      operations. And I think we still have one or two  
15      that are really running in that Eden Alternative  
16      model.

17                   The community at large -- this was Tom's.  
18      One of the things is that even though our nursing  
19      homes are going to be adapting, we're going to be  
20      dealing with more and more different levels of care  
21      and services that need to be provided. What this  
22      picture is meant to identify and to show you is that  
23      the community also needs to start to support  
24      geriatrics and people being allowed to age in place  
25      because you have to think for all those -- and

1 disabilities -- there has to be -- in the picture in  
2 the right there is no sidewalks, there are no safe  
3 place for people to walk or be in a wheelchair. And  
4 on the left you can see there are. That's what this  
5 is supposed to mean. Clearly marked crosswalks.  
6 The crosswalk signals -- Tom told me that the reason  
7 he put this up here was that certain parts of the  
8 country are already looking at adapting their  
9 community for the geriatric. If someone's older and  
10 needs to get across the street, they need more time  
11 on the crosswalk sign. So, that's what that's  
12 intended to show you.

13 Neil, anything you wanted to add?

14 MR. BENJAMIN: Yes.

15 So, as you can see, with everything that  
16 we've said, there is quite a challenge here. It's  
17 an aging infrastructure. We have in front of us  
18 right now about \$1.2 billion worth of modernization  
19 and replacement projects for over 30 nursing homes.  
20 And the challenge is it's difficult. We all know  
21 Medicaid pays for about 77 percent on average,  
22 provides 77 percent of revenues for nursing homes.  
23 The average cost per bed now is about \$200,000 a  
24 bed. So, the challenge of what's the future demand  
25 going to be? What are the types of service? How do

1       you most efficiently and effectively make decisions  
2       to invest dollars into programs and buildings that  
3       they themselves need a lot of flexibility? We  
4       really need to start looking at things much more  
5       creatively, much more out of the box.

6                   I kidded a little about where Tom is, but  
7       in all seriousness, Tom is on several national work  
8       groups through the National Architecture Association  
9       and he has convened a group that's looking  
10      specifically at two things: One is, simply, how can  
11      we be more effective in planning for the future and  
12      investing Medicaid dollars into nursing homes, and  
13      the second thing really is what are the real program  
14      initiatives and innovative ideas that are going on  
15      in other states that we can learn from.

16                   So, in summary, while we have this \$1.2  
17      billion in front of us, we can honestly say that it  
18      really doesn't -- what's represented in those  
19      dollars isn't really much of the innovation that  
20      Lisa talked about here. So, we're going to all need  
21      to collectively make some decisions about how do we  
22      move forward with more appropriate investments into  
23      the nursing home sector, long-term care sector  
24      actually.

25                   CHAIRMAN BERGER: Neil -- how did I know?

1 MR. ROBERTS: I have to comment.

2 First of all, I congratulate the staff on  
3 a fine presentation and there is nothing that  
4 they've said that I basically don't applaud. I  
5 mean, the nursing home of the future should look  
6 like they've described. It would be a wonderful  
7 thing. But when I hear the word "want," I get a  
8 little nervous because what our society, what are  
9 our consumers of nursing homes want is Medicaid to  
10 me and middle class entitlement. And we know we  
11 can't afford that. So, what people want and what we  
12 can afford to do are very different things.

13 My biggest question about what's been  
14 presented is does it work in our society regarding  
15 money and staff and all that kind of stuff?

16 Great job. You alluded to a lot of  
17 things. I'd like to just point out a couple of  
18 bullets where we can probably have a presentation  
19 that's just as in-depth and would get to the  
20 complexities of what you're dealing with.

21 You said that the programs of today don't  
22 match the '60s, '70s and early '80s. I don't need  
23 to tell this group that the financial system that  
24 we're based on is built off '80s data. You said  
25 that nursing homes compete with hospitals for staff

1 and are falling behind. True. What's also true is  
2 that most employees in nursing homes aren't  
3 employees that hospitals compete for, they're  
4 competing with Walmart and Wendy's for staff and  
5 failing there in many communities because the  
6 reimbursement structure hasn't updated. Lastly,  
7 what our consumers -- I never met -- first of all,  
8 most people enter a nursing home from an emergency  
9 room. They don't do it in a decisive process like  
10 you imply. But once they get there, they clearly  
11 have wants. So, you are right and you are wrong.  
12 But I had never met a nursing home resident who  
13 wouldn't trade some risk for freedom. Yet the  
14 regulatory environment we have makes it impossible  
15 for nursing homes to offer risk because they'll get  
16 slaughtered if it goes south.

17 So, all I'm saying to you is what the  
18 consumer wants has to be matched by staff, money and  
19 regulation. And each one of those three things  
20 could have a discussion this long and I'd like to  
21 believe that if we'd had that discussion we'd be  
22 able to support these ideas and they are great  
23 ideas.

