COMMISSION ON HEALTH CARE FACILITIES
IN THE 21st CENTURY

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

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

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

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

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

CHAIRMAN BERGER: Okay. Just checking.

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

CHAIRMAN BERGER: Let me begin -- Are the microphones on? No, they are actually here for show. And that's serious. We don't want anybody to hear what we are saying. Are they on? Tell me when they are on. This is not the pause that refreshes, either.
Can you hear me if I talk without a microphone? Then I will talk like that, because my patience is limited for technology, which is a major subject of this Commission, anyway.

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

AUDIENCE MEMBER: Please speak up.

CHAIRMAN BERGER: Who can't hear me?

All over. I need the damn microphones.

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

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

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

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

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

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

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

At our last meeting, under the bylaws, I had designated one of the staff people, Hilton Marcus, to be the recipient of all
comments and correspondence. Now, with the
establishment of the senior staff, I am
designating David Sandman as the Executive
Director to be the recipient of all such
information.

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

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

What is this, week three?
DR. SANDMAN: Week two.
CHAIRMAN BERGER: Week two for David
and we are very pleased with how fast he is
moving.

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

And the structure of the Commission
mandated the appointment of Regional Commission
members and their job is to guarantee that specific issues of each part of the state is fully considered during the deliberations.

There will be a total of 36 regional members: six from each region, two will be appointed - two have been appointed by the Governor. And two will be appointed by the leaders of each of the appropriate legislative bodies, the Senate and the Assembly. We are still waiting for those appointments and we hope to have them very soon.

The regional members are very important for a series of reasons. They vote with the Commission on issues pertaining to their region. And, therefore, we are very hopeful that the rest of the members will be appointed soon and so we can get Regional Commissions moving.

We have with us today several of the Commission members and I am just not going to spend a lot -- I would just like at least to introduce them so people can see them, say one line about them. Full bios are presently on the Health Department web site.

We are in the process of
establishing a Commission web site. When it is up, their bios, bios of the Commission members, and all the rest of the information will be on our web site.

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

Paul is Chairman of the Board of Directors of both Genesse Memorial Hospital and United Medical Center and we are glad you are here.

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

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

Is Bob Doar here or is he on the phone?

MS. NOVAL: He will be on the phone.

This is Lorraine Noval.

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

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

I saw Dick Guardino someplace.

Richard, there you are.

He is from the Long Island Region.

He serves as Vice President for Development at Hofstra University and he also served as Supervisor of the Town of Hempstead.

John Haggerty joins us. John is for the New York City Region. He is a former court examiner of the Appellate Division where he specialized in mental hygiene law.

Dorothy Harris, there is Dorothy.

Dorothy Harris from the Northern Region. She is the Director of State and Local Government Relations for the International Code Council and was also Deputy Secretary of State for the New York Department of State.

Heidi Nauleau, did I get it?

MS. NAULEAU: Yes, you got it.

CHAIRMAN BERGER: From the Western Region. She is Chairwoman of RQ Companies, a
privately owned holding company based in Jamestown.

Dr. Jeffrey Sachs, from the New York City Region. Jeffrey is a principal in Sachs Consulting. It's a New York based business consulting firm and he does a lot of consulting for corporations and others specializing in health care.

From the Northern Region, Arthur Spiegel. Arthur is Chairman and President of Transporter Customs Service, a U.S. customs brokerage and international freight forwarding firm. He is a former Chairman of the Clinton County American Cancer Society and a past Board Member of the Adirondack Medical Center.

Lelia Wood-Smith of the Hudson Valley Region is the founder and sole practitioner of an environmental law practice specializing in land use and zoning. And I don't think I missed anybody who is here, I hope.

Now, let me move on, if I may. In addition to the Regional Advisory Commissions, the legislation established what we
call RACs, Regional Advisory Committees, and these are very important.

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

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

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

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

MEMBER: So move.

MEMBERS: Seconded.
CHAIRMAN BERGER: Any opposition?

Thank you.

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

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

Two things which are under Item 6. Let me just, the first is confidentiality.

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

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

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

And that is the way we will function. And that is the way the Regional Commissions will function.

