
NEW YORK STATE DEPARTMENT OF HEALTH

STATE HOSPITAL REVIEW AND PLANNING COUNCIL

PLANNING COMMITTEE

Wednesday, July 23, 2008
1:00 p.m.
Empire State Plaza
Meeting Room 6
Albany, New York

MEMBERS PRESENT:

Michael Barnett
Howard Berliner, M.D.
Carolyn Callner
Fred Cohen
Joan Conboy
Renee Garrick, M.D.
Edwin Graham
James Kennedy
Marc Korn
Jeffrey Kraut
Anthony Lechich, M.D.

James Reed, M.D.
Lucille Sheedy

PUBLIC HEALTH COUNCIL MEMBERS PRESENT:

Peter Robinson
William Streck, M.D.

STAFF PRESENT:

Charlie Abel
Maryann Anglin
Neil Benjamin
Rick Cook
Christopher Delker
Thomas Jung
Mark Kissinger

Norma Nelson
Julia Richards
Lauren Tobias
Carla Williams

PRESENTERS:

UNITED HOSPITAL FUND
BY: James R. Tallon, President
BY: Sean Cavanaugh,

NEW YORK ASSOCIATION OF HOME AND SERVICES FOR THE AGING
BY: Daniel Heim,
Vice President for Public Policy

HEALTHCARE ASSOCIATION OF NEW YORK STATE
BY: Daniel Sisto, President

NEW YORK HEALTH PLAN ASSOCIATION
BY: Paul Macielak, Esq., President

NEW YORK STATE ASSOCIATION OF HEALTH CARE PROVIDERS, INC.
BY: Glenn R. Lefebvre,
Vice President of Public Policy

IROQUOIS HEALTHCARE ALLIANCE
BY: Gary Fitzgerald, President

FAMILY PLANNING ADVOCATES OF NEW YORK STATE
BY: Susan Pedo, Vice President
BY: Ronnie Pewelko, Esq., Counsel

NEW YORK STATE HEALTH FACILITIES ASSOCIATION, INC.
BY: Richard Herrick, President and CEO

PRESENTERS: (Continued)

CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE

BY: Michael Alvaro, Executive Vice President

CENTRAL NEW YORK HEALTH SYSTEMS AGENCY

BY: Timothy Bobo, Executive Director

HOME CARE ASSOCIATION OF NEW YORK STATE

BY: Al Cardillo, Executive Vice President

MEDICAL SOCIETY OF THE STATE OF NEW YORK

BY: Rick Abrams

MR. KENNEDY: Good afternoon everyone. This session of the Planning Committee of the State Hospital Review and Planning Council is an opportunity for stakeholders of the New York State health care system to provide input on proposed reforms of the Certificate of Need Program here in the State of New York. Should I continue speaking? And I would like to call this meeting to order.

There are a couple of people that I would like to mention and welcome here, in particular, my colleagues on the State Hospital Review and Planning Council, members of the Planning Committee, of course, Chairman Jeff Kraut, who is to my right. He will be our timekeeper today. The Vice-Chair of the Planning Committee, Dr. Howard Berliner, who is to my left, and also, the Chair of the Public Health Council, Dr. Bill Streck. I would also like to welcome in particular, two recent additions to the State Hospital Review and Planning Council, Carolyn Callner, who is the Deputy Commissioner of Schenectady County Public Health Services. Welcome. And also, Edwin Graham, who is the President and CEO of Gilda's

Club, Capital Region New York. Welcome. And to the rest of you, welcome to the July 23, 2008 meeting of the Planning Committee of SHRPC. Today is not only the opening day of the Saratoga race track. It is also the opening day of a public discussion among healthcare stakeholders, the Department of Health, the State Hospital Review and Planning Council and the Public Health Council about reforming the CON process.

Almost three weeks ago, the Department announced that its implementation of the Berger Commission, heretofore known as the Commission, recommendations that concerned hospital and nursing home closures and restructuring is now complete. The announcement capped a nearly three year in-depth review and reconfiguration of New York's health care delivery system under the auspices of the Commission and the Department.

