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

Held on Monday, November 20, 2006
NY Marriott Hotel
525 Lexington Avenue, Stuyvesant Room
Borough of Manhattan

1 Meeting convened at 11:00 a.m.

2 Statewide Members

3 STEPHEN BERGER, Chairman

4 CRAIG A. DUNCAN

5 MARK KISSINGER

6 ROBERT R. HINCKLEY

7 HOWARD T. HOWLETT

8 LEO BRIDEAU

9 PETE VELEZ

10 TERESA SANTIAGO

11 BISHOP JOSEPH SULLIVAN

12 PATRICK LEE

13 BUFORD SEARS

14 G. NEIL ROBERTS

15 ROBERT GAFFNEY

16 KRISTIN PROUD

17 DR. ROSA GIL

18 Commission/DOH Staff

19 DR. DAVID SANDMAN

20 MARK USTIN, ESQ.

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1 P R O C E E D I N G S

2 CHAIRMAN BERGER: Ladies and Gentlemen, I
3 would like to call the meeting to order. Please,
4 everybody, take your seats.

5 Thank you.

6 The meeting of the Commission on Health
7 Care Facilities in the 21st Century is now in order.

8 Dr. Sandman, do you want to give us a
9 progress report?

10 DR. SANDMAN: Thank you very much.

11 Good morning, Mr. Chairman. I am very
12 pleased to make this report on progress since our
13 last meeting.

14 It has been an exceptionally busy period
15 as we conclude the work of the Commission. Up until
16 the very end we have continued to have meetings on
17 an almost daily basis with providers and other
18 stakeholders across the state in order to gather the
19 most up-to-date information possible. We have also
20 continued our supervision of various voluntary
21 rightsizing initiatives that were undertaken under
22 the auspices of the Commission.

23 The Regional Advisory Committees have
24 also completed their work, and all of the RACs have
25 submitted their final reports on time last week.

1 Also last week, Governor Pataki announced
2 the availability of more than \$52 million in
3 additional HEAL-New York funding to advance Health
4 Information Technology Initiatives on a regional
5 level. Up to half of those funds awarded under this
6 HEAL 3 solicitation will be supported by F-SHRP
7 funding.

8 Successful applicants must demonstrate
9 that their projects will assist in building an
10 infrastructure in New York State to share clinical
11 information among patients, providers, payors and
12 public health entities; support the statewide
13 adoption of systems compatible with the Strategic
14 HIT Plan that is being developed at the federal
15 level; and be able to be a part of the planned
16 national network for sharing patient data.

17 This request for grant applications is
18 issued by the State Department of Health as well as
19 the Dormitory Authority of the State of New York,
20 and additional information is available on the
21 websites of those two agencies.

22 So in summary, Mr. Chairman, we have been
23 faithful to our timeline and we are on schedule to
24 complete our work at the end of this month.

25 Thank you.

1 CHAIRMAN BERGER: Thank you, David.

2 I would now like to turn to the issue of
3 the policy recommendations. Let me take, if I may,
4 a few minutes to take the liberty, as chairman, to
5 walk through them and to outline them for us.

6 I think there are a couple of very
7 important pieces here that we want to emphasize, and
8 I think we have known it ourselves, that it is
9 important for people to understand that the work of
10 the Commission is only one element in a
11 comprehensive reform agenda.

12 Our recommendations should be considered
13 a start, not an end, to system restructuring. It's
14 beyond the practical scope of a single Commission to
15 address or resolve all of the issues facing our
16 state's health care system, but we have an
17 opportunity to set an agenda for further work and to
18 create some outlines for people to follow going
19 forward.

20 During its deliberations the Commission
21 frequently considered the ways in which the
22 structure and financing of the health care delivery
23 system affect its mandate to create a system that
24 better meets community needs. In particular, the
25 Commission has developed recommendations -- they are

1 in front of you -- concerning ten broad topics. The
2 Commission's enabling statute provides for
3 nonbinding policy recommendations, and I would hope
4 that the Commission's policy recommendations would
5 provide a blueprint for further work toward
6 improving our health care system.