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

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

This is a reminder. I am not going
to have to say this again.

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

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

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

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

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

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

But first, David, you are finally on.

DR. SANDMAN: Thank you, Mr. Chairman. Happy to be here and look forward to working with all the members of the Commission.

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

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

Since the last meeting we have been
fortunate to receive some very valuable input
from some of the trade associations, from some
other groups. And we are very appreciative of
their participation in those discussions with us.

We have listened carefully to what
they have all had to say and I think it's fair to
say that we have demonstrated flexibility and a
willingness to make modifications when
appropriate.

In addition, the Department of
Health has shown flexibility on deadlines. They
have extended the opportunity to all hospitals in
the state to update their SPARCS submissions by
the end of this month as a way to further ensure
that the data being used by the Commission is as
accurate and complete as can possibly be.

At the same time, we all know that
we are operating under an extremely tight
timeline. It is quite important that we move
past this data discussion so that we can get on
with the substance of our work.

I think we are in a pretty good
place right now. Very pleased that we have
achieved a broad strokes agreement on the sources
of data on which the Commission will rely, as well as what data will be used to address what questions.

And let me just outline quickly what that agreement looks like.

There are two main sources of data in New York State. One is called SPARCS, one is called ICR or the Institutional Cost Reports.

And I am going to ask Neil Benjamin, in just a minute, to give you a little more background about those, let you know what they are, where they overlap and what's unique about them as well.

We are going to use ICR for certain purposes. We are going to be using SPARCS for others. But we are not going to be merging ICR or SPARCS.

We are going to use ICR for occupancy data rates as well as financial information on hospitals and residential health care facilities.

Just, the CD that is distributed at this meeting before you - this is a lot better than those huge books of data you got last time,
I hope - these CDs do contain on them the ICR based facility and regional occupancy rates for the past five years. And we are asking you to replace the SPARCS based occupancy data distributed last time with the information on this disc.

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

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

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

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

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

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

MR. BENJAMIN: Preferably one that works.

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

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

We are not getting any juice over
here, guys.

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

Neil, come sit here.

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

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

David defined ICR as Institutional Cost Report.

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

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

The purposes, the main purpose for ICR is to allow the Department to establish and set Medicaid rates and all corresponding adjustments to those rates.
The purpose of the SPARCS system is much more broad and quite a bit different. It is primarily to accumulate and assess clinical and demographic indicators of public health in New York State.

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

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

Whereas, the ICR is really two key areas. One, it's a plethora of fiscal data. It's income statements and balance sheets and all these other types of things, salaries, et cetera. And it also contains some statistical data that is also reported in SPARCS:
discharges, patient days, length of stay, and et cetera, those types of things.

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

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

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

Two other just quick points.

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

Whereas the SPARCS system, as we mentioned before - and as David and Mr. Berger commented on - we are in a major initiative right now to update, clean up, verify and provide the
most accurate set of SPARCS statistics that we
have ever had.

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

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

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

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

CHAIRMAN BERGER: Neil, would you do
a -- I think, why don't you do us a favor for
everybody. If you could take what you just did
here, which is the analysis of the two separate
systems, the values in one and the impact, and
just turn your notes into a readable memo - I can look at these notes. I got to tell you, I can't read it - into a readable memo and circulate it to the members of Commission, so that they can begin to frame the two data sets and get an understanding of them, as opposed to everybody having to sort of - those of us who don't know exactly - making notes as you are talking.

So we will circulate this to everybody.

MR. BENJAMIN: Absolutely.

MR. KISSINGER: I have a question, too.

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

MR. BENJAMIN: I failed to mention that.

The ICR's are due on, I believe, May 31st of the year following the calendar cost report year. And there are a couple of different - there is a provision to extend that and then there is a period for adjustment.
And there is - what I think is most important to the industry - is called a hotline appeal period. And during each of those we can process different types of changes to that.

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

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

CHAIRMAN BERGER: Anything else for Neil?

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

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

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

And there are also actually --

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

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

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

Any material changes we will provide to you.

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

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

Thank you, Neil.

And you will distribute that.

MR. BENJAMIN: Yes.

