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

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Meeting convened at 1:30 p.m.

PRESENT:

STATEWIDE MEMBERS:

STEPHEN BERGER - Chair
LEO P. BRIDEAU
ROBERT J. GAFFNEY
DR. ROSA M. GILL
ROBERT HINCKLEY - Vice Chair
HOWARD T. HOWLETT
DARLENE D. KERR
RUBEN JOSE KING-SHAW
MARK L. KISSINGER
KRISTIN M. PROUD
G. NEIL ROBERTS
THERESA A. SANTIAGO
BUFORD R. SEARS
ALBERT SIMONE - (via telephone)
BISHOP JOSEPH SULLIVAN
PETE VELEZ
COMMISSION/DOH STAFF:
DR. DAVID SANDMAN
MARK USTIN, ESQ.
NEIL BENJAMIN - Department of Health
LISA WICKENS - Department of Health

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REGIONAL MEMBERS:

PATRICIA ACAMPORA

STEPHEN L. ALBERTALLI

PAUL S. BOYLAN, ESQ. - (via telephone)

BERT BRODSKY

PETER CAPOBIANCO

CAROL CASSELL - (via telephone)

SUSAN M. CROSSETT

JEFFERY DAVIS

BONNIE DeVINNEY

ROBERT DOAR

R. ABEL GARRIGAN

RICHARD V. GUARDINO

JOHN F. HAGGERTY

DOROTHY M. HARRIS

KIM KUBASEK

PATRICK MANNION

HERBERT D. MARSHALL

JUDGE JOSEPH MATTINA

WILLIAM MOONEY

HEIDI A. NAULEAU

DONNA O'BRIEN

JOHN/JACK O'CONNELL

DR. JEFFREY SACHS

SISTER MARY ANN SCHIMSCHERINER

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REGIONAL MEMBERS: (Cont.)

ANDREW SICHENZE
HENRY SLOMA
ARTHUR SPIEGEL
JERRY WEBER
ARTHUR WEINTRAUB
LELIA WOOD-SMITH
LIAISONS:
DR. WILLIAM STRECK
PAUL MACIELAK, ESQ.
LAURA LEFEBVRE
MARY ANN GRIDDLEY
LORA LEFEBVRE - DASNY

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CHAIRMAN BERGER: I would like to call the meeting to order. We would like to begin. David, why don't you take us through the progress report. It's been quite a busy time in the last month.

DR. SANDMAN: Thank you, Mr. Chairman. I am pleased to make this report on our progress since our last meeting.

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

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

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

With respect to our work plan, we are in the analytic part of phase three. Much of the focus, as you know, is now on the Regional Advisory
Committees and providing them with the materials and the support that they need to be successful in their work. The staff is assisting the RACs by attending their meetings and their hearings, providing background research, compiling and analyzing additional data, and providing logistical support to them as needed. All of the RACs are highly engaged in their work. They are reviewing data relevant to their region and holding discussions with providers, as well as other stakeholders within their regions.

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

As previously reported to our members, we
have been developing a procedure that would
courage voluntary right-sizing discussions among
providers and address antitrust concerns. Our
Chairman and our Counsel, Mark Ustin, will have more
to say on this subject in detail. But I am pleased
to report that we have successfully developed such a
policy with support from the Department of Health
and the Office of the Attorney General. This
significant development is being promulgated today
by the Commission and Department of Health. Copies
will be sent to all providers in the state and will
also be posted on the Commission website later
today.

Also, as discussed at our last meeting,
the membership reiterated the need to examine the
reimbursement systems and to make recommendations to
realign the financial incentives to promote a
reconfigured system. To that end, the staff has
begun working on background papers that will be
shared with the Commission members to inform their
deliberations. We do, of course, continue to engage
in an active communications program, both for us to
receive information from the public and interested
organizations and to make information readily
available to the public and our membership.
Some recent meetings and presentations with various constituencies have included the New York State Health Facilities Association, the Greater New York Hospital Association, Central New York Health Systems Agency, in Syracuse, the New York City Council, Primary Care Development Corporation as well as the Community Health Care Association of New York State.

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

CHAIRMAN BERGER: Thank you very much.