Now that the first phase of the Commission's recommendations have been implemented, we can begin to focus on some of the fundamental delivery system challenges that were identified by the Commission. The

Commission's report criticized the State's delivery system for its overdevelopment of inpatient and nursing home beds, its uneven distribution of healthcare resources overall and inadequate investment in primary preventative care, and also, the continuation of the "medical arms race" among hospitals.

The CON process is one tool that can be deployed to alleviate these concerns. In the decade since our CON process was first conceived, our State's healthcare delivery system has undergone dramatic changes. Our CON process should and needs to respond to these changes. The Department, SHRPC and the Public Health Council are all committed to an improved CON process that promotes the alignment of healthcare resources in community health needs and supports the development of a patient-centered, high-performing health care delivery system. We are all committed to a CON policy that stimulates competition on the basis of cost and quality but not, at the same time, at the cost of, in real terms, duplicative technology for the construction of excess beds. With input from a diverse group of health care

stakeholders today and in other forums, we intend to make improvements to the ceiling process that advance these goals. We are looking forward to hearing the views of the stakeholders here today and that will be presented today and at our September 18th meeting in New York City.

First, let me lay out a few ground rules that I would ask our participants to follow to make this a productive meeting for everyone. First and foremost, Mr. Kraut, to my right, will be our timekeeper today, and Jeff will be calling -- will be reminding the presenters when they have ten minutes left and when they have five minutes left. He will be doing this with each of the presenters, so don't take it personally. Your presentation will also include questions and answers from the committee members around this table, so please keep that in mind as you get ready to present. I would also urge my colleagues on the Public Health Council and the State Hospital Review and Planning Council that this is your opportunity to ask questions of the presenters and to engage based on your observations and the thoughts that are prompted

as a result of the presentation. So I thank you in advance for doing that.

I would also like to remind everyone that these presentations are subject to the open meeting laws, of course, and are being broadcast over the internet at www.health.state.ny.us. The on-demand webcast will be available from today's proceedings no later than seven days after today and for a minimum of thirty days, and a copy will be retained in the Department for four months. I think that there will be DVD versions of this which will be available for the holidays. Also, I want to remind everyone that there is synchronized captioning, so it is going to be very important that people not interrupt each other. The first time you speak, to our presenters, please state your name and briefly identify yourself, also to council members or as members either of Public Health Council or State Hospital Review and Planning Council. This will be of assistance to the broadcasting company to record this meeting, and this is being broadcast by Total Webcasting, Incorporated. Please note that the microphones are hot mikes. We all know what that means. They pick up every sound. I

therefore ask that you avoid rustling papers such as I'm doing next to the microphone, and also, to be sensitive about personal conversations or side bars, as the microphones will pick those up.

Each presenter, again, is allotted approximately fifteen minutes for both his or her presentation, and again, that includes Q and A. I ask all participants to be mindful of this time so that everyone has sufficient time to present.

So at this time, I would like to invite Mr. James Tallon, President of the United Hospital Fund, forward. Thank you.

MR. TALLON: Chairman Kennedy and Vice-Chairman Berliner, members of the State Hospital Review and Planning Council and members of the Public Health Council, thank you for this opportunity to testify. I am going to say little in terms of specifics about Certificate of Need. I'm going to take the opportunity to sort of focus on the broad questions about the next generation of health planning. My name is James Tallon and I am the President of the United Hospital Fund. I'm joined by Sean

Cavanaugh. Sean is the principal author of our forthcoming paper on community health planning in New York City. And for the record, I am also the former executive director of the NY-Penn Health Planning Council from 1971 to 1974, located in Binghamton.

This reconsideration of local health planning is very timely. You mentioned the utilization of the recommendations of the Berger Commission. They are reshaping the environment to more closely align health care resources with the needs of our communities. I think it's fair to say that there is a waning of that unbridled enthusiasm in health care across the nation, resulting in market force wanes. As the Berger Commission proposals take effect in New York, it really sets the stage now to think about the next generation in health care policy, and health planning, in particular.

