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COMMISSION ON HEALTH CARE FACILITIES  
IN THE 21ST CENTURY  
RADISSON-MARTINIQUE HOTEL  
49 WEST 32ND STREET  
NEW YORK, NEW YORK  
1:00 P.M.  
BEFORE STEPHEN BERGER, CHAIRMAN

1

2 CHAIRMAN BERGER: This is the Commission  
3 on Health Care Facilities in the 21st Century.

4 I would like to call the meeting to  
5 order. Note, for the record, a quorum, and I would  
6 like to ask our Executive Director, Dr. David  
7 Sandman, to begin a progress report of what's taken  
8 place since the last meeting.

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

10 I'm pleased to make this brief report  
11 on progress. As I reported at our last meeting,  
12 the Governor has announced the availability of a  
13 \$269 million for new grant funding of hospitals and  
14 nursing homes, a restructuring initiative that is  
15 consistent with the goals of the Commission.

16 Funds coming from the New York program  
17 will ultimately provide one billion dollars for  
18 this program. Under this capital restructuring  
19 initiative, funds will be provided to support  
20 physical reconfiguration, the downsizing or closure  
21 of facilities, consolidation of providers' programs  
22 in acute areas and elimination of duplicate  
23 services, consistent with community needs for those  
24 services.

25 For this funding initiative, acting

1 jointly, DOH and DASN met in Albany on June 28, and  
2 the application deadline has been extended by two  
3 weeks, until August 15. Any additional inquiries  
4 related to that deadline should be directed to  
5 them.

6                   In addition, the Commission's Voluntary  
7 Rightsizing Procedure continues to gain momentum  
8 and continues to receive additional applications  
9 for providers wishing to engage volunteers in  
10 various types of consolidation and collaboration.

11                   The RAC's also continue to hold  
12 discussions with providers and other stakeholders  
13 in the region. The RAC's are sharing their  
14 findings from information gathering efforts with  
15 the Commission.

16                   In addition to working closely with the  
17 RAC's, the Commission staff also continues to  
18 engage in discussions with various providers across  
19 the State, as well as to evaluate different  
20 scenarios of providers.

21                   As always, we remain engaged and  
22 interested in outreach programs. In a few of our  
23 recent meetings we have met with the Council of  
24 Community-based Health Care, the National Hispanic  
25 Medical Association, the office of the Brooklyn

1 Borough President, and, this week, the Continuing  
2 Care Policy Committee.

3 In sum, Mr. Chairman, we have made good  
4 progress, and are right on schedule with the work  
5 plan adopted by the Commission last fall.

6 At this point, we are transitioning  
7 from the information gathering phase and moving  
8 into the Commission's next phase of discussion and  
9 deliberation, which will ultimately lead up to the  
10 development of recommendations.

11 Thank you, very much, Mr. Chairman.

12 CHAIRMAN BERGER: Any questions for  
13 David?

14 MR. ROBERTS: As we move toward making  
15 this transition, while you are going through the  
16 process of discussion and conclusions, at what  
17 stage would you get involved in that process with  
18 staff?

19 CHAIRMAN BERGER: Immediately.

20 Any other questions?

21 Thank you, David.

22 Today we have joining us somebody who,  
23 actually, many of you know quite well, Sharon  
24 Carpinello, the Commissioner. She is the  
25 Commissioner of the New York State Office of Mental

1 Health and, as part of our efforts at understanding  
2 the shape of services and the issues relating to  
3 the institutions that we are responsible for  
4 reviewing, several of you have asked that we look  
5 at some of the services that are part of the  
6 network, and to get a judgment of what is happening  
7 in those service areas and how they would affect  
8 our decisions.

9                   And so we asked Dr. Carpinello to join  
10 us, and she's going to talk a little about this  
11 area, and then she will answer the Commission's  
12 questions. I've met her before. She's not shy.  
13 Ask her questions and she'll answer them.

14                   COMMISSIONER CARPINELLO: Thank you  
15 Mr. Berger and members of the Commission for giving  
16 me an opportunity to talk about health care in New  
17 York.

18                   By the way, on the screen behind me  
19 here, the first slide is to provide you with an  
20 understanding of the New York Mental Health System.  
21 I'm talking about both the state-sided general  
22 hospital, and about private hospitals.

23                   I really want to say, once more, that I  
24 really thank you for allowing me to contribute. I  
25 know you are undergoing a thoughtful process and a

1 difficult one.