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

Moving chairs is okay. It keeps the audience awake.

MEMBER: And the speakers.

CHAIRMAN BERGER: That still not working?

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

DR. SANDMAN: I would ask the Commission members to turn their attention to the flow chart that we have distributed to you today,
which does illustrate the workplan and will serve as a roadmap for us in the remaining time of the Commission's life and give us all a sense of where we ought to be at various points and what we will be asking of the Commission members at various points in time.

We do only have about 14 1/2 months remaining before we must report our recommendations to the Governor on December 1st of '06. And somehow, despite this very short period, we have managed to split it into five different conceptual phases.

The first, as you will see, we have labeled the organizational phase which, for many reasons, is largely behind us and which we need to complete as quickly as possible, not the least of which because we have said it was associated with summer of '05 and tomorrow is the first official day of autumn, so we have got to finish.

Fortunately, we can put check marks next to many of those specific items in the boxes.

The bylaws have been established for the Commission. We have made a lot of progress
in building the Commission's infrastructure, just
to make it a real Commission that can function.

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

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

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

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

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

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

BISHOP SULLIVAN: David, is there
any expectation of the Commission to make
recommendations of people to serve on the RACs?
DR. SANDMAN: We would be happy to receive those.

One thing we are doing now is compiling lists of people from various regions. And we would invite all members - the Regional members, of course, as well as statewide members - to send names to us of of who you think would be good choices.

MR. VELEZ: David, are there any specific guidelines that will be given to the Regional Commission that would define the category, the type of individuals that they should solicit as members?

AUDIENCE MEMBER: Can't hear the question.

DR. SANDMAN: Well, the members of the RACs will themselves be appointed by the Governor and the Legislature in equal numbers. So it's for the RACs to seek out their own membership.

CHAIRMAN BERGER: The appointment process is the same appointment process that, in fact, we all went through. So the submission of names means,
what we will do is we will take the names and
sort of give them to the three appointing
officers and they will ultimately make the
decisions.

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

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

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

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

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

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

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

We will, of course, be examining and refining the statutory criteria that the Legislature and the Governor set up for us, identifying any additional criteria as the
statute, of course, allows and encourages us to do.

And what we hope to come back to you with at our November meeting is really a very thoughtful framework for decision-making and a set of criteria by which the Commission will conduct its work and then measure the data we have talked about against those criteria.

Finally, we will, of course, be helping the RACs to get set up and develop their own regional work plans that look like a quasi-modified miniature version of what the Commission is doing.

Having done that, we expect in the winter of this year and spring of '06, a really deep dive for probably about six months of time into the data, assessing and measuring those against the criteria and the framework to which we have agreed and making at least preliminary findings as to where the Commission may be heading.

We will, of course, during that same period, be holding regional public hearings in each of the six regions around the state so that
all groups, all parties, all voices that wish to
be heard and participate in this process will
have the opportunity to do so.

And because we want the RACs, of
course, to be developing their recommendations in
a timely fashion that can feed into the overall
Commission's deliberations, we will look to them
to develop at least preliminary findings as the
spring winds down.

We have allocated the summer, two or
three months then, for both the RACs, to move
toward a development of their final
recommendations and, of course, for this
Commission to be discussing and refining its own
preliminary findings on an iterative basis. We
do, of course, expect several rounds of that as
we move to a vision which we all can feel good
about.

Then in the fall we have allocated
about two month's time, essentially, for the
development of the final report, circulation to
the Commission.

And, again, that will be an
iterative process.
We expect several rounds of revisions and refinements again until we come to a consensus document that the Commission would like to formalize its recommendations in.

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

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

CHAIRMAN BERGER: Dr. Gil.

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

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

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

DR. SANDMAN: Dr. Gil makes an
excellent point and I think it is consistent with
the overall vision of this Commission, which was
established specifically for the purpose of
taking a holistic view on assessment of the state
health care system. And we are aware of the
interactive effects, some of which, of course, we
would like to encourage.

There are many levels of care.
For example, on the long term care side, well
below nursing homes: home health, assisted living
and so on.

And so all of those factors will be
part of that.