There are important changes in system performance going on. As Washington begins discussion in 2009 about the future of health system reforms, clearly that is going to be done within the context -- by State governments across the country and in New York to improve

performance. I think there was conventional wisdom when I started doing this that there was a trade-off between access, quality and cost control. I think, as we start this generation, the assumption is very different. If we have it, we'll move on all three dimensions simultaneously.

Over the past twelve months, as I indicated, we have been considering the future of health planning with a focus on New York City. We found -- in the course of our deliberations, we talked to many people across the State and found a growing chorus of interest in calling for the recreation of community health planning. At the same time -- and this is a very important consideration -- we found almost universal dissatisfaction with the prior era of planning. The conventional wisdom, I think, is that the erosion of support for health planning was driven in New York by providers, especially hospital opposition to limits on service, and certainly, there is some truth to that, but as we have spoken to a wide range of people who were involved in health planning in New York City, we have found deep wells of

dissatisfaction among consumers and community advocates within government, State and local, and certainly, among the payer community, as well. So the trick to resolving this, I think, is to build a new concept of planning suitable for our current health care system, and formed by the knowledge that may be gained by our past experiences.

Henrik Blum defines health planning as the deliberate introduction of desired social change in orderly and accepted ways. The change can range from improvements in population, health status and gains in the efficiency of the overall health care system. I think community health planning implies a broader participation in defining, prioritizing and implementing what that desired social change is. So at the most basic level, is any deliberate and cooperative effort to improve health system performance. In a sense, this isn't a defined common ground, along with diversification of agencies.

In the past, health planning was dominated by a focus on the functional and geographic distribution of health care facilities. As the executive director of

NY-Penn Health Planning Council in the seventies, I approached most planning questions initially as a matter of projecting utilization rates against population changes. Today, we have an opportunity to return -- to go back to the roots of health planning and embrace a goal of improving the health status of the people of New York, in the aggregate, within the grouping which define us.

We're still describing the size, shape and capabilities of components of the health care organization chart, but our attention needs to be directed to how people move through the various components and what happens to people in the hospital, in the nursing home, in the doctor's office and in a home -- in a person's home. What happens to people when they transit the boundaries of the individual units. Structure has to give way to performance as the coin of the realm in the new generation of health planning.

One model for this focus on health system performance -- certainly, it's not the only model -- is the Commonwealth Fund's State Scorecards that define and measure health system

performance at the State level across the country along five dimensions: Access, quality, equity, healthy lives and avoidable hospitalizations and costs of care. In the interest of complete disclosure, I serve as Chairman of the Board of the Commonwealth Fund, but I am only speaking for the Fund in these comments. New York needs to create its own definition of health system performance. It has to be based on the unique need and characteristics of our communities and its own measurement system, based on national, State and local data sources. The State government is the obvious choice to initiate this effort.

Long ago, New York established regulatory responsibility for health system performance, indeed, with adoption of the Articles of the Public Health Law under which your councils are organized. Within New York's comprehensive Medicaid program, State government has now assumed responsibility for cost growth above minimal targets that are assigned for localities. New York insures its own workers. It regulates the private insurance market where not pre-empted by federal law. It licenses

professional practice. Most importantly, a new vision of health planning, New York State is the repository of vast resources of information about health care's performance.

The need to define and measure health system performance highlights the critical role that data will play in the future of health planning. In another of my roles as a member of the Board of Regents, we have responsibility, pursuant to Chapter 655 of the Laws of 1987, to report annually to the Governor and legislature on the educational status of the State's schools. This 200-page report tracks enrollment, student performance and financial status, both point-in-time across 700 school districts, and with substantial longitudinal analysis. It's accompanied by a detailed statistical abstract. It creates an invaluable synthesis of a vast database. With an appropriate investment of resources, obviously, in an online format, New York could achieve substantially more aggressive dissemination of health and health system performance information.