24 Thank you very much.

25 MS. WICKENS: May I just comment?

1           I just want to actually make a comment on  
2           your last point. Coming from working 14 years in a  
3           nursing home and thinking about creativity within a  
4           nursing home and saying that it's actually the  
5           regulatory process that holds them back, in some  
6           ways I agree with you and in some ways I don't.  
7           I've had those fights with the surveyors myself and  
8           said, "You show me in regulation where it says I  
9           can't do this." But I think there is some -- I  
10          think there has to be some flexibility in allowing  
11          people to, one, make the decisions that they want  
12          and take the risk if they make that choice. And  
13          that's what part of the -- and that's when I say  
14          what the consumers are looking for. I believe that  
15          in last -- maybe in the '90s and earlier, residents  
16          ended up in nursing homes because that's where they  
17          ended up. They made no choices. I think now, with  
18          the level of education and the changes that are  
19          happening in our society, people are starting to  
20          look and plan prior to getting to that emergency  
21          state. And I'm hoping that as a society we'll get  
22          there.

23                       MR. ROBERTS: I am, too.

24                       MR. HINCKLEY: Lisa or Neil, what's the  
25          average size of the '60s, '70s, '80s type of model

1       you show in New York? 120 beds?

2                   MS. WICKENS: 120 is the average.

3                   MR. HINCKLEY: Now, what about the  
4       nursing home of the future that you discussed, what  
5       do they tend to be in terms of size?

6                   MR. BENJAMIN: I can speak, Bob, from the  
7       economics and I think you probably know this, too,  
8       that as we move through the very liberal bed policy  
9       days of the department, but there still were fiscal  
10      pressures there, nursing homes started to build more  
11      and more beds because that's the only way they could  
12      be affordable.

13                  MR. HINCKLEY: I was getting there.

14                  MR. BENJAMIN: Yeah, yeah. But in the  
15      future that's one of the things I mentioned is a  
16      challenge is the appropriate size of these places  
17      given everything that we talked about.

18                  MR. HINCKLEY: I guess I kind of have a  
19      multi-part question because it's -- I mean, I would  
20      assume it's fairly clear that under our current  
21      reimbursement system there is no way you could  
22      operate one of these new homes at 40 beds. Neil,  
23      I'm sure can opine on that. But is there a way to  
24      change the reimbursement structure to allow  
25      operators to make a decent living at that?

1 MS. WICKENS: All I can speak to -- I  
2 mean, there is a challenge -- I'm not going to go  
3 back to the 1983 base year, but we know that there  
4 has got to be some changes in the reimbursement  
5 system. But in the different levels of specialty  
6 that we mentioned, we only have a couple of  
7 different ways certified units in New York State to  
8 reimburse for that higher level of care. But yet we  
9 have people that are really serving a higher acuity  
10 and really have no way that they get reimbursed for  
11 it other than through the PRI. So, there has been  
12 and we are looking at regulations that would allow  
13 for different levels so that people could start to  
14 get reimbursed based on the services they are  
15 delivering. And if we could get to the MDS and the  
16 PPS that might actually work better as well.

17 MR. KING-SHAW: I don't remember you  
18 mentioned PACE at all, the Program for All-Inclusive  
19 Care for the Elderly?

20 MS. WICKENS: I didn't.

21 MR. KING-SHAW: Is that because you don't  
22 see it as a major future trend here in the State of  
23 New York?

24 MS. WICKENS: We have -- I want to say I  
25 can't remember how many we have but I don't think

1       they haven't been coming up and haven't been as  
2       large as we think we thought they would be. That's  
3       just my understanding and I can't really give you  
4       much more than that. But there are couple that I  
5       know are doing fairly well in the state.

6                   MR. KING-SHAW: The other was the nursing  
7       home diverging programs and managed long-term care,  
8       those kinds of trends, do you also not see those as  
9       having a major factor in New York's future?

10                   MS. WICKENS: I do. This presentation  
11       was really set towards institutions and nursing  
12       homes and bricks and mortar. It is one of the  
13       things I wanted to mention, that's why I was  
14       alluding to networking and different levels of care  
15       outside of institutional settings. I do see that as  
16       very -- and I think that's going to be changing a  
17       lot in regards to the sizes of the facilities, in  
18       regards to bringing the community in and to be able  
19       to partake in some of those clinical rehabilitative  
20       services.

21                   But, again, our presentation today was  
22       really about nursing homes.

23                   MR. KING-SHAW: Thank you.

24                   MR. O'CONNELL: In the beginning of the  
25       presentation you talked about 80,000 -- was it 8,000

1 or 80,000 unused beds?

2 MS. WICKENS: 8,000.

3 MR. O'CONNELL: Projected demographic  
4 shifts, populations getting older, seems to me there  
5 would be greater utilization of beds in the future?  
6 No? You are not thinking that?