2           A little about the mission of the  
3 Office of Mental Health. We have actually begun to  
4 focus, in the last couple of years, on promoting  
5 mental health for all New Yorkers. Now that is a  
6 little bit different, a public health agenda we  
7 never had before.

8           One reason is suicide prevention.  
9 Something happened at the national level, and we  
10 have that driving that agenda.

11           Secondly, people with mental illness  
12 actually die 24 years, on the average, earlier than  
13 the general population. Why does that happen? It  
14 doesn't happen because of mental illness but  
15 because of all the factors attributed to that:  
16 Obesity, type-two diabetes, cardiopulmonary  
17 disease, or related to medications being taken.

18           And, of course, the second mission of  
19 the Office of Mental Health is to focus on the home  
20 and recovery of serious illness in children with  
21 emotional disturbances.

22           Many people with mental illness live at  
23 home, in our communities. They do activities, they  
24 can work, they can go to school, they can be with  
25 their peers, socialize with friends, go to the 4th



1 of individuals who are developing the awful  
2 psychology, the impact of being traumatized. And  
3 you know that there certainly were a lot of people  
4 over the past couple of years, the last five years,  
5 as a result of the impact of 9/11, and I'm happy to  
6 say our knowledge-base today is better than it was,  
7 but we can do a lot in this area, in terms of  
8 prevention.

9           The impact of mental illness, I think  
10 that we know more today, but we are still, sort of,  
11 the best kept secret. The reason for that is we  
12 don't usually talk about the 30 percent of  
13 Americans each year diagnosed with mental  
14 disorders. Only three out of ten adults diagnosed  
15 seek mental health treatment; three out of ten.

16           Four of the ten leading causes of  
17 disability in the United States and other developed  
18 countries are mental disorders, including major  
19 depression, bipolar disorder and schizophrenia. If  
20 you haven't been following Harvard's second study,  
21 and I think it's a wake-up time for you, in terms  
22 of the impact of mental illness and the prevalence  
23 of mental illness.

24           Here you see statistics. Mental  
25 illness, a diagnosed mental disorder, the national

1 prevalence is estimated at 24 percent. In New York  
2 it translates into 3.5 million people with a  
3 diagnosis. Serious mental illness is prevalent in  
4 an estimated of 5.4 percent of people, and that  
5 means diagnosis, plus some functional impairment.

6                   Finally, serious, persistent mental  
7 illness, a combination of mental health disorder  
8 and substantial functional impairment, with a  
9 prolonged duration, again that's a national  
10 estimate. About 400,000 people in New York State  
11 have this prevalence.

12                   Sometimes we forget to talk about  
13 children. Although it may seem my presentation is  
14 more focused on adults, I want to say that the  
15 impact of serious emotional disturbance in children  
16 is very serious. Only 30 percent of children aged  
17 14 and older, with emotional disturbance, graduate  
18 with a standard high school diploma. Among all  
19 disabilities, emotional disturbance was associated  
20 with the highest rate of school drop-out.

21                   Suicide is the third leading cause of  
22 death for college students, second in the past  
23 couple of months. It's a huge problem with the  
24 Latino population, and I'll talk more about that.  
25 On the children's side, the prevalence of SED,

1 serious emotional disturbance, is diagnosed as a  
2 functional impairment in children 9 through 17 at  
3 12 percent. About 500,000 children in our State  
4 have serious emotional disturbances.

5           For those in the back, I say look at  
6 the colors here. The color tells you a lot.  
7 There's green and purple. The green illustrates,  
8 if you look at the colors, the difference between  
9 State and non-State. Somehow, there is a myth that  
10 the State is the big business person in mental  
11 health.

12           In fact, the green is the non-State,  
13 and you can see the difference in the little pie  
14 slice the State has here. We see, broken down on  
15 this slide, which makes the point that most people  
16 who have serious emotional disturbances receive  
17 services in the community, and don't receive them  
18 in hospitals.

19           We serve more than 600,000 people a  
20 year. Two-thirds of these individuals have SMI, or  
21 serious mental illness, or SED, serious emotional  
22 disturbance. Most services are not delivered by  
23 the State-operated providers.

24           If you look to your far right, on the  
25 screen, over to the right, are inpatient services

1 and the total amount. Again, you can see the total  
2 amount on an annual basis, that 11,288 people are  
3 served inpatient by the State.