7 Let me quickly move through some of
8 these and then I would like to open it to
9 discussion.

10 First, and perhaps most important, is the
11 issue of reimbursement and Medicaid. Reimbursement
12 reform may be the most important topic of all.
13 Funds flow help to determine the system we have
14 today and the type of changes that we can or cannot
15 accomplish in the future.

16 At times, financial incentives distort
17 the patterns of service delivery. Driven by the
18 imperative of financial survival, providers might
19 pursue high-margin services rather than services
20 that best align with community needs. Fiscal
21 pressures can also drive facilities to provide
22 otherwise redundant or unneeded services solely to
23 cross-subsidize other elements in their service mix
24 that are crucial but unprofitable.

25 Direct state action to change the amount

1 and distribution of funding for Medicaid and public
2 goods would be an important step in reforming the
3 reimbursement system in New York. Furthermore,
4 Medicaid policy has the potential to influence the
5 actions of private and federal payors. You have to
6 bring everybody into that new reimbursement
7 configuration.

8 The report in front of you recommends
9 that the State of New York undertake a comprehensive
10 review of reimbursement policy, a review that should
11 deal with this series of principles: The current
12 growth rate of Medicaid expenditures is an
13 unsustainable burden on taxpayers; diversion of
14 health care resources is unacceptable. Dollars that
15 are freed up must be reinvested in the health care
16 system; reimbursement reform should strengthen the
17 long-term viability of institutions that
18 disproportionately serve vulnerable populations,
19 including the uninsured and low-income patients;
20 reimbursement reform should encourage the provision
21 of preventive, primary and other baseline services
22 and discourage the medical arms race for duplicative
23 provision of high-end services; the relationship
24 between private payers and the financial viability
25 of the health care delivery system needs to be

1 carefully examined. Reducing unnecessary hospital
2 capacity and maintaining critical health services
3 are as important to the insurance sector as they are
4 to the public sector. As such, it is reasonable to
5 expect these companies to participate in initiatives
6 to promote financial alignment between payors and
7 providers, and to participate in reinvestment
8 strategies by reimbursing adequately while
9 maintaining adequate reserves to meet current and
10 future health care needs; future capital investments
11 should reflect shifts in the venue of care from
12 institutional to home- and community-based settings.

13 Within the specific arena of long-term
14 care, New York State should: Expand the
15 availability of home- and community-based
16 alternatives to nursing home placement and educate
17 physicians, paraprofessionals and consumers about
18 these alternatives; implement recently enacted
19 reforms to the current method of facility-based
20 reimbursement; explore alternate payment methods
21 such as resident-based pricing and/or the expansion
22 of managed care models on a demonstration basis;
23 implement its single point-of-entry system; develop
24 programs and reimbursement mechanisms for
25 high-quality, cost-effective chronic care

1 management; and address the disproportionate burden
2 on particular institutions of uncompensated
3 long-term care patients.

4 The second area that we have discussed
5 with this Commission deals with the uninsured. The
6 uninsured remains one of the most serious and
7 persistent health care problems both in the nation
8 and in New York. Nearly one in five non-elderly
9 individuals in the U.S. and New York State lacks
10 health care coverage.

11 Uninsured Americans often present to
12 hospital emergency rooms where their care can be
13 uncoordinated and more expensive to deliver. In
14 addition, health care providers bear a substantial
15 burden in providing care to the uninsured and the
16 indigent population.

17 New York State has made major strides in
18 creating access to health care for its residents,
19 and the percentage of the uninsured in New York
20 State between 2000 and 2004 has declined while the
21 percentage nationally has increased.

22 New York State has large and generous
23 public insurance programs. The Commission
24 recommends that New York State reaffirm its historic
25 commitment to health care for the poor and other

1 vulnerable populations. New York State should
2 ensure that health care coverage is universal,
3 continuous, affordable to individuals and families,
4 and affordable and sustainable to society at large.

5 While guarding against fraud, New York
6 should lower administrative barriers to enrollment
7 to help ensure that all uninsured but eligible
8 persons are placed in appropriate programs.

9 Furthermore, New York should study
10 coverage expansion programs in other states and
11 adopt additional strategies to sustain its recent
12 progress in reducing the number of uninsured
13 New Yorkers.