7 MS. WICKENS: From my perspective and  
8 from what I've heard from other states is that  
9 consumers are continuing to age, but they are  
10 healthier, they are making better choices, there is  
11 prevention. There is no one who says, "I want to go  
12 into a nursing home."

13 MR. O'CONNELL: But they are dying later  
14 and they don't have family support.

15 MS. WICKENS: The integration of the  
16 community services, that's also going to be  
17 something that New York State is going to be  
18 building upon.

19 CHAIRMAN BERGER: What we will get to  
20 you, since you just sort of arrived today, is we've  
21 done some of this work and we've had some of this  
22 discussion at the last meeting on what the trends  
23 look like. Why don't you take a look at it and then  
24 we'll come back and talk some more.

25 BISHOP SULLIVAN: Our recommendations at

1 the end, when we talk about reconfigurations and so  
2 on and keeping money in the system. Is it possible  
3 that we could make recommendations moving -- because  
4 I really believe housing policy is more important to  
5 the elderly than what we do in the medical  
6 community?

7 CHAIRMAN BERGER: I have a feeling -- you  
8 and I have been doing this stuff for a long, long  
9 time. I have a feeling that this Commission, when  
10 it comes to grips at the end with a whole series of  
11 issues, will find that it has to make  
12 recommendations outside our basic mandate directly  
13 because to achieve some of those goals would require  
14 the state government over a period of time to change  
15 some long-term policy issues. And probably there  
16 will be a list of recommendations which will require  
17 some deep gulps and some big swallows on the part of  
18 people.

19 We've talked about a couple, and this may  
20 also be one, but one thing we have to do, and I'm  
21 doing it with the next presentation, as sort of a  
22 reality check, when Neil began his comments, one  
23 thing he pointed out is partners. A part of the  
24 underlying problem here is the notion of the middle  
25 class entitlement. And part of the funding that we

1       have and part of the levels of funding that we have  
2       today and where it's going are not sustainable.  
3       That's part of what's triggered this. But beyond  
4       that, as we look at this over the next six months,  
5       there are some very good ideas we've seen there.  
6       And Lisa really started pushing you on the other,  
7       the other alternatives delivery network, which  
8       include the family and support from the family and  
9       support in the community and changes in the basic  
10      community are absolutely necessary. Because we  
11      cannot have the dollars to reconfigure the whole  
12      system so it sort of all looks like Scarsdale. It's  
13      just not going to happen. You don't have the  
14      dollars, you don't have the people. So, it's got to  
15      be a very different system because costs -- because  
16      it's got to be a better system in which costs are  
17      under control. Because all we're going to do --  
18      this is -- I haven't done this commercial yet -- but  
19      all we're going to do, unless we face up to some of  
20      this, is put ourselves in the worst possible  
21      situation several years down the road where we have  
22      a system which is not flexible, unable to adapt and  
23      finds itself totally squeezed by the shrinkage of  
24      available public dollars. And as bad as it is now,  
25      I can tell you it can get a lot worse unless we make

1       some recommendations and do some changes.

2               I think we've got to balance, we got to  
3       find a way of getting to the better levels of  
4       service and make recommendations which are both  
5       physical, which is our basic responsibility, as well  
6       as some areas where we have to just lay it on the  
7       line for people that they have to deal with. And I  
8       agree.

9               I want to thank you guys again for coming  
10       and for adding this piece to our discussion. We're  
11       very grateful. As you could see by the comments,  
12       this triggers not just physical and architectural  
13       discussion, but some very basic public policy issues  
14       which is something we will have to try to address as  
15       we move forward.

16              Part of our mandate, a good part of our  
17       mandate, as we will look at the structure of the  
18       acute long-term care system, is to look at structure  
19       of the acute and long-term care system, at the  
20       physical facilities, at the institutions, at the  
21       question of how large a physical infrastructure we  
22       have and to deal -- and as we come to deal with  
23       that, we will be dealing with a whole series of  
24       imbedded issues. One of which is the imbedded costs  
25       that exist, the capital costs that exist, the debt

1 service that exist. And we will have to deal within  
2 our recommendations not merely with what exists and  
3 not merely with the past, but with the future as  
4 well. Because part of the goal will be obviously to  
5 have a health care system which has access to  
6 capital. If it doesn't have access to capital, over  
7 the years it can't change, it can't grow, it can't  
8 reinvest, it can't do the technology and all the et  
9 ceteras that we take for granted. So, we thought,  
10 again, as sort of one of the last pieces of laying a  
11 foundation, that we would ask some of the people who  
12 know about those capital issues to talk a little bit  
13 about it and give us a little background.

14 We've asked Lora Lefebvre, of DASNY, as I  
15 remember, the Managing Director of the Office of  
16 Policy and Program Development? Is that still your  
17 title?

18 MR. LEFEBVRE: Portfolio Manager.

19 CHAIRMAN BERGER: We have asked Lora to  
20 lay a little foundation as to what we're going to be  
21 dealing with, what we have to face and what we have  
22 to cope with as we start thinking about some of the  
23 institutional structures in the state.