4           A substantial portion of mental health  
5 services are delivered by New York State hospitals,  
6 many of whom provide both inpatient and outpatient  
7 mental health services. That means they run  
8 clinics, and I'll talk about that. Private  
9 psychiatric hospitals and State psychiatric centers  
10 have different, complimentary roles.

11           The State is not in the acute business.  
12 It is in the intermediate, long care business. We  
13 work closely with our general hospitals, and that  
14 has been in place over many years. A substantial  
15 number of additional inpatient beds have been  
16 approved or are under consideration. The IMD  
17 exclusion has important implications for the  
18 configuration of inpatient services.

19           In New York State, this shows on a  
20 state-wide basis, there are 167 hospitals for  
21 adults and children. This does not include all  
22 hospitals in the other centers. The number of beds  
23 is almost 12,000, and statewide there is a 90  
24 percent occupancy rate.

25           I have to say that, statewide, there

1 are very big regional differences, in terms of  
2 occupancy rates, something all of you are looking  
3 at and, on that note, the occupancy rates tend to  
4 be very misleading. There are other factors you  
5 should look at, in terms of occupancy rates. A lot  
6 has to do with the hospital beds approved, the  
7 characteristics of the population, ethnic,  
8 cultural, age groups, et cetera. All these are  
9 taken into consideration.

10                   The breakdown for general hospitals in  
11 New York State are 117 Article 28 hospitals, 9  
12 Article 31 hospitals, 19 residential treatment  
13 facilities and 22 state psychiatric centers, not  
14 including Washington Heights, forensic hospitals or  
15 research centers.

16                   When we look at inpatient hospital  
17 capacity, this is just within New York City.  
18 There's a difference in the breakout from hospital,  
19 RTF state psychiatric centers and, again, you see  
20 that the biggest players are general hospitals,  
21 Article 28 hospitals, of which 46 are in the New  
22 York City area and are serving almost 3,000 people.

23                   I've broken those out by different  
24 regions, but I think if you just look at the little  
25 dots, the little red things are meant to show, if

1 we look at every section we'll see, not  
2 surprisingly, that those little dots are closer to  
3 larger cities and urban areas.

4           When you look at geographic differences  
5 and are trying to make decisions for the  
6 Commission, you have this breakout by hospital  
7 numbers, and also it shows bed utilization rate, so  
8 it looks like this area is pretty well populated.

9           But how do we make decisions about the  
10 need for our inpatient mental health services for  
11 all of our services? It is not just The Department  
12 of Mental Health making that decision alone, the  
13 outline of the statute or the prior approval  
14 process.

15           Applicants need to substantiate their  
16 need. They are reviewed by multiple players: The  
17 local government units of New York City -- that  
18 would be the mental hospital services of the New  
19 York City Office of Mental Health, the New York  
20 State Office of Mental Health, the DOH.

21           Sometimes, people tell me, it is  
22 torturous, but we do our best. Article 28  
23 hospitals are a key component of the Mental Health  
24 Services safety net. They do emergency psychiatric  
25 services, acute inpatient psychiatric services and

1 critical outpatient psychiatric services. An  
2 estimated 1.2 million adults and children with  
3 serious emotional disturbances are served statewide  
4 by 5800 beds and 271 outpatient programs,  
5 underneath the general hospital umbrella.

6           Two-thirds of hospitals with adult  
7 inpatient psychiatric services also provide  
8 licensed outpatient services on the general side.  
9 Outpatient services are the services that help to  
10 keep people with serious mental illness out of the  
11 hospital. They make that connection, keeping  
12 people in the community, a very strong component.

13           There have been big changes in the  
14 adult mental health system since 1950, certainly  
15 over the last ten years. We have able to take our  
16 savings from eliminating unneeded adult psychiatric  
17 inpatient capacity and reinvesting those dollars  
18 into the community. In doing that, a total of 1.9  
19 million people can live at home with their friends  
20 and family.

21           Also, acute inpatient care has been  
22 moved from State psychiatric hospitals to general  
23 hospitals. We see, on the State's side, very high  
24 occupancy rates, almost 100 percent, lots of  
25 closures and consolidations, and the focused

1 delivery of intermediate and long-term care.

2           In 1950, a long time ago, we served  
3 over 90,000 people in our hospitals, almost  
4 unbelievable. The largest hospital had 14,000  
5 people. It is hard to believe.