I know the Department of Health will

soon be releasing data on Prevention Quality Indicators for use by the public. This is an excellent first step, but more could be done. The Department has extensive data on hospital utilization, emergency department utilization, vital statistics, Medicaid claims and encounter data and many other measures. Apart from large health care providers, the United Hospital Fund and perhaps a few other organizations, most New Yorkers do not have the resources or the capacity to purchase, store, process and analyze these data. The State, perhaps with private sector partners, can and should systematically collect, analyze and make community-level measures of health system performance accessible to all.

I want to spend a bit more time on the centrality of information policy to future planning efforts. My generation of planners counted beds, discharges, lengths of stay, occupancy rates, with an occasional link to morbidity and mortality data. We measured a relatively limited number of variables with data that were easy to standardize.

The health care landscape of 2008 is

more complex by many orders of magnitude. Hospitals are concerned with non-hospital players. Communities, urban and rural, see shifts of case mix intensity to larger, specialized facilities. Assertions of variation in supply-driven utilization enter the cost debate. Concerns about significant ethnic and racial disparities in access to the processes and outcomes of care abound. Central to our ability to address any of these policy concerns is an absolute need for comparability in measurement of the variables. This is complicated work. It is very timely work. But make no mistake, the first refuge of those who are unwilling to accept the need for change is that the data are inadequate to measure the problem at hand. A new vision of planning moves State government, or potentially an innovative private or combined public-private arrangement, to an ongoing development of the highest attainable levels of content, analysis and reporting of information about health system performance and population health.

As we think broadly about planning this next iteration, let me suggest several building

blocks with which to develop an agenda.

We should focus on public engagement in health care decisions, broadly defined. Our people are bombarded with messages about their role in our health care future. Perhaps it's possible to capture the spectrum of those messages as "pay more, eat less." In reality, serious observers from a wide range of perspectives put the individual person, patient, consumer at the center of future improvements. The prior vision of planning sought individuals from diverse constituencies to represent balanced perspectives. The democratization of our information infrastructure challenges us to create far greater public understanding of individual health care issues, variations in cost and quality among health care actors and to fundamentally challenge the "more is better" paradigm which dominates current behavior.

MR. KRAUT: Mr. Tallon, you have five more minutes.

MR. TALLON: Thank you. A second building block is the emergence of genuine concern, which we identified in our discussion in New York City, with the availability of

capital investment in future years across wide ranges of our health delivery infrastructure. Between 2000 and 2006, we identified a dramatic rise in the age of physical plant in New York City hospitals, from fourteen percent above the national average to forty-seven percent above the average. Whereas improved CON review may allow us to better judge between competing development alternatives, there seems to be an emerging need to examine our basic capacity to sustain capital investment. While the Berger Commission focused on what we could eliminate, we also need to address how to sustain what we need.

Thirdly, while we have focused this discussion on planning and CON review, we have to keep in mind the multiple dimensions through which the State envisions regional and local engagement in health system improvement. The premise is simple. Within a strong State framework, real advances are likely to be worked out at a more local level. That is the premise of New York's strategy and investment in health information technology. It's our vision to improve primary care services. It's key to our

aggressive restructuring of Medicaid payments. It is where we will find meaningful action to advance public health. How planning engages the full range of State's local and regional improvement strategies is a critical design challenge.

Finally, I think it's fair to conclude that an earlier generation of health planning made large investments in representation and process. We worked toward comprehensive plans with broad engagement in their development. Perhaps a starting point for our next round of planning activity should be a focus at the local or regional level on discrete issues around which local participants can engage in targeted, time-limited problem solving. In this vision, a next step to those parts of the State not served by existing health planning agencies might be to support lean investments in entities, with the capacity to engage local participants in addressing specific urgent issues. Our lesson is that people are much more likely to be engaged successfully around specific problems, at least initially, rather than being overwhelmed by the complexity of comprehensive

change.