BISHOP SULLIVAN: Will the RACs be
working off the same criteria and applying, as
they develop their workplans, and who will
oversight that to see that there is kind of an
equal assessment?

DR. SANDMAN: Actually, the staff
now is preparing a set of materials for the RAC
members, not too dissimilar from the welcome
packages that you received, with our
recommendations for how to structure themselves,
what their work plan should look like.
It will mimic very closely what this Commission is doing so that we are, again, marching in a coordinated way towards the same end goal. And the staff, in large part - I wouldn't say staffing the RACs, that would be overstating - the best word is probably coordinating and supporting the RACs to ensure that, again, we are coordinated and not going in multiple directions that we cannot pull together at the end.

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

CHAIRMAN BERGER: I think, Joe, the whole concept of having Regional Commissions and RACs was a recognition that - and this is part of the difficulty - there are very different areas of the state. We are all aware of this and we want input which relates to those different kinds of jurisdictions, kinds of areas.
Hopefully, we can come out with a set of criteria and guidelines that work in Manhattan and work in Buffalo and work in Dutchess County and work in the Southern Tier, taking into account the different configurations.

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

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

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

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

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

And what I would like to do with each subsequent meeting of this Commission is perhaps devote ten minutes to see where we are in the work plan, both to hold our feet to the fire and hold your feet to the fire a little bit.

Because I want to ensure that we are making progress as we go along and don't get to the summer or the fall of 2006 and have to jam everything into a few months.

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

CHAIRMAN BERGER: Kristin.

MS. PROUD: At the first meeting of the Commission there was a provision in the bylaws, I believe, for the appointment of
subcommittees as part of this state-wide body. And I am wondering if there has been, in the formation of the work plan today, any contemplation of establishing subcommittees?

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

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

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

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

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

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

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

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

It may not be, but --

CHAIRMAN BERGER: We will have to, in order to have a serious meeting in November, we have got to get some material out to you before so we can begin talking about it. I understand that. I think David understands that. And, in fact, to some extent I think it is fair to say that you could argue that the
entire process is sort of a crunch.

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

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

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

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

CHAIRMAN BERGER: That technology is probably do-able.

MR. SEARS: Right.

CHAIRMAN BERGER: Should we move on? Would I like my seat back? I don't know, why not. It's good for my knees and my
hips to move. It's a health therapy issue.

Let me move to Point 9 on the agenda.

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

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

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

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

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

The question, and Bob who has sat on - some of us have - on all sides of this issue, has been thinking about it.
And do you want to raise this and talk a little bit about it?

MR. HINCKLEY: Yes.

CHAIRMAN BERGER: It's a substantive issue that at least ought to be talked about.

MR. HINCKLEY: Thanks, Steve.

This issue has been getting a lot of concern in a number of areas over the past few months since this Commission was formed, whether that be from members of the State Hospital Review and Planning Council, we see it in the media, we hear it from the industry.

Steve's right, there is about $3 billion worth of projects somewhere along the pipeline for the Department of Health and State Hospital Review and Planning Council. And I felt that it was important that we have a discussion about it and at least provide some sense of the Commission as guidance to the Department of Health and SHRPC.

Our work is going to take us fourteen months to do and we have to recognize that the hospitals and the nursing homes have work to do as well and they have projects that
they have been planning for significant amount of
time and have invested resources in. So I think
we have to weigh that.

I would like to believe that all
$3 billion worth of projects were designed to
make the system more efficient. In that case,
maybe our work would be done. But I don't think
that's quite the truth.

However, we have to recognize, we
can't just say that we can't allow any projects,
the Department of Health and SHRPC shouldn't
allow any projects to go through until we report.
There is work that has to be done by the
hospitals and nursing homes.

They have patient safety issues;
they have plans that will right-size or make
their systems more efficient.

So I think we need to look at maybe
some criteria to provide to the Department of
Health and SHRPC going forward, while we do our
work. I think we would be abrogating our
responsibility if over the next fourteen months
these next $3 billion worth of projects went
through without any comment or guidance from us.
And I know the Department of Health has done some thinking about this. Clearly, I would believe that any project that's consistent with the goals and objectives of this Commission - to make the system more effective, more efficient, to downsize it, if they feel - if the hospital or nursing home - feel that's the right thing to do - that type of project should go through.