6           This is a big picture. You are not  
7 going to be able to see the little print. It shows  
8 census trends in the last 20 years. You see  
9 inpatient care moving to general hospitals. The  
10 reintegration, the little purple lines of census  
11 trend for 2004 to 2006 sort of ended there. It  
12 looks like we are where we need to be. Our  
13 patients are much more complex.

14           This is a picture that looks at the  
15 inpatient services, and most individuals are served  
16 in acute- or short-stay settings. Most are served  
17 in non-State operated settings.

18           Those are the fifteen trends for  
19 general hospitals and I really want to show,  
20 though, to make the point that New York is not like  
21 every other state in the nation.

22           Last week I was at a meeting of mental  
23 health contractors. They devoted hours to the  
24 acute care crisis across the country. There's been  
25 a key increase in the number of our acute care beds

1 over 15 years. We've been able to do that. Why?  
2 Because we decreased the length of stay. In 1990,  
3 the length the stay was almost 25 days. .

4 Look where we are in 2004. The length  
5 of time, about fifteen days for discharging people  
6 in and out. Why? Because we have more on the  
7 effective treatment, doing a better job in that  
8 way.

9 Mental health directors don't talk  
10 about New York, in terms of what's happening in the  
11 nation. Unless you look, because we are all  
12 different. New York State and New York City  
13 account for 37 percent of total expenditures for  
14 mental health services. 48 percent on the  
15 inpatient side, and 40 percent on the outpatient  
16 side. That's a huge percent of the pie. I think  
17 this slide shows this in a little different way.

18 Article 28 hospitals and general  
19 hospitals spend more total and inpatient mental  
20 health care dollars than Article 31 hospitals, and  
21 Article 28 hospitals provide nearly as much  
22 outpatient care as article 31 hospitals and are  
23 much more broken down into bills. The total is 4.6  
24 billion dollars for inpatient and outpatient side  
25 services.

1                   Article 28 hospitals are an integral  
2 part of the safety net. That means, as we talk  
3 about this, certainly over the last 15 years,  
4 80 percent of inpatient stays are being reimbursed  
5 by Medicare and Medicaid. We know that's very,  
6 very different than 1990. The number of inpatient  
7 stays reimbursed increased over 60 percent during  
8 that period.

9                   Before I wrap up, or whatever, I want  
10 to tell you about a positive change I think I would  
11 ask you to look at, as you make these difficult  
12 decisions. I'm really proud, in this regard. This  
13 is a recognition, in closure, of a psychiatric  
14 center that serves Sullivan County, in  
15 consolidation of all 115 beds in Middletown to  
16 Rockland Psychiatric Center.

17                   I would say this is the best of the  
18 Department, the best working together. This is the  
19 best of family members and recipients' needs,  
20 needed in the community, establishing a priority  
21 for expansion.

22                   We talked to State carriers and the two  
23 county health Commissioners. This is what they  
24 said they needed. How did we do this?

25                   Some staff stayed in Sullivan County.

1 Some had the opportunity to go to Rockland County,  
2 12 different counties. Our staff served 300  
3 people. This is what we did, reinvesting  
4 \$7 million which are the operating expenses for  
5 Middletown Psychiatric Hospital, Orange and  
6 Sullivan County. This is what people wanted and  
7 what we did.

8                   We added 221 bed CR's. We added a  
9 total of 48 beds to Middletown. We provided the  
10 psychiatric opportunity to move people to a lesser  
11 controlled environment, from a housing perspective,  
12 and get them ready to move to supportive housing in  
13 the community.

14                   It was very, very successful, and we  
15 have been trying a little in that area. That is  
16 what the community said they wanted, all inpatient  
17 services. Now if you don't know what that is, it's  
18 a 24 hour mobile team of assertive community  
19 treatment, 68 people, today, in New York.

20                   Our most important commodity is that we  
21 listen to every single one of the work force. Our  
22 staff's entire career was doing inpatient services.  
23 Now they have an opportunity to do outpatient, in  
24 areas they never worked before.

25                   In summary, first, mental illness is

1 prevalent. People with mental illness live  
2 successfully in the community with appropriate  
3 supports and services.

4           The mental health system is an  
5 interrelated set of community support, outpatient,  
6 inpatient and emergency services. State  
7 psychiatric centers provide intermediate and  
8 long-term care.

9           Article 28 hospitals provide a  
10 substantial portion of acute inpatient and  
11 outpatient mental health services.

12           Two-thirds of Article 28 hospitals with  
13 inpatient psychiatric units also provide licensed  
14 outpatient services. Article 28 inpatients are  
15 predominantly Medicare and/or Medicaid funded.