David mentioned, and I'm going to ask our general counsel to take us through the procedure that we're going to promulgate on voluntary right-sizing. When this Commission was established, it was clear that the task was enormous, but the environment was ready for a serious review of structure as it existed. The Commission was established and exists because there was general support through the industry for a good, clean look at the institutions as they existed in the future.

One of the things that has -- that I found very positive during the last several months as we've been organizing ourselves, working on data, meeting with communities, that I found and other members of
this Commission have found and members of the
regional commission members have found and members
of RAC have found is that the industry itself has
been thinking about -- somewhat triggered by the
existence of this Commission, but out there in the
environment -- ways in which right-sizing
reconfiguring could take place. But, frankly, every
place we went they said, "well, we really can't sit
down and do this. It's complicated, it's
cumbrousome, there is the antitrust issue, there is
the Health Department, there is this, that and the
other."

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

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

MR. USTIN: Sure.

Just a couple of initial points.

First, as many of you already know, the
Commission's mandate extends not only to formulating recommendations for the right-sizing of the hospital and nursing home systems, but also "fostering discussions" among stakeholders. So this process is completely consistent with our mandate under our enabling statute.

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

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

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

In some cases, where the states enact or are exempt from antitrust laws based on principles of federalism; that is, the federal government cannot dictate policy to a state. And from the point of view of the state's own laws, its antitrust laws can confound policies that are expressed in other statutes.
Another useful one is where anticompetitive action involves the petitioning of state government. That's actually protected under the First Amendment. And that's called the Noerr-Pennington Doctrine, named after two seminal cases in the area. Both the state action doctrine and the Noerr-Pennington Doctrine are clearly applicable to the Commission.

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

Now, it's also arguable that the existence of the Commission may provide some level of state action protection to voluntary initiatives. The problem there, though, is the active supervision component. Unless some state agency, whether it's the Commission or DOH, has a role in the development...
of such initiatives, its arguable that the degree of
state supervision will not be sufficient to meet
that threshold.

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

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

If at any point the Commission or DOH
determines that the contemplated right-sizing
activities are not consistent with policy objectives, the procedure terminates and the participating facilities are on their own at that point.

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

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

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

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

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

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

MS. CASSELL: This is Carol Cassell.
CHAIRMAN BERGER: Carol, welcome to your
first Commission meeting.

MS. CASSELL: Yes. Pleased to be here.
DR. SIMONE: Al Simone.
CHAIRMAN BERGER: Welcome.
DR. SIMONE: Thank you.
MR. BOYLAN: Paul Boylan. I'm still

here.

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

Are there any questions on the procedure? Kristin.

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

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

CHAIRMAN BERGER: As a non-lawyer I asked the same question and got that answer.
I think that at some point having the full support of the state -- sort of the entire state's position, we are going -- we'll have some conversations with Washington, if they think we have to. But we thought it was very important having all the state apparatus lined up as the basis for us to proceed.

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

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

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

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

CHAIRMAN BERGER: Right.

And I want to thank both our staff, the staff of the Health Department and the Attorney General's staff, all of whom worked together on this.
smoothly and clearly and it was terrific seeing the three organizations pull this off.

Anything else? Okay.

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

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

The next stage is for us, as the Commission, and that means the full Commission as well as regional members from each area, to begin to take in some of that information so we can begin to discuss it in the framework that we will create with data and other information. But what we said from the beginning, the data is only one small piece of the deliberation process. A big part of it is what
we learn from the field and it's getting time to
begin to hear from the field.

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

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

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

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

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

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

MR. USTIN: Yes.

CHAIRMAN BERGER: It's publically posted
so everybody will know what we're doing. But if we
ever make a decision in executive session, the law
requires that we come back out into the public
meeting and report it.
The next few months we're just going to be gathering information about what's been found out there.

Any comments from any of my colleagues?

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

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

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

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

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

Are you guys going to take it over?

MS. WICKENS: Yes.

MR. BENJAMIN: Thank you.

We're going to pick up where we left off last time. Unfortunately Tom Jung, who took a large part of the lead last time, is down in St. Croix.