24 MR. LEFEBVRE: Thank you very much and  
25 good afternoon.

1                   Can everybody hear me okay?

2                   Thank you, Chairman Berger, and  
3                   Commission members for the opportunity to speak with  
4                   you today about New York State's health care and  
5                   capital financing.

6                   As the largest issuer of health care  
7                   bonds in the state, the Dormitory Authority is  
8                   uniquely qualified to offer some perspective on  
9                   capital financing and the trends that will effect  
10                  New York State hospitals and nursing homes in the  
11                  future. We hope this information will be useful to  
12                  you as we deliberate the future of health care  
13                  facilities New York State.

14                  As you proceed, the Commission has been  
15                  asked to consider a number of factors, two of which  
16                  relate specifically to my comments today. I've just  
17                  kind of put them up on the screen for you. Debt is  
18                  an important factor in the consideration of health  
19                  care restructuring. DASNY, the largest issuer of  
20                  health related debt in New York, believes that the  
21                  state must consider how to restructure or retire the  
22                  debt of effected facilities, not only because DASNY  
23                  has an obligation to speak on behalf of their bond  
24                  holders, but also because reconfiguration will  
25                  require extensive reinvestment in capital and

1        technology, as you've heard, that in all likelihood  
2        will have to be borrowed. For reasons I'll discuss  
3        in a few minutes, such borrowing capacity will  
4        probably not be available if restructuring results  
5        in bond defaults or requires the mortgage or bond  
6        issuers or the credit enhancers to assume the costs  
7        of the state's restructuring plan. However, before  
8        we get to that, let me just take a moment and  
9        discuss the Authority's role in health care  
10       financing.

11                    The Authority is the largest issuer of  
12       tax-exempt debt in the nation for higher education  
13       -- or we're one, we're not the largest -- we're one  
14       of the largest issuers of tax-exempt debt in the  
15       nation for higher education and health care. Our  
16       outstanding bond portfolio at this moment is \$32.7  
17       billion. It's split mostly onto the public sector  
18       side, about 53 percent of our outstanding portfolio  
19       are bonds that have been issued for public entities  
20       such as the Office of Mental Hygiene, Health and  
21       Hospitals Corporation, Department of Health,  
22       Department of Education, Office of Court  
23       Administration, SUNY, CUNY, school districts and the  
24       State economic development programs. The remaining  
25       share of our bonds have been issued on behalf of

1 not-for-profit corporations, organizations, most of  
2 which are health care and higher education  
3 institutions.

4 This is a list of health care entities  
5 that we are authorized to provide funding for in our  
6 statute. You can see hospitals, nursing homes,  
7 facilities for the aged is a peculiarity of our  
8 statute. Generally speaking, we use that to provide  
9 financing to senior housing with components of  
10 related health care at that senior housing. We also  
11 can provide funding for health maintenance  
12 organizations and also not-for-profit housing and  
13 health facilities. Again, that generally tends to  
14 go for housing related, staff housing related to  
15 hospitals with related medical services located in  
16 the building. Our clients are distributed all over  
17 the state. Upstate we serve about 30 hospital and  
18 hospital systems and have about 38 nursing homes  
19 that we've lent to. Whereas downstate, 38  
20 hospitals, hospital systems we've lent to with about  
21 51 nursing homes that we have provided financing  
22 for.

23 This is our outstanding bond, health care  
24 bond portfolio. While we do not provide all lending  
25 to the health care industry in New York, we do have

1 an almost \$9 billion outstanding health care  
2 portfolio and believe that we represent about 70  
3 percent of all outstanding long-term debt to the  
4 hospital sector and about 53 percent of the  
5 not-for-profit nursing home sector. I would just  
6 note here that we don't issue debt for for-profit  
7 nursing homes, so the priority nursing homes really  
8 aren't included in that figure.

9 Here is what our bond portfolio for  
10 hospitals looks like. The money which the Authority  
11 lends to its clients is derived from the proceeds of  
12 bonds sold by the Authority to investors. These  
13 investors get repaid only if the institution makes  
14 the payments due under our loan agreement with us  
15 and unless the bonds are also secured by credit  
16 enhancement. Most of our bonds issued for health  
17 care customers have some type of bond or mortgage  
18 insurance or other type of credit enhancement. The  
19 Federal Housing Administration, through its Hospital  
20 Mortgage Insurance Program, insures nearly half of  
21 our clients' mortgage loans. Private bond insurance  
22 or other letter of credit secure nearly a third of  
23 our hospital bonds. Eleven percent of our bonds are  
24 backed directly by the state. And only 13, only 13  
25 percent of our bond portfolio bonds were sold based

1 on the hospital's underlying credit on its own.