14 We have also talked a great deal and had
15 discussion with the Commission members about the
16 issues of primary care, and while that has not been
17 our basic responsibility, the Commission members
18 talked about this issue of primary care, and it is
19 clear that effective reform and investment in
20 primary care is essential to reversing long-term
21 trends affecting health care costs, access and
22 quality, especially for underserved populations.

23 Evidence shows that having a primary care
24 physician promotes overall community health. The
25 emergency room is not a primary care physician

1 base, despite the way it is presently being used.
2 Patients in low-income communities particularly face
3 enormous difficulties in accessing primary care
4 outside of that hospital setting. There aren't
5 enough primary care providers in many neighborhoods,
6 so care is often sought in emergency departments.
7 It is very expensive.

8 The Commission recommends pursuit of a
9 primary care reform agenda, including the following
10 elements: Ensuring that all New York residents have
11 a primary care "home"; stemming the erosion of
12 primary care capacity; investing in primary care
13 infrastructure, including investment in facilities,
14 equipment information technology; ensuring adequate
15 financial support to the primary health care safety
16 net; gaining participation by all payors to support
17 such investments; and investing in the development
18 of a primary care workforce.

19 We have got to develop hybrid delivery
20 systems. The Commission has repeatedly identified
21 communities whose needs could be well served with
22 less than a full service hospital but which require
23 more than an ambulatory care center. In these areas
24 there tends to be a single hospital with low
25 utilization, weak finances and inferior quality.

1 While such institutions may appear to be
2 candidates for closure, they cannot be closed unless
3 there is an alternative set of services that remains
4 available to community residents. Most often, the
5 services that require preservation include a
6 combination of emergency or urgent care, ambulatory
7 care, and to a lesser extent, ambulatory surgery and
8 imaging.

9 Today's reimbursement system makes this
10 an unprofitable and unviable set of services. The
11 lack of alternatives has led to a situation in which
12 whole hospitals must be maintained in order to
13 deliver the smaller subset of needed services that
14 could be provided by more focused facilities.

15 To better align community needs and
16 resources, the Commission recommends that the State
17 and industry collaborate to test and develop new
18 hybrid delivery models.

19 An area which we have talked about
20 concerns the State University of New York and SUNY
21 hospitals. The State University of New York
22 operates teaching hospitals at its Health Science
23 Centers in Brooklyn, Syracuse and Stony Brook.

24 The SUNY hospitals are important
25 resources. They are recipients of public funds and

1 subsidies. Their academic mission is to train
2 physicians and their mission is to serve patients
3 regardless of their ability to pay.

4 Similarly, the SUNY hospitals must be
5 able to compete within the marketplace, operate cost
6 effectively, and they must be able to establish
7 stronger relationships with community hospitals. As
8 state-controlled institutions, the SUNY teaching
9 hospitals face unique challenges adapting to new
10 market conditions. Legislation has been proposed
11 that would further expand operational flexibility,
12 even going so far as to restructure the SUNY
13 hospitals as private not-for-profit corporations.

14 Other states, including Massachusetts,
15 Michigan and Wisconsin, have taken this approach and
16 spun off their teaching hospitals to allow them to
17 function more effectively in the market.

18 Supporters of privatizing the SUNY
19 hospitals cite numerous advantages to spinning-off
20 the hospitals from the State University system.
21 Privatization could decrease or eliminate the need
22 for ongoing State subsidies, which currently amount
23 to over \$147 million in annual operating costs and
24 \$350 million in capital costs.

25 Proponents also point out that many

1 leading academic medical centers operate their
2 medical schools and principal teaching hospitals
3 under separate ownership without diminishing the
4 effects on their research enterprise.

5 There is also considerable opposition to
6 potential privatization of the SUNY hospitals. The
7 Commission recommends that the Commissioner of
8 Health, in consultation with other relevant parties,
9 conduct a comprehensive analysis of the feasibility
10 of privatizing the teaching hospitals at Stony
11 Brook, Syracuse and Brooklyn, and based on the
12 results of this analysis, the Commissioner should
13 develop a concrete timetable for action.