He wasn't able to convince me it was a business trip, even thought he said he was going to check out their nursing home structures.

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

Right now in the state there are 679 nursing homes that are in operation. About two-thirds of them, as with hospitals, are concentrated in the New York City region. But there are quite a bit in rural areas, and we'll talk about that later. The age of plant, we haven't really been able to calculate the average age of plant, but I think what is important for this discussion is 80 percent of the nursing homes that are currently in operation were originally built before 1980. And
you'll see the importance of that also later on as we talk about the construct of some of those and the challenges that they face. Occupancy, just again to remind everyone, occupancy steadily declined beginning in 1998 in the high 98 percent to our latest numbers for 2004, which show about 93.6 percent occupancy statewide. That translates into eight to 9,000 excess beds depending upon the day and the closure situations that we have in front of us. Between 20 and 25 nursing homes have closed over the past five years. And we have a couple of plans in front of us right now. And I only mention that because you'll see the importance of it later. Nursing homes, the vast majority of the ones I mentioned were built basically as cookie cutter models to serve the traditional geriatric nursing home population. That's why they were built. They probably served their purpose for the generic programs that were provided, but we all know right now that the programs provided in nursing homes today bear no resemblance to the programs of the '60s, '70s are even early '80s. A large catalyst of that was Medicare and moving into paying for rehabilitation services in nursing homes. That program began in the early 1990s.
And lastly, you have all talked and it's been in some of our correspondence and it actually goes all the way back to the work group report, but we talked about it a lot in the hospital context and that's the competition for patients to generate revenues. And there are many reasons for that. And also the rate paradigm issue that Mr. Berger has mentioned many times. Hospitals possibly attempting new services that they shouldn't be in solely for the dollars. Well, that same concept is creeping into nursing homes; competition for residents given the specialty services that are being provided just about everywhere, as well as education and awareness of the consumer, is driving an intense competition for occupants of the beds. You know, there are different dynamics at play there, but nevertheless we struggle all the time with, well, should simply looking at it, should we get rid of all the physical As and Bs or attempt to change the planning process so those beds are assumed not to be available? And what we're finding and what we did in the nursing home bed need formula that we updated, we're finding that even though they are like care and even though there may be other settings, nursing homes have not stopped competing for those residents because they
do contribute towards overhead. And in an era of declining occupancy, that's a business strategy that they continue to pursue.

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

MS. WICKENS: Thank you, Neil.

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

Technology, which I'll go into a little later, is also important in nursing homes. It's not, obviously, as far along as it is in hospitals, but right now the nursing homes are competing for staffing, they have lots of different care levels that they are dealing with right now. So, they need
technology to, one, help them with the safety and
management of the residence that they're dealing
with; two, help the staff to be able to do their job
quicker and more efficiently; and three, be able to
identify and gather all of the assessment data
that's required under Medicare and Medicaid just to
make sure that people and the staff have more time
at the bedside versus in the charts trying to do
MDS's.

Consumers preferences and awareness.

Neil just mentioned this, but the consumers and the
family members of the consumers that are going into
long-term care alternatives and nursing homes right
now are more educated. They know what they want,
they know how they want it and they know where they
want it. So, that is actually something that
nursing homes are adapting to. They are trying to
adapt to those needs.

The acuity. We have a lot of vacancies
in nursing homes and I actually started watching
this happen in the mid '90s when the acuity level
was such that residents either came into the nursing
home older and much more frail because they had a
certain network or support system at home so they
could age in place, so when they did come to the
nursing home they had so many co-morbidities and
were so ill they didn't live as long or we had the
types of patients that came in for the short-term
rehab. And they also didn't stay long. So, length
of stay has really changed in nursing homes.

Neil.

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

It's difficult and it's becoming more
difficult for nursing homes to compete with
hospitals for a lot of their direct care staff due
to the fiscal pressures that they're facing. Yet
they do need a lot of the same type of support
staff. And when you combine that with sporadic
shortages around the state, nursing homes right
now -- and again we're trying to tie all this into
what the building of the future may look like -- a
lot of them are really constrained right now with squeezing efficiencies out of their building. Because, as we said, buildings just are not constructed to produce efficiencies for the types of programs that are there now.