2 Our entire -- I didn't show the nursing  
3 home split, but let me briefly -- the nursing home  
4 portfolio is all credit enhanced, 62 percent of it  
5 FHA insurance, Federal Housing Administration  
6 insurance, 16 percent has been ensured by the State  
7 of New York Mortgage Agency, a state entity, and  
8 then another 21 percent has been insured or assisted  
9 through private insurance or letter of credit.

10 Whether there is credit enhancement or  
11 not, if an institution fails to make a payment on  
12 its loan agreement, the Authority or the bond  
13 trustee will be obligated to foreclose and liquidate  
14 the assets pledged to the Authority to secure its  
15 loan. Generally, this security includes a first  
16 mortgage lien on the bricks and mortar of the  
17 hospital or nursing home.

18 As you can see, the hospital portfolio  
19 mostly has some type of credit enhancement. This is  
20 directly related, we believe, to New York State's  
21 health care credit profile as measured by rating  
22 agencies. I'm sure you've heard a great deal about  
23 New York's weak credit profile compared to the rest  
24 of the country.

25 CHAIRMAN BERGER: How would this look in

1 other states? How would that chart look?

2 MR. LEFEBVRE: How would that chart look?

3 I can't specifically answer that question. I can  
4 certainly do some research. I think this chart  
5 shows you -- no, it does not show you. We can get  
6 back to you with that. I don't have a specific  
7 answer. It's different.

8 CHAIRMAN BERGER: Very different. No one  
9 has got this level of enhancement.

10 MR. LEFEBVRE: That is a very -- I would  
11 have to agree with that statement. And, as I'll get  
12 into it further, the FHA insurance, we use FHA  
13 insurance dramatically more than the rest of the  
14 country.

15 So, this chart shows New York State  
16 medians for selected benchmarks compared to rating  
17 agency ratings established by S&P, Standard and  
18 Poor's, and Fitch rating agencies. Credit ratings  
19 are provided by these companies -- in addition to  
20 Moody's also, there are about three credit rating  
21 agencies -- to give bond investors independent  
22 assessment of their overall risk when they are  
23 purchasing a health care bond, or any other bond for  
24 that matter. Ratings above triple B are considered  
25 investment grade, triple A is the highest and least

1 risk of default rating, and below triple B is  
2 considered a speculative buy. As you can see,  
3 generally, New York State hospitals do not meet  
4 investment credit standards in many benchmarks.  
5 Compared to a rating agency median, the State's  
6 hospitals have older physical plants, as you've  
7 heard many times, lower profitability and liquidity  
8 levels and are more leveraged. They have borrowed  
9 more money to do the building that we've got.

10 In a February '06 report, a Moody's  
11 rating agency referred to New York State as "one of  
12 the most difficult, if not the most difficult,  
13 states to operate a hospital." Only a handful of  
14 our strongest hospitals and hospital systems were  
15 able to achieve independent credit ratings high  
16 enough to allow access to capital in the public  
17 markets on their own credit profile. Eighteen have  
18 been rated by Moody's credit rating agency, seven of  
19 them, or 39 percent, are now below investment grade.  
20 So, at the time they went out, it was good, but now  
21 39 percent of those 18 are below investment grade.  
22 For all of Moody's rated not-for-profit hospitals  
23 nationally, that figure is ten percent below  
24 investment grade. That kind of speaks somewhat to  
25 your question a little bit indirectly. Moody's has

1       downgraded New York providers 11 times in the last  
2       three years. They have upgraded only four times.  
3       Six of the ratings carry a negative outlook and none  
4       of their ratings carry a positive outlook for New  
5       York State health care.

6                   Now, Moody's, in their report, has cited  
7       any number of factors that they feel has contributed  
8       to this kind of financial picture. Many of these  
9       issues you've had presentations on and probably will  
10      into the future as you kind of consider your  
11      deliberations. They are, of course, the challenging  
12      demographics, payor concentration -- I believe we  
13      discussed this with Neil, because Neil is like  
14      what's that? Payor concentration, I believe, what  
15      they mean there is the tightening number or  
16      consolidation of the insurance industry that we're  
17      experiencing, just fewer and fewer commercial  
18      insurers to be sitting across the table from. Close  
19      physical proximity of competitors and high degree of  
20      competition, high cost of operation. There have  
21      certainly been some serious difficulties in mergers  
22      that have been undertaken over the last couple of  
23      years, as evidenced in the paper any number of  
24      times. There are a large number of high cost  
25      academic medical centers in this state,

1           comparatively speaking. And then lastly, but not  
2           least, the legacy of a highly regulated system, the  
3           system that we left back in '97.