14 Several other points that are very
15 important in the whole issue of healthcare workforce
16 development: The health care workforce is a large
17 component of New York's economy. It accounts for
18 one in nine jobs across the state. The success of
19 the health care system across the continuum of care
20 is dependent upon an adequate supply of qualified
21 personnel at all levels.

22 Over the past several years,
23 approximately \$1.3 billion has been invested in
24 workforce recruitment, retraining and retention, but
25 we need additional strategies that should be

1 implemented. We have got to deal with the
2 persistent shortages in a variety of occupations
3 including registered nurses, pharmacists, radiology
4 technicians, home care attendants and other
5 paraprofessionals. We have got to educate and
6 retrain workers to prepare them for the increasing
7 uses of advanced health technologies in their jobs,
8 and we have got to facilitate the timely transfer of
9 personnel displaced by the Commission
10 recommendations to other employment within the
11 health care sector.

12 Several other comments, if I may, and I
13 am going to try to wrap up.

14 Information technology: The
15 reconfiguration of the health care system will place
16 a higher demand on information sharing, and the
17 effectiveness of information technology is
18 constrained if health care providers cannot share
19 with each other.

20 The State must ensure that systems are
21 able to communicate using open architecture and
22 embracing the principles of interoperability. The
23 availability of HEAL New York grants for IT
24 investment is a promising opportunity to further
25 advances in this area.

1 There are three other areas in the report
2 and let me just quickly mention them.

3 It is time to review the issue of county
4 nursing homes. County nursing homes play an
5 important role in taking care of the indigent.
6 Whether or not these facilities as they presently
7 exist -- they are losing money each year -- should
8 continue to exist in their present form is a very
9 serious question.

10 Given the complexity of this issue, we
11 believe New York State should undertake a
12 comprehensive review of the future role of
13 county-owned and operated nursing homes, and
14 establish a clear policy to guide the decision
15 making about these homes. It is a changing
16 environment and there should be a new review, one
17 that protects poor and indigent residents.

18 We talked about niche providers, and we
19 have talked about niche providers now for a long
20 time. A significant amount of health care services
21 has migrated out of the hospital care setting to
22 other settings.

23 Ambulatory niche providers are unburdened
24 by the large overhead costs borne by the hospitals
25 and so they can be less costly for payors and users,

1 and the patients benefit from a wider choice of
2 venues in which to receive care, and this process is
3 likely to continue.

4 This would not be a problem except that
5 the hospitals are left with a disproportionate share
6 of complex and difficult high-risk cases, while
7 other providers effectively "cherry pick." As a
8 result, the out-migration of high-value services
9 from hospitals to niche providers has the potential
10 for weakening these public good funding sources.

11 Alternative financing mechanisms for
12 these essential services are needed, and niche
13 providers must share in the burden of paying for
14 public goods and charity care. In addition, there
15 may be a need to enhance quality-of-care monitoring
16 and reporting in nonregulated and private settings.

17 And finally, we have raised many issues
18 to this commission both on direct mandate and on the
19 issues related here in the policy arena. There are
20 many opportunities in front of this state to improve
21 health care. We need to build on the effort of this
22 commission and address the ongoing need for some
23 structural decision-making regarding health care
24 resource allocations.

25 The speed of change in health care,

1 driven by changing technology, populations and
2 finance, makes it essential that the work of
3 reforming the system and the regulatory framework be
4 continuous. We believe the state should implement
5 an ongoing process to sustain the efforts initiated
6 by this commission.

7 That is basically my summary of the
8 report.

9 I apologize for taking so long, but I
10 would like now to open the floor to a motion to
11 adopt the policy recommendations, and to any
12 comments.

13 MR. HOWLETT: I move.

14 MR. DUNCAN: I second.

15 CHAIRMAN BERGER: Are there comments?

16 Dr. Gil?

17 DR. GIL: Mr. Chairman, I know that this
18 was not discussed in the meeting in October, but
19 after having had the opportunity to review all of
20 the documents that the committee director had
21 submitted to us for review, I just wanted to point
22 out, Mr. Chairman, that although we have
23 consistently talked about the need to look at the
24 mentally ill, and after having had a presentation
25 here of the State Commissioner of Mental Health and

1 looking at all documents, that continues to be
2 absent.