16           And, finally, Article 28 hospitals  
17 account for 37 percent of mental health  
18 expenditures in New York State.

19           I do believe that the sample I gave  
20 with Middletown and Rockland show how when we do  
21 this, a very positive change can be achieved for  
22 hospital reconfiguration.

23           Thank you, Mr. Berger.

24           CHAIRMAN BERGER: Thank you, Doctor.

25 Let me say that this will be posted on our website

1 for Commission members. If you would like to read  
2 it, we will give you a hard copy here.

3 Are there any questions?

4 BISHOP SULLIVAN: To what extent is the  
5 length of stay dropped, due to policy regulatory  
6 requirements, so that they only stay a certain  
7 amount, number, of days?

8 COMMISSIONER CARPINELLO: I gave the  
9 estimate, initially. For acute care, 30 days or  
10 less. There are areas where that policy may have  
11 impacted, but I believe the majority of the  
12 decrease has to do with a number of things, most  
13 about better treatment. Certainly we know more  
14 today than ten years ago. We have been on a roll  
15 with evidence of practices in the field.

16 MR. WEBER: On this Commission, what are  
17 your fears about what we might do, or your worries?  
18 Is this first, do no harm?

19 COMMISSIONER CARPINELLO: I say do no  
20 harm. I want to be sure the State doesn't go back  
21 into the acute care business. People should be  
22 served in the community. As we look, hospital by  
23 hospital, you must look at the outpatient services.  
24 We have taken down beds, but we survived and came  
25 up on the community side. I think you have to look

1 at the outpatient side.

2 MR. ROBERTS: I have a small window and  
3 you are saying you don't want to go back into acute  
4 care. When they gave us the statistics, I was  
5 struck at how inefficient the people who use it,  
6 the recipients of this care use the hospital system  
7 but, as doctors, is there anything that can be done  
8 from the other side of the street, assuming this is  
9 correct? Can they access traditional health care  
10 in a more traditional way?

11 COMMISSIONER CARPINELLO: We have a  
12 major agenda, if I can go back to the promise of  
13 the public health side of things. A lot of times  
14 people with mental health illness go to the  
15 emergency room and take medications. They have  
16 mental health symptoms.

17 Why did they stop medication? Often  
18 because the side effects related to the medications  
19 are not very pleasant. Our defeat is a side,  
20 technical outcome of that. I think to what I  
21 started to say, particularly the children's area,  
22 the whole public health part of the public health  
23 initiative.

24 This year, for the first time,  
25 \$62 million in the Governor's budget went to expand

1 mental health services, with a focus on early  
2 intervention, never done systematically in the  
3 State. For example, routine screenings and an  
4 assessment of those dollars.

5 I think that the more we work with  
6 primary care doctors, the more we work with  
7 pediatricians. We are doing that. I'm pleased to  
8 share that we have five total in-school pilot  
9 programs for New York State schools, suicide  
10 prevention in the schools, and programs and in  
11 other ways. We've also partnered with Sesame  
12 Street in releasing, rolling out, in August, a DVD  
13 that Wal-Mart will carry, showing the needs of  
14 military families and children. We need to look at  
15 the molding of success and stop investing our  
16 dollars in things that aren't working.

17 MR. WEBER: You said a substantial  
18 number of inpatient beds are approved or under  
19 consideration.

20 Could you go into more detail about  
21 those beds and your overall plan for  
22 community-based outcare, as well?

23 COMMISSIONER CARPINELLO: I don't have  
24 that detail with me on a statewide basis. Probably  
25 150 beds are approved. We are constantly going

1 through that process about beds, and those beds are  
2 not operational, but will be. I'm sure I could  
3 provide the details.

4 DR. GIL: My question is to the staff of  
5 the Commission, as well as to the Commissioner.

6 I just heard the Commissioner answer  
7 questions that the State has approved additional  
8 beds in the psychiatric area.

9 How is it that the staff of the  
10 Commission -- how are you integrating this whole  
11 discussion about reinvesting, the same that we saw  
12 in Middletown?

13 For example, how are we using this as a  
14 model to reinvest in community health alternatives,  
15 outpatient housing, and so forth? What is the  
16 interaction between this State agency and the  
17 persuasive conversation that the executive director  
18 had with many closings and hospitals?