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

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

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

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

The specialty services. Specialty
services are continuing to pop up. When consumers
now live longer, they have more co-morbidities. And
those consumers are not just the older geriatric or
just the young, there is also the pediatric
population that may need long-term care that before,
20 years ago, might not have survived. That's just
one area of specialty services that we're seeing
that needs to be cared for in a nursing home.

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

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

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

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

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

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

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

So, nursing homes in the future. I don't know if everyone here has heard about resident-centered. OBRA '87 basically said people have the right to receive the care that's based on
the residents, it's based on what they need, it's resident outcome. The survey process became resident outcome based. And culture change is now something that CMS is focusing on in nursing homes. They have the right to make the choice of what they want, when they want to get up. And that also is very difficult in the old physical plants because you may have 40 different individuals wanting to get up at different times and it makes it very difficult to actually be able to provide those services if everyone wants to get up at a different time. It just doesn't work.

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

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the same services. So, the community is integrated.

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

Household models. This is a picture of an actual nursing home in, I believe, Pennsylvania. This actually, for those of you who have been at the Desmond, in Albany, that's what it reminds us of. It's a really nice hotel in Albany. But this is a nursing home and it's a community. It was based on what do people want. They still want to feel like they're in a community. They want to have types of services and they want to have a place where, when people come in to see them, they have a place to go and show and say this is where I live. So, they have everything from the barber shop, they have stores, they have actual stores that would normally be on the street corner, probably a Starbucks right within the nursing home. The household model is actually again going back to efficiencies and staff time. The staff are actual parts of the household. Nurses and CNAs don't just do those types of tasks, they help with the cooking, they help with all the other pieces and include the residents in that.
Technology, again we'll talk about that and I have some pictures to explain, technology is not maybe where it could be in nursing homes, but it's starting and it's starting to become more and more efficient. Again, I think it's being really driven by staff shortages and the specialty of services that are being delivered.

Emphasis on hospitality is obvious from this picture.

Adaptable construction. This is very important and it's also very expensive. We know that construction costs are going up, but we also know that people want different options and they are demanding those different options. Tom had mentioned this during the hospital presentation regarding the one-bedded rooms and the two-bedded room. Many people believe that residents, geriatric residents or younger residents, want to just be by themselves, they don't want a roommate. Well, when you talk to different consumers, that might not always be the case. Some consumers do want to be with their spouse -- sometimes not -- but there should be that chance to actually be adaptable with moveable walls, moveable partitions. That's where this is really important.
Also in a time when we have MRSA and we have VRE and we have these types of bacteria that we have within homes and within hospitals and institutions, it's also important to have the adaptability that you need to be able to move those partitions, move the walls and adapt to the needs of the residents.

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

And community integration I've beat to death.

Technology in nursing homes. Here you see actually the neon lights. Again, we're not where we would like to be in nursing home technology, but this is a start. For safety issues,
also for staff, for people that actually are sleeping but staff need to go into the room, this is a nursing home in our capitol district area, in upstate New York, and they actually have lights around the sink in the bathroom, along the floors and along the doors for safety for the residents, but also for safety of the staff. These other models you're just seeing pictures of screens. There are a few different nursing homes in the state that have begun to try to assist their staff to be able to complete all of the paperwork that you'll hear people complain about in a nursing home to be done takes a lot of fact gathering and it's something called minimum data set, or the MDS. In order to make that fact gathering and the data easier to obtain, they've actually put PDAs into the nursing homes for the direct care staff to be able to collect some of that information. That information automatically will go into a central system where the clinicians, the doctors and the interdisciplinary care team can review it at the same time and come up with a care plan. That saves time. It also improves the efficiency and it has also helped with cutting down on medication errors because this is also being utilized for medication errors.
administration and for treatments. So, it's really
starting to make change.

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

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

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

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

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

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

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

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services.