I thank you for allowing me to offer these comments about a conceptual work in progress. We, at United Hospital Fund, look forward to ongoing engagement in these discussions. Allow me a postscript in closing. Among the many important issues you may wish to examine are the structure and functioning of both the State Hospital Review and Planning Council and the Public Health Council. Your roles have proven invaluable through generations of policy discussions for almost half a century. As discussions of planning and CON review proceed, there is a genuine opportunity to re-examine the fundamental mechanisms through which State government engages the important constituencies concerned with health care's future. Our history teaches us one lesson: There's no substitute for leadership. Thank you.

MR. BARNETT: Thank you. Mr. Kraut, how much time do we have left for questions?

MR. KRAUT: Two minutes.

MR. KENNEDY: Okay.

MR. BARNETT: In your presentation, you mentioned -- you talked about Article 28 providers. What about access and retrieval of non-Article 28 health care providers on access, quality, equity and those kind of things?

MR. TALLON: As in my comments, thinking about this starts with how the data infrastructure will work, how many times we've been through discussions where the complexity of this and the variation of the data simply overwhelm the discussion, so my mission would be the design of a broadly-based state information structure that deals both with health status issues, community health issues -- community health status issues and also deals with system performance. I would design the performance as broadly as the data sources would allow. I think that addresses your question, but I think that what this says is as you're thinking about how to make these decisions, start with this -- the fact that we just have an explosion in availability of data sources. We spend a great deal of time in understanding a fair portion of those data sources, but we really understand that the public just is not engaged in this

broader activity. We have to think about how to get it there. Whether the score cards are the right way to do it or whatever is open to discussion.

MR. BARNETT: Let's just focus a little. We have office-based surgery guidelines now. We don't regulate private practice. Are you suggesting that information be obtained from private practices that are not regulated by the Article 28 process?

MR. TALLON: I think that ultimately, we need to be able to understand quality issues that are linked to practice. Most of the research that you may have found on this indicates that the problem is our sophistication about performance at the individual physician level is likely to exclude the outreach and science of this for quite a while, and there may be the aggregate groups of physicians that are the places we want to be looking for the aggregation of physician data. But I mean, generally speaking, I think all the components of the system have to think about themselves as reporting in an environment that allows there to be some aggregation and analysis

of performance.

MR. KENNEDY: Dr. Berliner.

DR. BERLINER: Mr. Tallon, let me follow up on Mr. Barnett's question. In your vision of health planning moving forward, is CON, as it's currently constituted an essential part of that?

MR. TALLON: Howard, here is the issue. Planning doesn't exist to serve CON. CON serves to support a broader planning commission. I believe that CON is a very important level, but I think it -- clearly to alter decision making, but I think, in a sense, it also clearly has its limitations in terms of the broader change agenda. So in my sense, and I applaud you for all excellent things that you're doing, and we may try to sneak back in at the September 18 hearing and say a little more about that, but I do think that it's part. But what I'm really suggesting here is a step back, as part of this, and take a thought about just how this broader planning enterprise would work that would not simply go back and honestly repeat a previous generation which was a big part of my life, but as you've heard, we

published -- and we'll ask you to read the publication that we put out next week -- dissatisfaction with planning as it sort of permeated in New York, with the exception of around 1996.

MR. KENNEDY: Thank you, Mr. Tallon.

MR. TALLON: Thank you. And I thank Mr. Cavanaugh for sitting next to me and backing me up on this.

MR. KENNEDY: At this time, I would like to introduce Daniel Heim, Vice President for Public Policy at the New York Association of Home and Services for the Aging.

MR. HEIM: Thank you Mr. Kennedy. Good afternoon, everyone. I'm Dan Heim, VP for Public Policy of the New York Association of Home and Services for the Aging, NYAHSA representative of 600 providers throughout New York State. We thank you for the opportunity to be here before you to discuss CON performance. NYAHSA also appreciates the leadership role that the Department has taken on in orchestrating these discussions and reaching out to various stakeholders.