19 CHAIRMAN BERGER: We are trying to  
20 integrate.

21 DR. SANDMAN: We do provide psychiatric  
22 services, either inpatient or all other types of  
23 specialty services.

24 CHAIRMAN BERGER: We have another  
25 presentation. We are going to do the following. I

1 have pencil and made sure we are going to take  
2 e-mail questions. I'll give it to everybody later.  
3 We have to move on. We have a long agenda and we  
4 could be here for hours. We can't quite do that.  
5 Thank you for coming. As part of this area of  
6 concern, so the other matching piece. We have  
7 asked Shari Noonan, Commissioner, to come and talk  
8 about the alcoholism and substance abuse service.  
9 That's sort of another set of matching  
10 presentations at future meetings, some of the other  
11 different areas of financial concern. This is your  
12 microphone.

13 COMMISSIONER NOONAN: Good afternoon.  
14 I've been asked to talk about the chemical  
15 dependency system in New York and, more  
16 specifically, detox services. Just to put it in  
17 perspective, there are various levels of care:  
18 Detox services inpatient services, residential  
19 services, outpatient services, methadone.

20 I'll talk briefly about each one. To  
21 give perspective, inpatient services was for  
22 patients who were obviously unable to receive  
23 treatment on an outpatient basis. They are  
24 required to have a chemical abuse diagnosis. It  
25 really involves chemical use disorder diagnosis and

1 intensive medical management and monitoring of  
2 physical or mental complications.

3 Services are being provided in both  
4 hospitals and other settings. The lengths of stay  
5 are primarily in the 20- to 40-day range.

6 It is important to note that about  
7 40 percent of the Medicaid services are provided in  
8 the hospital setting. An example is St. Luke's-  
9 Roosevelt Hospital, which provided this level of  
10 care.

11 Residential services are provided for  
12 patients needing 24-hour treatment support,  
13 patients who are not in need of acute hospital or  
14 psychiatric care or of chemical dependence  
15 inpatient services. It requires a chemical use  
16 disorder diagnosis, and there are three levels of  
17 care.

18 Within the categories, from highest to  
19 low, are: Intensive residential treatment  
20 (therapeutic community); community residential  
21 halfway houses; supported living (transitional  
22 housing).

23 Services are provided in free-standing,  
24 non-hospital settings, and are not Medicaid  
25 eligible. The length of stay varies from four

1 months up to two years in some of the other  
2 residential levels of care.

3           Outpatient services are for patients  
4 able to abstain outside of a 24-hour, structured  
5 setting. Again, it requires a chemical use  
6 disorder diagnosis. There are two levels of the  
7 care: Outpatient and outpatient rehab services.  
8 They can be free-standing or hospital based. The  
9 length of treatment is around a year, and the  
10 frequency of service decreases over time.

11           About a third of outpatient Medicaid is  
12 billed in hospitals, at this level. For example,  
13 Glens Falls Hospital.

14           Methadone services are designed to  
15 manage heroin addiction. They are administered in  
16 conjunction with other medical care, counseling and  
17 support controls. It controls the physical problem  
18 of heroin dependence and is delivered, primarily,  
19 on an ambulatory basis. It is provided in  
20 free-standing and hospital settings. Hospitals  
21 represent over 40 percent of Medicaid billed.

22           For example, Beth Israel is one of the  
23 biggest providers of Methadone detox services. I  
24 was asked to talk about patients in physical  
25 withdrawal, or at risk for withdrawal from alcohol



1 now in New York State are billed to Medicaid as  
2 uncomplicated cases. We believe 60 percent are not  
3 needed to be done in a hospital setting.  
4 Eighty percent of all hospital cases are not linked  
5 to follow-up treatment.

6                   Following the detox, 44 percent of all  
7 hospital Medicaid cases end up back to detox, let  
8 the record reflect.

9                   Looking at here Medicaid recipients,  
10 '04 - '05, on the last pie chart, all Medicaid  
11 recipients, detox still accounts for 35 percent of  
12 the pie. If you look at the highest 1500  
13 recipients, the top 1 percent of detox accounts for  
14 83 percent of the Medicaid dollars in our system.

15                   Again, a little further behind that,  
16 Medicaid programs, using '04 - '05 data, medically  
17 managed withdrawal hospital detox, there is about  
18 \$319 million in Medicaid billings, 245,000 days or  
19 visits, and the average rate per day visit is  
20 \$1,300.