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

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

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

This is something that more -- it's
actually in Tupelo, Mississippi. This is a picture
of one of the facilities in Tupelo, Mississippi.
But this goes back to the household model. This
goes back to building nursing homes that are more
home like, that are smaller units. So, instead of
having a unit of 40 on one long corridor, you have a
small house for six to ten people, with a kitchen,
with the staff that stays within that house and
cares for all those residents no matter what their 
needs are. So, it means adaptability is critical. 
But it's expensive. You still have to have the 
people to be able to get to all the other small 
houses. And it probably works a lot easier when 
there is not snow on the ground between the houses. 

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

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

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

Neil, anything you wanted to add?

MR. BENJAMIN: Yes.

So, as you can see, with everything that
we've said, there is quite a challenge here. It's
an aging infrastructure. We have in front of us
right now about $1.2 billion worth of modernization
and replacement projects for over 30 nursing homes.
And the challenge is it's difficult. We all know
Medicaid pays for about 77 percent on average,
provides 77 percent of revenues for nursing homes.
The average cost per bed now is about $200,000 a
bed. So, the challenge of what's the future demand
going to be? What are the types of service? How do
you most efficiently and effectively make decisions
to invest dollars into programs and buildings that
they themselves need a lot of flexibility? Weeally need to start looking at things much more
creatively, much more out of the box.

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

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

CHAIRMAN BERGER: Neil -- how did I know?
MR. ROBERTS: I have to comment.

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

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

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

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

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

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

Thank you very much.

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

MR. ROBERTS: I am, too.

MR. HINCKLEY: Lisa or Neil, what's the average size of the '60s, '70s, '80s type of model
you show in New York? 120 beds?

      MS. WICKENS: 120 is the average.

      MR. HINCKLEY: Now, what about the

nursing home of the future that you discussed, what
do they tend to be in terms of size?

      MR. BENJAMIN: I can speak, Bob, from the

economics and I think you probably know this, too,
that as we move through the very liberal bed policy
days of the department, but there still were fiscal
pressures there, nursing homes started to build more
and more beds because that's the only way they could
be affordable.

      MR. HINCKLEY: I was getting there.

      MR. BENJAMIN: Yeah, yeah. But in the

future that's one of the things I mentioned is a
challenge is the appropriate size of these places
given everything that we talked about.

      MR. HINCKLEY: I guess I kind of have a

multi-part question because it's -- I mean, I would
assume it's fairly clear that under our current
reimbursement system there is no way you could
operate one of these new homes at 40 beds. Neil,
I'm sure can opine on that. But is there a way to
change the reimbursement structure to allow
operators to make a decent living at that?
MS. WICKENS: All I can speak to -- I mean, there is a challenge -- I'm not going to go back to the 1983 base year, but we know that there has got to be some changes in the reimbursement system. But in the different levels of specialty that we mentioned, we only have a couple of different ways certified units in New York State to reimburse for that higher level of care. But yet we have people that are really serving a higher acuity and really have no way that they get reimbursed for it other than through the PRI. So, there has been and we are looking at regulations that would allow for different levels so that people could start to get reimbursed based on the services they are delivering. And if we could get to the MDS and the PPS that might actually work better as well.

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

MS. WICKENS: I didn't.

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

MS. WICKENS: We have -- I want to say I can't remember how many we have but I don't think
they haven't been coming up and haven't been as
large as we think we thought they would be. That's
just my understanding and I can't really give you
much more than that. But there are couple that I
know are doing fairly well in the state.

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

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

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

MR. KING-SHAW: Thank you.

MR. O'CONNELL: In the beginning of the
presentation you talked about 80,000 -- was it 8,000
or 80,000 unused beds?

MS. WICKENS: 8,000.