3 You know, I know it is 11 1/2 hour now to
4 request a recommendation, but I am asking,
5 Mr. Chairman, that in some way and fashion that we
6 are on the record that there is no excess of beds
7 for substance abuse and mentally ill patients. On
8 the contrary, there is a lack of capacity for those
9 populations.

10 CHAIRMAN BERGER: Doctor, that was not an
11 area that we actually studied, and what I suggest
12 that we could do, therefore -- it is very hard -- I
13 understand your comments. What we have tried to do
14 in all our recommendations is to be able to say
15 something we can back up.

16 My suggestion to you: We have the
17 recommendations, we have the comments made by the
18 commissioner, who was here, and we will obviously
19 make sure they will be part of the public record. I
20 want to make clear that their not commenting is not
21 because they don't agree with you. It's just that
22 we have not done the study and therefore I think it
23 would be hard for commission members to vote when we
24 have not made an actual study on this subject.

25 But your comments will be part of the

1 public record. We just can't justify it the way we
2 can with our other recommendations.

3 Other comments?

4 Bishop Sullivan?

5 BISHOP SULLIVAN: Would we be able to
6 basically say in the conclusion of this that there
7 are areas that have not been touched?

8 We did not look at mental health, you're
9 right. But it's a major, major area and I think
10 more and more people see that there has got to be
11 some kind of balance as far as physical and mental
12 health, and that we might be able to add that as an
13 area that we could potentially look at.

14 CHAIRMAN BERGER: With the concurrence of
15 the members of the commission, we could add that.

16 There is a lot of stuff we did not touch
17 and this is the beginning of a process. It is a
18 long process. You know, you've got 100 years of
19 building a system and now the world is changing. We
20 are not going to change it with one commission and
21 one set of actions. But it has got to be the
22 beginning of the process. I think we could easily
23 accommodate that.

24 Please, let's see some other hands.

25 Pete?

1 MR. VELEZ: The basic principals
2 articulated in this policy recommendation, at least
3 to me, represent the basic foundation that should
4 drive restructuring health care in the state.

5 My question is: How can we ensure that
6 the Commission's report integrates very, very strong
7 recommendations as the basic foundation to drive
8 change in health care?

9 I have not looked at the two different
10 packages.

11 CHAIRMAN BERGER: Pete, with all due
12 respect, part of the reason we thought it was
13 important to have these policy recommendations voted
14 on first and early was to focus on them, and I think
15 that part of our responsibility going forward will
16 be not to allow the discussion to be broken into
17 pieces.

18 I was going to say a little later in this
19 meeting that there are certain -- there is nothing
20 anybody can do about it -- but it is disturbing, as
21 we try to make very broad and very specific
22 judgments, to be sitting around with everybody's
23 grocery list suddenly appearing in newspapers as if
24 they were final decisions and all the rest. That is
25 not what we are trying to do.

1 I think what we are trying to do is begin
2 a process that is comprehensive and long term. I
3 believe that that's part of what we have to do both
4 now, over the next several months, and with a new
5 administration that will be arriving in Albany.

6 We have worked very hard and we will talk
7 some more about this as individuals to try to make
8 sure that the totality of the agenda is understood.
9 You are not wrong, but we have to work at it.
10 That's part of our Commission job.

11 Leo?

12 MR. BRIDEAU: Thanks, Mr. Chairman.

13 I agree that the recommendations really
14 cover the waterfront very, very well and strongly
15 support them.

16 The concern that I have is that the way
17 that we have structured them, they may appear to all
18 be equal, and I don't think they are and I would
19 like to take the opportunity to put on the record
20 where I think some of the highlights really ought to
21 be.

22 First, in the area of the uninsured, we
23 say in our report that we need action from the
24 federal government to deal with this problem. I
25 think we're going to be waiting a long, long time,

1 frankly. These really need to be state actions and
2 state-funded initiatives.