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

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

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

MS. PROUD: Is there a way that the Health Department can give us some sense within all of those Certificate of Need applications that are pending of how many of them are for
downsizing related purposes versus increasing capacity versus patient safety and some of the other categories that you mentioned?

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

That kind of information might be helpful.

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

Craig, go ahead.

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

You expect, when you put an application in, it's going to be fourteen to sixteen months in the process. If we are doing something now that is catching somebody that is
twelve months into it, we may really be impacting
the system in a very negative way.

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

    CHAIRMAN BERGER: I think, if I may,
I think the point Kristin made is important.
The Department of Health does not
work for this Commission. And I want to be very
clear that they have their separate
responsibilities and we have ours.

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

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

    You have in front of you $3 billion
worth of projects. We would like to know how
many are them are for safety; how many of them
are expansion; how many of them are for
downsizing and all the rest.

We would like to sort of know that.
We, as a Commission, would like to know that now.
We would like to understand the nature of the
project.

By the way, and that is information
that once you guys tell us, that helps us
understand where the hospital systems think they
are going, which is information.

But by beginning to flesh it out for
the Department and the Council, as to putting
them in those buckets and those criterias, if
nothing else in the next month, begins to change
the shape of the dialogue. I think that's part
of what you want to do here at this point.

And as we get more specific criteria
which we agree upon, assuming we get there in
November, we can go back to the Department and
say, you have your responsibilities, and the
Council, but here is what we think you ought to
consider.

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

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

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

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

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

But did I leave you out there alone.

MR. HINCKLEY: Yes, yes.

CHAIRMAN BERGER: But the answer is,
that I do think, I mean, I do think that this is
going to be a substantive issue for the state
going forward and that I think we ought to at
least indicate, the Commission ought to indicate
to the Health Department, that they have to take
into account what's going on here. And we will
be more specific with them certainly in the next
month.

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

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

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

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

When we talk about the different
level of care that the Commission is going to
look at, we talk about the hospitals, we talk
about the skilled nursing facilities and we talk
about sub-levels of care in skilled nursing.

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

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

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

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

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

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

MEMBERS: Yes.

CHAIRMAN BERGER: We will come back
to you in November as we focus on our criteria to
encourage you - you can't, remember - to
encourage you to take what we are doing into account.

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

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

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

Let me, if I may now, I would like to sort of shift the discussion a little bit. I want to, there is an item, it says, we started talking about the principles for future reform. We started that discussion today and that's sort of going to be the criteria and principles discussion that we are going to be having over the next, I think, all the way through, but certainly in the next six months.

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

Because we are now in David's Phase
2. We got to David Sandman's Phase 2 on the work chart after what has really been about a three year process which began with the establishment of the Governor's Task Force on Health Care Reform three years ago.

We started with sort of two basic issues in front of us. One was cost and the other was quality of care - and they were always there - and the structure of the institutional networks.

And part of the way that legislation is carved here is structure of the institutional networks, with Dr. Gil and people who have raised the issue, we all want to talk about it.

We have got to go beyond that.

But that was the core and that is the core because that is where the bulk of the dollars is spent. This Commission has got to be concerned about the future.

Bishop Sullivan's point is, we have got to be concerned about where we go; we have got to be concerned about costs; we have got to be concerned about changing demographics; we have got to look at changes in the pattern of the
health care delivery. And we know what a lot of
that is and we don't know what some of it is
going to be.

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

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

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

What David Sandman and the staff,
working with us, has to do in the next five
months, what I call is to create a decision -
develop a decision tree - a process, a model, a
framework - that will allow us to make judgments
that are both economically, mathematically, data
base sound, but are fundamentally and
qualitatively intelligent.

And that's going to be the
responsibility, to step from the data to making
qualitative judgments.

How do we attack the issue of the
rightsizing the system? What are we thinking the
hospital of the future is going to look like?

Not trying to predict it, but we
know a lot of things are taking place.