4                        So, what does a low rating mean to a  
5           hospital who wants or needs to borrow money? Well,  
6           it can mean limited access to the market and higher  
7           cost debt. It all translates generally into access  
8           and cost. As a result, for most hospitals and  
9           nursing homes in New York State, credit enhancement  
10          of one form or another is needed and purchased to  
11          access the market and lower interest rate expense  
12          when they borrow. Historically, due to the weaker  
13          nature of New York's hospital credit, credit  
14          enhancement from insurance and banking entities has  
15          been largely unavailable to New York State  
16          hospitals. Consequently, FHA insurance, mortgage  
17          insurance, is the most widely used credit  
18          enhancement for hospitals in New York. Outside of  
19          New York, hospitals have generally been more credit  
20          worthy and have been able to access capital on their  
21          own or have had private enhancement available.

22                       I would just note here, also, that  
23          outside of New York State the hospitals had been  
24          able to at least develop enough liquidity in terms  
25          of their own capital to be able to put up

1 significant amounts of cash to actually finance  
2 these things as opposed to actually leveraging it  
3 and going into the debt market.

4 Outside of New York, hospitals have  
5 tended not to use FHA mortgage insurance because of  
6 the relative length of the application process and  
7 the degree to which FHA monitors and restricts  
8 hospitals in its portfolio. It is a lengthy  
9 process. They have been working on it hard, but it  
10 is still a very long process.

11 In 1996, New York State represented 87  
12 percent of FHA's national hospitals portfolio.  
13 Pretty stunning figure for an insurance product.  
14 This brought Congressional scrutiny regarding  
15 concentration in our state. This concern was  
16 certainly heightened when New York State shifted  
17 their reimbursement into a more deregulated  
18 environment in 1997. In response, as I mentioned,  
19 FHA has made a concerted effort to diversify writing  
20 insurance to other parts of the country. They have  
21 done this through a combination of legislative  
22 changes, marketing, increased staffing and focusing  
23 on their own processes to try to make them more  
24 efficient. As a result of all of those efforts, New  
25 York State, in '05, represents 65 percent of the FHA

1 portfolio. And it's not because they haven't been  
2 writing business here, it's because they've been  
3 writing business other places.

4 At the same time FHA was going through  
5 their kind of diversification effort, the Dormitory  
6 Authority revised its credit guidelines to provide  
7 greater flexibility and facilitate the use of  
8 alternative credit enhancement, instead of relying  
9 so heavily on FHA. I think one of the things we've  
10 heard from our clients is that it's difficult to  
11 access capital and they wanted other alternatives to  
12 FHA. So, we tried to respond. As a consequence, we  
13 have over time issued more unenhanced bonds on a  
14 case-by-case basis. Unenhanced meaning totally  
15 uninsured. As a practical matter, however, because  
16 so few health care institutions are able to secure a  
17 rating of A minus or better or to qualify for an  
18 exception to our guidelines, institutions usually  
19 are required to obtain credit enhancement to borrow  
20 through DASNY, although there have been certain  
21 exceptions.

22 In addition to respond to the industry's  
23 need to access capital, the legislature passed first  
24 in 1999 an ability for health care institutions to  
25 use their local industrial development agencies,

1       they're called IDAs, to issue tax exempt debt for  
2       health care facilities under the amount of  
3       \$30 million. Although some IDAs may issue debt for  
4       weaker health care credits, this, in our view,  
5       exposes the State's health care system to other  
6       risks, specifically the imprudent use of access to  
7       capital where access is not unlimited.

8                       Despite these changes, health care  
9       financing in New York State remains heavily  
10      dependant on FHA insurance to get to market and it  
11      is the most widely used form of credit enhancement  
12      in New York.

13                      I would just add the tics on the slide  
14      also, we've worked very hard with the Health  
15      Department to try to streamline our processes also  
16      to make them as efficient and effective as possible.  
17      We heard complaints about length of application  
18      process also. So, we're all working to get more  
19      efficient.

20                      So, the industry has not sat still  
21      through all of this. The health care industry is  
22      clearly responding, Chairman Berger, as you noted in  
23      the beginning, to all of the externalities and the  
24      pressures that are being put upon it. These are  
25      things like rapid consolidation of the insurance

1 market, which they are experiencing new clinical and  
2 information technology. This whole concept of a  
3 hospital or a nursing home of the future, those are  
4 pressures that all of them are trying to grapple  
5 with. And, of course, the ever increasing pressure  
6 on reimbursements that they are receiving, not only  
7 from commercial payors but also the governmental  
8 payors.

9 We have in our portfolio and certainly  
10 more widely observed contracting, consolidating and  
11 reconfiguration in the industry already. But even  
12 as we collectively contemplate reconfiguring and  
13 reducing the number of acute care and long-term care  
14 beds in New York, the Dormitory Authority believes  
15 that reinvestment of capital, both bricks and mortar  
16 type, as you were talking about today, as well as  
17 the acquisition of technology capital will be  
18 necessary to actually reconfigure and restructure  
19 the industry. You're going to need capital to do  
20 this. To obtain it, hospitals and nursing homes  
21 must retain access to the public capital markets.  
22 We believe that if our State's method of  
23 restructuring the health care industry includes a  
24 pattern of sustained financial failures, either bond  
25 defaults or claims on insurance or other credit

1 enhancement, it is likely that future credit  
2 enhancement will be unavailable, it will be  
3 difficult to procure or it will be just too costly.