21                   For medically supervised withdrawal,  
22 you can see that rate was \$368 for inpatients. For  
23 outpatients, it's \$118. Down at the bottom,  
24 medically monitored withdrawal is not eligible for  
25 Medicaid reimbursement. The average rate is \$142

1 per day. There's a dramatic difference in payment  
2 rates between levels of care.

3                   What we did here is break down, by DOH  
4 region, detox services by hospital. There's a  
5 handout that breaks that down by count. You will  
6 see, in New York City, 22 hospitals with certified  
7 beds, 32 with scatter beds. That gives us a total  
8 of 735 detox beds and a utilization rate of  
9 71 percent.

10                   You see that Medicaid utilization is  
11 not quite as high outside of New York City, which  
12 has the highest concentration of hospitals and  
13 services. The State-wide rate is about 63 percent.  
14 This is a breakdown, more specifically, of New York  
15 City by county. You will see it looks fairly  
16 consistent, with Staten Island a little bit lower  
17 than the other boroughs.

18                   Here are recipients of hospital  
19 Medicaid detox services, for Medicaid patients in  
20 the year 2004. You can see that, for the top 100  
21 patients, we spent over \$12 million on them in  
22 detox, representing .3 percent of the patients,  
23 .29 percent of the billing average, for \$128,000  
24 per patient.

25                   Really telling here is the yellow bar.

1 The top five thousand recipients use \$157,000,000.  
2 What's telling is that they only represent 17.4  
3 percent of the recipients, and over 50 percent of  
4 the cost provided.

5                   This shows trends since 1997. The  
6 trend for the amount of dollars spent on detox is  
7 rising. Leveling off at the end, we attribute that  
8 to managed care. The chart shows two things. The  
9 blue line shows a 16 percent decrease in  
10 recipients. That means, while the pie chart  
11 slightly increase in dollars spending, a little  
12 more money, there are 16 percent less patients.  
13 Why is that?

14                   What is that episode per recipient for  
15 Medicaid? You see an eight percent increase in the  
16 number of episodes per individual. The slide shows  
17 two things. The blue line is the number of  
18 recipients of more than five episodes of detox.  
19 There's been an 11 percent increase in the number  
20 of recipients for detox action, five episodes or  
21 more in a year.

22                   The pink line shows the average number  
23 of episodes for recipients with more than five  
24 episodes. These detoxes increased by five percent.

25                   This used to be my favorite chart. For



1 levels of medically supervised linkage rates were  
2 about double, nothing to write home about. For  
3 medically supervised withdrawal, 43 percent were  
4 linked to treatment, or 41 percent for medically  
5 monitored discharges.

6           Here are just Medicaid patients. There  
7 are 20,000 episodes of hospital-based detox. If  
8 you look across the chart, 75 percent of the time  
9 the next episode of treatment was either another  
10 detox or nothing. Community based detox does a  
11 little better. Forty-nine percent of the time, the  
12 next episode was another detox episode this year.

13           The Governor proposed a major reform  
14 package for detox, considerable time and data. We  
15 proposed phasing down the payment rate for  
16 uncomplicated detox over a three-year period,  
17 starting at 75 percent of the current payment.

18           We also were working to establish  
19 medically supervised capacity in the hospital, not  
20 just at the community level; to audit peak claims  
21 criteria, whether a higher level of care only  
22 needed a lower level of care, and looking to  
23 develop a package of financial incentives for  
24 patient placement, post-discharge-warm hand-off,  
25 something that we learned that Pennsylvania was

1 doing, quite successfully. Paying treatment  
2 providers to come in while the patient was still in  
3 detox, to make that link and connection, paying the  
4 hospitals to insure the patient actually made it  
5 into treatment, post detox.

6           It was very successful in reducing that  
7 rate, cycling over an over into detox. Reaction  
8 was not exactly positive. Reactions from hospitals  
9 had to do with reduced capacity. They asked the  
10 State to implement observation, or triage, beds for  
11 detox. They wanted the audits of claims to be  
12 quite limited. They did like the financial  
13 incentives.

14           Our final proposal ended up as a  
15 combination of legislation and some administrative  
16 action. There will be no rate reduction this year;  
17 to establish medically supervised withdrawal  
18 capacity inside hospitals; we will be auditing peak  
19 claims against admission criteria; also, detox  
20 regulations are to include triage beds and we asked  
21 for redeveloping, along with a DOH hand-off  
22 program.