3 I think we would do well to look to what
4 the State of Massachusetts has done in this area. I
5 realize their problems are much less severe than
6 those in the State of New York, but what they did
7 was a bipartisan, practical, pluralistic approach to
8 it.

9 There is no one magic bullet on this. If
10 there were, I think we would have found it by now.
11 And so, I think we need to look to other models as
12 well, in addition to the progress we have made as a
13 state.

14 In the area of the health care workforce
15 the only concern that I have there is that we
16 address the current workforce shortage. There is a
17 shortage and it needs to be addressed.

18 The difficulty is that if you look ten
19 years down the road at the shortage we're going to
20 be facing in the health care industry when the baby
21 boomers retire, today's shortage will pale in
22 comparison to that. Dealing with that shortage
23 really requires variable actions, and, in
24 particular, actions that cure the
25 underrepresentation of African Americans and other

1 minorities. That is a huge problem for us. We have
2 to proactively go after that.

3 Finally, with regard to county nursing
4 home recommendations, again, I am in agreement with
5 those recommendations but I also want to stress that
6 in addition to ensuring access for the hardest
7 placed patients, the most vulnerable patients, and
8 that being an important social responsibility that
9 we have, we also need to recognize that there is a
10 link to the rightsizing recommendation that will
11 come from this commission, and that is if we burden
12 the acute care hospitals with patients they are no
13 longer able to place in, let's say, our county
14 nursing homes, we could undermine many of the
15 recommendations that we have put forward.

16 So as we ask others to look at this issue
17 of county nursing homes, I think that is one of the
18 key concerns, and that is that we keep access for
19 the hardest to place patients.

20 CHAIRMAN BERGER: Any other comments?

21 A motion to accept all recommendations?

22 MR. HOWLETT: So moved.

23 CHAIRMAN BERGER: Do we have a second?

24 MR. BRIDEAU: Second.

25 CHAIRMAN BERGER: All in favor, please

1 raise your hands so the votes can be recorded.

2 (Complying.)

3 (Votes being recorded.)

4 CHAIRMAN BERGER: Those are the hardest
5 words I've said in a long time.

6 (Laughter.)

7 Opposed?

8 There are none opposed.

9 Thank you.

10 I would just like to make, if I may, a
11 quick comment.

12 Because we have been working now for
13 18 months, and it has been a long 18 months, I
14 really want to thank all the members of the
15 commission, the regional members, the members of the
16 RACs, and particularly I want to thank the staff,
17 which has done an amazing amount of work and pulled
18 together some material, some of which has really
19 never been evaluated before by the state.

20 So I want to really, truly thank all of
21 you.

22 The process is -- and I am going to say
23 it for the fourth time today and I will say it
24 again -- this is just the beginning. It is a
25 beginning of rethinking how we deliver health care

1 in the state and to try to do it in a way where we
2 can control some of the costs and we can deliver
3 some other services as well. That improvement will
4 take a long period of time.

5 Several people have said to us, "How do
6 we know it's going to be done right going forward?"

7 We're going to do the best we can and
8 we're going to try to influence those who come after
9 to approach this as sort of a holistic set of
10 programs which have to come together piece by piece
11 over time, each step leading to the next, and that
12 is my hope and I want to thank all of you.

13 MR. HINCKLEY: Mr. Chairman, for the last
14 time, thankfully --

15 (Laughter.)

16 -- I move that we enter executive session
17 to address in detail the medical, financial and
18 credit histories of particular general hospitals and
19 nursing homes that may be subject of Commission
20 recommendations for restructuring, resizing,
21 closing, consolidation or conversion.

22 CHAIRMAN BERGER: Is there a second?

23 MR. KISSINGER: Second.

24 CHAIRMAN BERGER: All those in favor,
25 please raise your hand.

1 (Complying.)
2 Are there any opposed?
3 Motion to adjourn, please.
4 All in favor -- we just did.
5 All right. No more questions.
6 (Time Noted: 11:30 a.m.)

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

I, ELLEN SANDLES, a Shorthand Reporter
and Notary Public, do hereby certify that the
foregoing is a true and accurate transcription of my
stenographic notes.

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

ELLEN SANDLES