What will long term care network
look like? What will the institutions look like?
What will the non-institutions look like? How
will they come together?

Because we are spending a lot of
money and we have got to figure out where that
ought to go.

How do we guarantee the safety net?

And then, as we go through these and
other questions that I think we will all start
putting on the table, how should reimbursement
patterns change to reflect the system we are
driving to create, as opposed to the system that
now exists?

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

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

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

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

And one of them, and I asked – we
didn't give a microphone, I don't know if
that's --

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

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

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

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

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

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

First let me say that what I am about to do here is describe what I would term as
the policy directions that Washington is
currently focusing on. It's a function of what
the Administrative branch, HHS and Congress,
actually, have been pursuing.

And in each one of them - and there
are seven different categories or directions - I
would characterize each one of them as either
aggressive or permissive - something that they
are actually advocating for and something that
they are agnostic - but what permits states to do
in the name of Medicaid reform, should the state
want to do it, but not strategic objectives.

And then also, for each one, I would
like to share some sense, at least in my view,
whether this is a new money opportunity where the
policy would be to invest capital in these
things, or a saver opportunity, where the
government is looking to limit the growth of
expenses or actually recoup savings from them.

And just one more word of preamble,

I did spend time in the current administration at
CMS and the Department of the Treasury.

And so this is in part, I think, a
communication of what has been, at least for the
last several years, the policy direction.

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

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

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

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

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

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

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

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

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

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

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

So I do think there will to be some
cost-sharing and eligibility discussions that
will be driven by the need to meet the spending reduction targets that will be a part of the program.

And then, of course, the last two we have heard a lot about - you have yet to resolve them - these clawback provisions, that tends to be a very difficult discussion but eventually it does have to be finalized. And this, for those people who do not know, when Medicare picks up the prescription drug costs of Medicaid eligibles, the state will have to give back some of the money that it used to get to pay for those drug expenses.

That will have a clear financing effect on the state's ability to serve the population that remains.

I do think also in this 10 billion bucket is a continued stress on inter-governmental transfers of repayment limit, disproportionate share programs. I lump all those in possible ways that this $10 billion reduction is going to play out in state Medicaid programs.

And I think all of that has or could
have implications on our discussions here about
the facilities and organizing the health care
delivery system going forward.

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

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

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

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

Cash and carry types of programs,
where programs - Medicaid programs, federal
programs - that put cash in the hands of
beneficiaries for self-directed care type
initiatives, is a financing vehicle that I think
will continue to get some priority out of
Washington.

Focus on the developmentally
disabled I think will continue to develop.

I think that there will be continued
interest in what is commonly called nursing home
diversion program. These are programs that
traditionally have been billed as ways to
redirect from the nursing home path individuals
who can be cared for in a home or community based
setting.

There are some questions as to
whether you are just delaying that admission, if
you are truly reducing the capacity or the demand
for nursing homes. But they are programs that,
nonetheless, do have some strong support in
Washington and around the country. I don't see
that diminishing.

And then I think you do have some
issues around home health where current budgets
actually reduce reimbursement to home health
organizations.

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

So that I would regard as the second policy direction.

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

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

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

But, clearly, I think the whole
managed care strategy is one that CMS is not
going to discharge.

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

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

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

Of course the next thing that
everybody knows about would be health care
information technology. This also I think is an aggressive technology and a new money strategy.

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

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

CHAIRMAN BERGER: We can do that.

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

The pay-for-performance is a policy direction that has a lot of aggressive support
in Washington. These are generally seen as new money in the short term, because you are getting superior, if you will, reimbursement for a specific performance.

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

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

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

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

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

If you look at Medicare policy and a series of the recent Medicaid waivers, there is a
general sense that when state payers actually render either competitive contracting for delivery of services - albeit the ancillary services are network rightsizing, even prescription drugs now - that there is a sense that there are savings to be had there.

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

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

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

Or having Dennis Smith or someone from Washington attend the Committee to again lay
out in more specific ways what the Medicaid policy directions are, I would imagine, knowing the parties involved, that they would be happy to do so.

I hope that was helpful in what you wanted.