4 A former colleague of mine basically  
5 compared it to car insurance. You know, if you keep  
6 getting tickets and keep getting into accidents, you  
7 can't purchase car insurance anymore or it just  
8 becomes so expensive that you don't drive. So, it's  
9 very similar we believe to that.

10 This concept was aptly demonstrated when  
11 the Allegheny Health Education and Research  
12 Foundation, a very large hospital system in  
13 Pennsylvania, filed bankruptcy. The bond insurer  
14 for the debt was called upon to pay out a very, very  
15 large claim. Based on that experience and also the  
16 weak financial fundamentals of New York's  
17 institutions, private bond insurance for health care  
18 issues has become very scarce in New York. We just  
19 don't see it.

20 In sum, bond holders, existing bond  
21 holders and their credit enhancers must be treated  
22 equitably, very equitably, in order to assure future  
23 low cost capital for reinvestment as we approach  
24 this restructuring effort.

25 Now, to assist this effort, the Authority

1 has worked with commercial banks and other bond  
2 insurers to try to craft new products and respond to  
3 this continued need. We have a tax exempt leasing  
4 program that is available not only for health care,  
5 but also for institutions of higher care that is  
6 really targeted at shorter life assets, high  
7 technology leases of equipment. We have also been  
8 very active in monitoring turn arounds and work  
9 outs. And there have been a few in the last couple  
10 of years. The other thing that we've done is we  
11 have worked very hard with FHA over the last ten  
12 years to develop strong working relationships with  
13 them. It's focused on cooperative problem solving  
14 and communication. These relationships have served  
15 to be very critical in the last few years as we  
16 worked through at least four chapter 11 bankruptcies  
17 with them. And in each one of them, none of them  
18 have resulted in a claim on FHA insurance. And it  
19 was an extraordinary effort, not only with FHA, but  
20 also with the Department of Health and the  
21 administration. We really all kind of pulled  
22 together and worked through those things.

23 This relationship, this continued  
24 relationship, will be very important as Congress and  
25 the Government Accountability Office, even in a

1 recently released report, I think it was two weeks  
2 ago, continued -- despite the lower level of  
3 exposure to New York -- continued to be concerned  
4 about FHA's exposure in New York State.

5           So, despite all of these efforts, it  
6 should be clear that if DASNY determines that its  
7 bond holders are at risk, DASNY will need to fulfill  
8 its obligations to its bond holders and the credit  
9 enhancers that stand behind our bonds. This may  
10 include making claims on insurance and foreclosing  
11 on assets. Clearly, in our view, it would be  
12 preferable to work with health care institutions and  
13 the State to reconfigure existing debt so that it  
14 can be effectively managed by the institutions that  
15 continue to provide health care services in this  
16 state.

17           In conclusion and very simply stated, the  
18 Commission's deliberations should consider  
19 responsible treatment of current debt as it will  
20 facilitate future capital reinvestment. DASNY  
21 stands ready to assist both the Commission and the  
22 industry as they undertake this very necessary and  
23 difficult task.

24           That would complete my comments.

25           CHAIRMAN BERGER: Anybody, comments?

1 MR. BRIDEAU: Just a question.

2 As we do our deliberations going forward,  
3 how will the Commission gain an insight into the  
4 status of these various debt issuances on a  
5 by-hospital basis, so that it's not simply a  
6 question of who is defaulting, but who is at risk?  
7 What actions might enhance the risk, or worse, or  
8 better?

9 CHAIRMAN BERGER: We'll have access to  
10 all that information in our deliberations.

11 MR. LEFEBVRE: And we also serve as  
12 liaison to the Commission and we would be happy to  
13 assist.

14 MR. VELEZ: I was going to ask a similar  
15 question.

16 This is just a thought that's going  
17 through my mind at this time. With revenues  
18 stagnating, reducing, how much debt service could  
19 the industry continue to assume taking into  
20 consideration your protected capitalization?

21 MR. LEFEBVRE: Good question. I think it  
22 depends on a case by case -- I think it really is  
23 dependent on what that restructured industry,  
24 restructured provider, looks like. I think that  
25 there is a presumption as you restructure that there

1 is a more efficient health care system left that  
2 will be able to sustain itself and be able to take  
3 on more capital.

4 I think the other thing is that debt  
5 service as a percentage of expense is not  
6 necessarily out of line with the rest of the  
7 country. It generally represents about four to four  
8 and a half percent of a hospital's expense base.  
9 And that's not out of line with the other parts of  
10 the country.

11 I think what I heard Tom Jung say last  
12 time is that it's operationalizing the buildings  
13 that you build, filling them with patients and  
14 paying for their care. That's what drives, you  
15 know, a greater expense.