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

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

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

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

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

BISHOP SULLIVAN: Our recommendations at

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

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

We've talked about a couple, and this may also be one, but one thing we have to do, and I'm doing it with the next presentation, as sort of a reality check, when Neil began his comments, one thing he pointed out is partners. A part of the underlying problem here is the notion of the middle class entitlement. And part of the funding that we
have and part of the levels of funding that we have
today and where it's going are not sustainable.
That's part of what's triggered this. But beyond
that, as we look at this over the next six months,
there are some very good ideas we've seen there.
And Lisa really started pushing you on the other,
the other alternatives delivery network, which
include the family and support from the family and
support in the community and changes in the basic
community are absolutely necessary. Because we
cannot have the dollars to reconfigure the whole
system so it sort of all looks like Scarsdale. It's
just not going to happen. You don't have the
dollars, you don't have the people. So, it's got to
be a very different system because costs -- because
it's got to be a better system in which costs are
under control. Because all we're going to do --
this is -- I haven't done this commercial yet -- but
all we're going to do, unless we face up to some of
this, is put ourselves in the worst possible
situation several years down the road where we have
a system which is not flexible, unable to adapt and
finds itself totally squeezed by the shrinkage of
available public dollars. And as bad as it is now,
I can tell you it can get a lot worse unless we make
some recommendations and do some changes.

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

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

Part of our mandate, a good part of our mandate, as we will look at the structure of the acute long-term care system, is to look at structure of the acute and long-term care system, at the physical facilities, at the institutions, at the question of how large a physical infrastructure we have and to deal -- and as we come to deal with that, we will be dealing with a whole series of imbedded issues. One of which is the imbedded costs that exist, the capital costs that exist, the debt...
service that exist. And we will have to deal within
our recommendations not merely with what exists and
not merely with the past, but with the future as
well. Because part of the goal will be obviously to
have a health care system which has access to
capital. If it doesn't have access to capital, over
the years it can't change, it can't grow, it can't
reinvest, it can't do the technology and all the et
ceteras that we take for granted. So, we thought,
again, as sort of one of the last pieces of laying a
foundation, that we would ask some of the people who
know about those capital issues to talk a little bit
about it and give us a little background.

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

MR. LEFEVBRE: Portfolio Manager.

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

MR. LEFEVBRE: Thank you very much and
good afternoon.
Can everybody hear me okay?

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

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

As you proceed, the Commission has been asked to consider a number of factors, two of which relate specifically to my comments today. I've just kind of put them up on the screen for you. Debt is an important factor in the consideration of health care restructuring. DASNY, the largest issuer of health related debt in New York, believes that the state must consider how to restructure or retire the debt of effected facilities, not only because DASNY has an obligation to speak on behalf of their bond holders, but also because reconfiguration will require extensive reinvestment in capital and
technology, as you've heard, that in all likelihood
will have to be borrowed. For reasons I'll discuss
in a few minutes, such borrowing capacity will
probably not be available if restructuring results
in bond defaults or requires the mortgage or bond
issuers or the credit enhancers to assume the costs
of the state's restructuring plan. However, before
we get to that, let me just take a moment and
discuss the Authority's role in health care
financing.

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

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

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

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

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

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

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

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

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

CHAIRMAN BERGER: How would this look in
other states? How would that chart look?

MR. LEFEBVRE: How would that chart look?

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

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

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

So, this chart shows New York State
medians for selected benchmarks compared to rating
agency ratings established by S&P, Standard and
Poor's, and Fitch rating agencies. Credit ratings
are provided by these companies -- in addition to
Moody's also, there are about three credit rating
agencies -- to give bond investors independent
assessment of their overall risk when they are
purchasing a health care bond, or any other bond for
that matter. Ratings above triple B are considered
investment grade, triple A is the highest and least
risk of default rating, and below triple B is considered a speculative buy. As you can see, generally, New York State hospitals do not meet investment credit standards in many benchmarks. Compared to a rating agency median, the State's hospitals have older physical plants, as you've heard many times, lower profitability and liquidity levels and are more leveraged. They have borrowed more money to do the building that we've got.

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

Six of the ratings carry a negative outlook and none of their ratings carry a positive outlook for New York State health care.

Now, Moody's, in their report, has cited any number of factors that they feel has contributed to this kind of financial picture. Many of these issues you've had presentations on and probably will into the future as you kind of consider your deliberations. They are, of course, the challenging demographics, payor concentration -- I believe we discussed this with Neil, because Neil is like what's that? Payor concentration, I believe, what they mean there is the tightening number or consolidation of the insurance industry that we're experiencing, just fewer and fewer commercial insurers to be sitting across the table from. Close physical proximity of competitors and high degree of competition, high cost of operation. There have certainly been some serious difficulties in mergers that have been undertaken over the last couple of years, as evidenced in the paper any number of times. There are a large number of high cost academic medical centers in this state,
comparatively speaking. And then lastly, but not least, the legacy of a highly regulated system, the system that we left back in '97.