While CON has stemmed the proliferation of health care service capacity, the State is now faced with a growing and changing demand for services, rapidly evolving care modalities and systems and an aging infrastructure.

In long term care, there is a consensus on the need to rebalance the system to emphasize development of home and community-based services and correspondingly, rely less on nursing home capacity.

However, State policies and laws can and do impede these efforts. There are longstanding CON-related moratoria and/or limitations on developing additional home and community-based services.

For these and other reasons, NYAHSA supports reevaluation of the state's CON process to identify changes that are needed to develop a high quality, accessible and cost-effective system while avoiding the need for another forced downsizing.

My remarks today will focus on the questions that were posed in the letter of invitation that we received, and further details are provided in our written testimony.

The first area is projects that are subject to review, and the first question: How can CON be improved to respond to changes in the marketplace? First, we must be sure that the most current utilization of data are used to evaluate these. In the Berger Commission exercise, we saw instances where stale data led to less than optimal recommendations.

Secondly, as the care modalities and settings evolve, decisions made on CON policies and individual applications can have ramifications on the types of facilities, agencies and systems. The dangers of making decisions about one line of service data in isolation of other service lines are multiplied in a complex and dynamic system. CON reform provides an opportunity to more thoroughly consider the implications of these decisions in the context of the broader delivery system.

Third, the CON process to promote greater uniformity of approach and process across provider types. For example, providers that are established under the Social Services Law are reviewed under a different process than facilities and agencies established under

Article 28 of the Public Health Law. There may be legitimate reasons for these differences. With all of the changes going on in the marketplace and individual service areas, there may be value in placing greater emphasis on the need for CON applicants seeking to initiate or expand services, to identify and propose to respond to a currently unmet need. Although utilization data and public need formulas can be useful, CON applicants may be able to provide more direct and current information on unmet need and how that need can best be accommodated.

Finally, making the CON process, itself, more timely and streamlining the applications and reviews will also enhance responsiveness. And I'd like to address that area now.

We believe that the CON process should be streamlined by no longer subjecting certain projects to full CON review, including initiating Article 28 facility-sponsored outpatient clinic services and adding dialysis services in a nursing home setting. These services have evolved in a way that make administrative or limited review more appropriate.

Secondly, amendments of existing construction approvals that simply represent increases in construction or borrowing cost due to timing and unit cost increases and not changes in the actual project itself should be reviewed administratively and not require full review.

Are there projects, services and equipment that are currently not regulated, but should be? NYAHSA believes that any type of facility, service, equipment or project that is subject to CON review in one setting should be subject to CON review across all settings.

For example, look-alike Article 28 facilities sponsored by physicians that provide outpatient clinical rehab services for which existing Article 28 providers would need to secure CON approval to offer should be subjected to review.

Are there types of facilities or services that should be licensed, but not subject to a need test? Are there other regulatory mechanisms or controls that might make more sense? We understand that there is an interest in the idea of expanding the

application of the need methodology to nursing home CONs involving renovation or changes in ownership of existing facilities. Under longstanding policy, need reviews are normally limited to the establishment of new facilities and increases to the certified capacity of existing facilities.

We're very concerned about this idea, particularly as it would relate to facility renovation projects. We believe it is likely to be used as an opportunity to leverage these applicants into reducing their licensed capacities while leaving untouched the capacities of providers that do not seek to improve their facilities. This, we believe, would create a significant disincentive for existing operators to upgrade their facilities, undertake innovative designs and delivery models and otherwise improve quality of care and quality of life for their residents. In the bigger context, this could diminish the integrity of the entire service infrastructure.

Under local planning and public notice, what are effective ways to notify interested stakeholders about pending Certificate of Need

applications that are actively under review? NYAHSA recommends a combination of a more timely notice of pending actions, greater access to meetings, more internet-based information and directed outreach to alert interested stakeholders to pending CON applications.

Council meeting agendas are finalized and published a very short time before the meetings are held, which gives applicants and other interested parties very little, if any, advance notice or ability to provide timely input or otherwise react. While there may be last minute adjustments to agendas, a greater effort should be made to publish these agendas earlier.