16 MR. SEARS: Pete, I think if you would  
17 have had on your chart the various metrics about  
18 what the medians are in New York State and I think  
19 if you has a debt service coverage line there, you  
20 would find that the debt service coverage in New  
21 York is about one times less. In other words, it's  
22 about 2.3 or something like that. Whereas, S&P and  
23 Fitch look for about 3.3, 3.5. As Lora said, as  
24 compared to the revenues, it's not out of whack.  
25 It's the amount of debt that is out of whack.

1 MR. LEFEBVRE: Exactly. Well put.

2 CHAIRMAN BERGER: Pete, the other piece  
3 that you raise is that -- and I think that part of  
4 Lora's answer that is important is that as we go  
5 through the process, we will find different kinds of  
6 situations that we have to deal with and they will  
7 have different solutions. There will be solutions  
8 that combinations will help take care of the capital  
9 problem, there will be other solutions where we'll  
10 need external funding, which is part of what we have  
11 talked about, to make it work. And part of it will  
12 be there will be solutions that work in shorter term  
13 and things we'll try to create that will work over  
14 the longer term. And, obviously, where you want to  
15 get over the longer term is to have -- and it won't  
16 happen overnight -- is institutions which have  
17 operating cash flow which allows them to access the  
18 public markets without credit enhancement.

19 And Lora, as you may know, some time ago  
20 I was the chairman and CEO of one of those financial  
21 enhancement organizations, one of the companies, and  
22 I wouldn't do New York State health care  
23 institutions because the risk was much too high.  
24 And we got to get out -- we got to get to a point  
25 where they will do it and then the capital markets

1 will do it. And that's down the road. But we will  
2 have to come up with different strategies, and they  
3 will be different for different institutions and  
4 different regions, we'll find we have different ways  
5 of doing it. But we're going to be restructuring.  
6 And part of that is you cannot -- and some of us  
7 faced this 30 years ago for the city -- you cannot  
8 create an environment in which the health  
9 institutions of this state are sort of barred from  
10 the capital markets for ten years. That can't be  
11 what we end up with. That would be a disaster. So,  
12 we're going to have to be sensitive when coming up  
13 with ways of doing this.

14 Comments?

15 BISHOP SULLIVAN: Just one.

16 It strikes me, this system doesn't  
17 reimburse people for the work that they do at a  
18 level of what the cost is. And one of the things in  
19 New York State, we're highly leveraged in a sense  
20 because we have an organized community of workers,  
21 so we pay a lot more money for our workers than  
22 around the country. Secondly, to me, when you're  
23 operating on a day-to-day basis and the Medicaid  
24 gets cut, and the federal government is going in  
25 that direction more strongly, how do you get back

1           into this business where you can generate the  
2           capital and pay off your debt?

3                       MR. VELEZ:  You can't.

4                       BISHOP SULLIVAN:  It's really not a  
5           profit making business.

6                       CHAIRMAN BERGER:  And you have fewer  
7           insurers and you get squeezed more in terms of  
8           negotiations.  And there are also payors.  So, as  
9           was said before, that's part of the payor issue as  
10          well, not just Medicare and Medicaid.  Those are  
11          issues we've got to put on the table.  I agree.

12                      Any other comments?  Okay.

13                      Thank you.

14                      So, today we've talked a little bit about  
15          the operating costs and some future capital costs  
16          and we're slowly beginning and we have people out in  
17          the communities who are presenting testimony and  
18          we'll begin to hear about it at the next session.

19                      The future meeting schedule:  The next  
20          meeting, there are two things about this -- I just  
21          want to make it clear publically, there are two  
22          things.  First, the next meeting, which is  
23          April 5th, will take place in Rochester.  It's  
24          posted on our website, at 1:30.  The meeting after  
25          that is May 11th.  That will be in New York City, as

1 will the June meeting, on June 8th, both in New York  
2 City. The time, however, is to be determined. And  
3 I point that out because we'll have to go through it  
4 with all our members, but they will be longer  
5 meetings and they will also have executive sessions  
6 to get reports from the Regional Advisory  
7 Committees. But they will be longer meetings. So,  
8 I am just alerting all the Commission members to  
9 that fact.

10 Then we will come up with a summer  
11 schedule very soon.

12 Have I missed anything?

13 DR. SANDMAN: No.

14 CHAIRMAN BERGER: Members, any comments?  
15 Questions?

16 I will take a motion to adjourn?

17 MR. SEARS: So moved.

18 MR. HOWLETT: Second.

19 CHAIRMAN BERGER: Thank you very much.

20 See you in Rochester.

21 (Time noted: 3:05 p.m.)

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

I, KELLY FINE-JENSEN, a Registered Professional Reporter and a Notary Public, do hereby certify that the foregoing is a true and accurate transcription of my stenographic notes.

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

KELLY FINE-JENSEN, RPR