MR. HINCKLEY: I want to ask Ruben two questions. One might be getting beyond your realm of experience.

But first, in light of just yesterday or maybe the day before, you had John McCain talking about delays Part D to help pay for Katrina and Iraq and other federal initiatives, you know, which was I think pretty soundly rejected.

But, do you think that will cause, those forces will cause an increase in the $10 billion Congressional target?

And then my second question is unrelated, but it's something I think we have to wrestle with here, is, the Department of Justice view, anti-trust view in health care delivery system, because there has been attempts - at least in the hospital systems - to join together
to make results more efficient on anti-trust
issues.

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

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

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

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

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

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

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

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

There are health care systems and there are integrated delivery systems. And if you call into question the ability of health care providers to link up and provide integrated care, then you are calling all kinds of other health care models into question. I'm not sure where they would draw the box or draw the line.
They may figure out where and then
go after that sweet spot. I just don't believe
they have done that yet.

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

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

The next round they may be changing
our system.

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

That's the biggest fear they have.

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

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

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

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

Other issues?

Craig.

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

MR. SHAW: Thank you.

MR. DUNCAN: Very informative.

Just as a word of comment, perhaps caution, the discussion of the principles and the framework and the criteria, all being based on
data, is good, coming up with a common framework for us to work from.

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

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

MR. HINCKLEY: I agree 100 percent.

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

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

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

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

And I am reminded, for example, even with the data that I saw from the previous meeting, and I think that we have known this for a while, that, for example, pediatric in-patient, the census has been low and low and low and low. And the question is, is that trend - because with the system has reconfigured itself in creating more primary care services that have prevented admissions in hospitals.

Same concern I had for the opposite side of the data that I have seen, which is behavior health care is overwhelming hospitals with a capacity of about 100 percent where they are using psychiatry or substance abuse services. And I certainly hope that we are not
going to sit here and repeat the process of
de-institutionalization that happened in the '50s
as we emptied out the state psychiatric
hospitals, because I think that then the great
City of New York, Fifth Avenue, will be really -
we will have those roaming on the street that
really belong in a safety environment where care
is being provided.

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

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

And I hope that we are going to be
considering here, as safety net issues, the problems of the uninsured and the City of New York and the state and who are the facilities that treat them, and who are the facilities that do not treat the underserved.

And by doing so, what we do is we increase the health disparities.

So as we struggle with that issue of the criteria, I think that we need to put these elements on the table.

CHAIRMAN BERGER: Pete.

MR. VELEZ: David, my question is, in reference to Phase 2, as you begin to evaluate trends, historical trends, to hopefully get a projection of trends going forward, my recommendation would be, rather than waiting to finalize this trends and coming up with a potential recommendation, I think it is critical that we begin to be transparent in the process, share that information with as many people outside of this entity as possible, so that we can get the right feedback to see whether what we have decided of the potential trends, as we define health care going forward, that we share
that information so we can make better decisions going forward.

CHAIRMAN BERGER: I saw a hand.

MR. SHAW: Right here.

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

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

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

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

So if we are looking for additional criteria to use, then my suggestion would be that we make sure that they are not already addressed
in the current nine factors that were given to us, and then average whichever ones we don't.

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

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

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

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

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

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

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

MR. SIMONE: (via speakerphone)
Steve, I have a comment when you have an opening.

CHAIRMAN BERGER: Sure.
MR. SIMONE: Opening now?
CHAIRMAN BERGER: Yes, go ahead.
MR. SIMONE: Just real quick, you
started out by saying that we had 65 percent
capacity utilization. That means some parts of
the state are going to be 100 percent and some
are going to be 35 percent and we are talking
about criteria.

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

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

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

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

But we will get you some of the --
As you look at the information by
hospital, you will be surprised at some of the
occupancy rates, even at hospitals you didn't
expect; you would think would be higher.

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

Anything else?

MR. ROBERTS: Occupancy rates and
things like that, this Commission has some
diversity in its knowledge base.

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

I can tell you about nursing homes.

CHAIRMAN BERGER: 100 percent.

MR. ROBERTS: 100 percent.