23           This is a picture of the current  
24 system, as I see it. You look at this picture and  
25 all patients complicated, uncomplicated, need

1 inpatient detox appropriate for outpatient.  
2 Everything goes into the hospital, for the most  
3 part. In New York State, very few patients get  
4 diverted to community-based detox, a very poor  
5 linkage, cycling back into the hospital. This is  
6 how we envision it, in a perfect world.

7           Uncomplicated and complicated patients,  
8 appropriate for outpatient detox, will now go into  
9 the 24-hour triage at a few community-based care  
10 facilities. The 23-hour bed triage will be farmed  
11 out into the appropriate level of medically  
12 supervised care within the hospital. They will be  
13 medically managed and medically supervised, and  
14 have better linkage of detoxes to follow-up  
15 treatment.

16           Something, I think, of particular  
17 interest to the Commission is that we mapped detox  
18 hospitals in New York State. The size of the dot  
19 represents the volume of Medicaid business. You  
20 see a big, big blob down in New York City. There  
21 are some parts of the State with no red. That's  
22 something the Commission will have to be cognizant  
23 of. In New York City, more specifically, there's a  
24 real concentration, in midtown Manhattan, of detox  
25 hospitals.

1           I'll share with you, in a hand-out, a  
2       breakdown by count of the hospital capacity, in the  
3       whole State, by count, something the Commission  
4       will need to be looking at carefully.

5           The take-away message is that the  
6       existing detox system is very expensive and has  
7       poor outcomes; lower levels of care are cheaper,  
8       but the capacity is not developed to the point it  
9       needs to be. A lot of the detox capacity is  
10      located in some portions of the State, and not so  
11      much in other portions of the State.

12          From my point of view, the message is  
13      that I think this Commission needs to look at those  
14      areas of the State where there is insufficient  
15      capacity to replace it.

16                  CHAIRMAN BERGER: Questions?

17                  DR. GIL: Thank you for your  
18      presentation. Can you talk about the incidence and  
19      prevalence of addiction?

20                  In other words, to describe the overlay  
21      of incidence and prevalence of the detox capacity.

22                  COMMISSIONER NOONAN: If my reading is  
23      correct, there's a higher incidence and prevalence  
24      in urban areas, as opposed to rural areas.

25                  If you look at the map, that is

1 something we need to be doing and be cognizant of,  
2 in large urban areas. We can certainly estimate  
3 that the hospitals make 125 million in profit, a  
4 conservative estimate, on detox.

5 MR. WEBER: How can hospitals reinvest  
6 that, if creating the capacity for linkage?

7 You are talking about that. It doesn't  
8 seem to exist as a requirement. My patients have  
9 to wait a long time to get treatment, detox  
10 treatment in the community.

11 What are the plans? How does the staff  
12 of the Commission plan to integrate these things  
13 into the recommendations of the Commission?

14 COMMISSIONER NOONAN: We need to work  
15 with you to develop community. I would like to  
16 take that money into community-based capacity,  
17 because it is a far cheaper alternative. It could  
18 be treated. That will be something we are looking  
19 to expand.

20 CHAIRMAN BERGER: There have been a lot  
21 of questions for both Commissioners. You will give  
22 us questions, and the Commission staff will send  
23 the Commission the questions so we can send  
24 everybody both the questions and the answers.

25 Last question?



1 inviting the two Commissioners to come and make  
2 these presentations.

3 CHAIRMAN BERGER: By the way, this  
4 presentation will be on our website. For members  
5 who want a hard copy, we will get that and  
6 distribute it later.

7 Any other questions?

8 One announcement. We shifted the  
9 official meeting from August 10 to August 24. The  
10 next meeting, August 24, will be here, hopefully,  
11 again. Do I have a motion?

12 MR. HINCKLEY: I move that we enter in  
13 executive session to address in detail the medical,  
14 financial and credit history of particular general  
15 hospitals and nursing homes that may be the subject  
16 of Commission recommendations for restituting,  
17 resigning, closing, consolidation and conversion.

18 CHAIRMAN BERGER: All in favor?

19 Any opposition?

20 The motion is carried. This part of  
21 the meeting is adjourned.

22 (Time noted: 2:10 p.m.)

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

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I, Jeffrey Shapiro, a Shorthand Reporter and Notary Public, within and for the State of New York, do hereby certify that I reported the proceedings in the within-entitled matter, on Thursday, July 20, 2006, at 49 West 32nd Street, New York, and that this is an accurate transcription of these proceedings.

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

JEFFREY SHAPIRO