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

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

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

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

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

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

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

In addition to respond to the industry's
need to access capital, the legislature passed first
in 1999 an ability for health care institutions to
use their local industrial development agencies,
they're called IDAs, to issue tax exempt debt for health care facilities under the amount of $30 million. Although some IDAs may issue debt for weaker health care credits, this, in our view, exposes the State's health care system to other risks, specifically the imprudent use of access to capital where access is not unlimited.

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

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

So, the industry has not sat still through all of this. The health care industry is clearly responding, Chairman Berger, as you noted in the beginning, to all of the externalities and the pressures that are being put upon it. These are things like rapid consolidation of the insurance
market, which they are experiencing new clinical and
information technology. This whole concept of a
hospital or a nursing home of the future, those are
pressures that all of them are trying to grapple
with. And, of course, the ever increasing pressure
on reimbursements that they are receiving, not only
from commercial payors but also the governmental
payors.

We have in our portfolio and certainly
more widely observed contracting, consolidating and
reconfiguration in the industry already. But even
as we collectively contemplate reconfiguring and
reducing the number of acute care and long-term care
beds in New York, the Dormitory Authority believes
that reinvestment of capital, both bricks and mortar
type, as you were talking about today, as well as
the acquisition of technology capital will be
necessary to actually reconfigure and restructure
the industry. You're going to need capital to do
this. To obtain it, hospitals and nursing homes
must retain access to the public capital markets.
We believe that if our State's method of
restructuring the health care industry includes a
pattern of sustained financial failures, either bond
defaults or claims on insurance or other credit
enhancement, it is likely that future credit enhancement will be unavailable, it will be difficult to procure or it will be just too costly.

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

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

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

Now, to assist this effort, the Authority

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

This relationship, this continued
relationship, will be very important as Congress and
the Government Accountability Office, even in a
recently released report, I think it was two weeks ago, continued -- despite the lower level of exposure to New York -- continued to be concerned about FHA's exposure in New York State.

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

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

That would complete my comments.

CHAIRMAN BERGER: Anybody, comments?
MR. BRIDEAU: Just a question.

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

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

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

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

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

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

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

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

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

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

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

And Lora, as you may know, some time ago I was the chairman and CEO of one of those financial enhancement organizations, one of the companies, and I wouldn't do New York State health care institutions because the risk was much too high. And we got to get out -- we got to get to a point where they will do it and then the capital markets...
will do it. And that's down the road. But we will
have to come up with different strategies, and they
will be different for different institutions and
different regions, we'll find we have different ways
of doing it. But we're going to be restructuring.
And part of that is you cannot -- and some of us
faced this 30 years ago for the city -- you cannot
create an environment in which the health
institutions of this state are sort of barred from
the capital markets for ten years. That can't be
what we end up with. That would be a disaster. So,
we're going to have to be sensitive when coming up
with ways of doing this.

Comments?

BISHOP SULLIVAN: Just one.

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

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

MR. VELEZ: You can't.

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

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

Any other comments? Okay.

Thank you.

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

The future meeting schedule: The next
meeting, there are two things about this -- I just
want to make it clear publically, there are two
things. First, the next meeting, which is
April 5th, will take place in Rochester. It's
posted on our website, at 1:30. The meeting after
that is May 11th. That will be in New York City, as
will the June meeting, on June 8th, both in New York
City. The time, however, is to be determined. And
I point that out because we'll have to go through it
with all our members, but they will be longer
meetings and they will also have executive sessions
to get reports from the Regional Advisory
Committees. But they will be longer meetings. So,
I am just alerting all the Commission members to
that fact.

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

Have I missed anything?

DR. SANDMAN: No.

CHAIRMAN BERGER: Members, any comments?

Questions?

I will take a motion to adjourn?

MR. SEARS: So moved.

MR. HOWLETT: Second.

CHAIRMAN BERGER: Thank you very much.

See you in Rochester.

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

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

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

KELLY FINE-JENSEN, RPR

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