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

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

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

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

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

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

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

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

CHAIRMAN BERGER: I got to tell --

Absolute.

DR. GIL: Absolute.

CHAIRMAN BERGER: And I think that when we come to deal with that, which will be near the end, as we start to figure out where we want to go, just everybody understand, every
person you ever met anywhere in the health care
industry will be visiting you on your lawn and in
your apartment building and in your elevator.

MR. VELEZ: It's already started.

CHAIRMAN BERGER: Because everybody
who has a public -- I am going to speak about
the Medicaid.

Everybody who has a public Medicaid
dollar today believes in their heart that they
own it and it should really be $1.10.

MEMBER: No, $1.40

CHAIRMAN BERGER: And I agree. I
have said that before. We have got to deal with
reimbursement, I absolutely agree.

Any other comments?

We have created a mission and a
charge for our staff to start getting back to us
and to start thinking.

I also encourage the following: I
encourage members of the Commission to
communicate directly, obviously, with the
Executive Director of the staff, to talk to them,
to give them ideas, to go back and forth.

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

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

Business - organizational business.

The next meeting will be November 10th. It will be from one to three p.m.

Do I know where? Here.

And the mikes will work.

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

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

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

I encourage everybody who is here at the Commission - the regional members, and our
friends in the audience - to encourage the
appointment of the remaining Regional Commission
members and the RAC members.

       Any of you who have friends in the
Legislature, I encourage you to reach out to
them, because we want to get this process started
and we need the rest of the Regional Commission
members appointed to begin scheduling the public
meetings.

       Is there anything else?
Kristin.

       MS. PROUD: I have a point to raise
that I think carries over from last meeting and
from some of the discussion that we had today
about the data, and that is with respect to the
nursing home data.

       Prior to the first meeting we
received data about hospital closures in the last
two or ten years and what, if anything, has
happened with those facilities in terms of the
actual infrastructure.

       And there has been a request for
similar data, if it exists or if it can be
compiled, with respect to nursing homes.
DR. SANDMAN: It has been compiled and we will get that out to you.

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

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

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

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

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

My reaction is that as a gathering of knowledge, if there is a regional meeting and you want to attend, I think as a knowledge-
gathering feel and touch for what's happening,
it's fine.

But they are separate activities.

And they are separate meetings and there are
meetings for both the RACs and the regional
people and we shouldn't participate.

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

But my sense is, for information
it's fine. But it's not your meeting; it is not
our meeting. And we ought to leave it to the --
It's the regional people's meeting.
Isn't that the way sort of the --

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

CHAIRMAN BERGER: Joe.

BISHOP SULLIVAN: Is mental health
part of our responsibility?

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

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

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

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

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

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

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

MR. HINCKLEY: I think it's a difficult task to take, because if you are going to do it right, you have to start dealing with
the state psychiatric institutions and that's a whole different --

MR. SHAW: If I can make a statement.

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

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

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

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

CHAIRMAN BERGER: Could I make a suggestion, because when I was initially asked before the Commission legislation sort of finally passed, what do you think - because it's going to be a base closing commission - I said no, whatever the Commission legislation mandate is, once you step into this field, and no matter how narrow - and this statute is not narrow by the way - no matter how narrow it is, it will open up on day one, because all of these issues will suddenly appear in front of you and you are going to have to deal with that.

I think what we have to do, so as not to get swallowed by any piece of this --

By the way, we could get swallowed and it doesn't have to be mental hygiene issues - it could be the acute care; it could be the long term care; it could be the at home care; it could be just any one of these issues; it could be reimbursement issues - we have to try to keep ourselves so that what we create is not the perfect answer and the total solution that nails
every - dots every 'i' and crosses every 't'.

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

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

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

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

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

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

BISHOP SULLIVAN: Because it strikes me that there is a fair amount of change in mental health and there is, to a large extent,
it's an ambulatory care system, not all that well put together. And it's a housing system as well.

CHAIRMAN BERGER: Or lack thereof.

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

CHAIRMAN BERGER: Still want the job?

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

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

Anything else? We covered a lot.

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

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

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

____________________
ELLEN REACH,
Shorthand Reporter