Council meetings are typically held in New York City and Albany, with teleconferencing available to DOH staff and webcasts available to the public. In order to increase the public's access to these meetings, consideration should be given to opening the Albany teleconferencing facilities to outside stakeholders and developing a need by which webcast participants can electronically participate in meetings and submit questions and input for consideration by

DOH and council members.

The DOH website should include a designated area that enhances and consolidates the available information. This area of the website should include all relevant CON information posted in one place, including an easy-to-understand summary of the CON process, CON applications and instructions, upcoming meeting agendas, more detailed project summaries, current status of each application, public need information, SHRPC and PHC member listings, information on how to provide input on applications and summaries of DOH staff reviews and council actions.

In terms of directed outreach, efforts could be made to seek input from service providers and other stakeholders that might be affected by the proposal within an established timeframe. This could be accomplished by sending letters to affected parties, posting information on the HPN and/or hosting regional forums in the CON area of the DOH website.

How can the Department support the development of collaborative efforts to access community health needs and make recommendations

to develop and/or deploy effectively the health care system resources needed to address those needs? NYAHSA does not support recreating the local Health Systems Agencies or the regional structure used by the Commission on Health Care Facilities in the 21st century. While these approaches had some positive aspects, they alternately introduced processes and outcomes that we believe were often cumbersome, costly, time-consuming and politically charged.

Having said that, there is a need for community-based efforts to bring providers and other stakeholders together to examine local needs and resources, identify and address emerging trends and unmet service needs and avoid duplication of services in an apolitical way. These need to be ongoing efforts, not a one-time exercise. The Local Health Planning Initiatives RGA recently issued by DOH provides an opportunity to encourage flexible demonstrations of different models.

We believe there is no universal model that can work in every region or community. We also encourage DOH to use the RGA to fund demonstrations of different approaches and to

systematically evaluate these to determine critical success factors, limitations and ability to sustain and replicate the approach in other communities.

Let me talk on the issue of migration of services. NYAHSA argues that the playing field should be leveled one way or the other for these services. The bifurcated current approach is leading to service volume generation and dispersion and creating a competitive disadvantage for regulated institutional providers, which are, for the most part, required to serve anyone regardless of payor and to provide a full range of services.

It is concluded that there is a compelling need to certify these services, ensure quality, manage overall capacity and promote equitable access, then they should be subject to CON review at some level, regardless of which they are offered. If, on the other hand, it's believed that a free-market model should be the predominant approach, then these services should be deregulated from CON across the board.

There's also question about whether CON

plays a role in preserving community hospitals. Many NYAHSA members are located in areas served by community hospitals, and these facilities provide services to their residents and patients when acute and primary care is needed. If these hospitals were to disappear, individuals who receive long-term care services would have reduced access to hospital services in their local communities, potentially adding to transfer trauma and imposing more travel and other burdens on family members and friends.

MR. KRAUT: You have five more minutes.

MR. HEIM: How can the Department encourage more collaboration among health care providers in order to achieve economies of scale, avoid duplicative services and improve access to care and quality? At the outset, NYAHSA does not believe that collaboration is always a reasonable and workable expectation among co-existing organizations, nor does it necessarily lead to the most desired outcome. The system objectives should be to promoting economy and efficiency, avoiding duplication and improve access to high quality services.

Collaboration should be seen as but one strategy to pursue these objectives.

If encouraging collaboration connotes a predominantly passive role rather than seeking to force fit incompatible providers together, then it could be an effective policy tool under certain circumstances. NYAHSA sees opportunities to encourage facilitated discussions among providers as part of the local planning function, as well as offering incentives, where appropriate, for exploring collaborative efforts, such as expedited review and regulatory flexibility.

And the next question is regarding active supervision, and the approach of active versus passive parent models. We don't advocate for any change at this point, following the Department's roles in these areas.

Let me turn finally to CON submission and review process. Are there ways in which the CON could be streamlined and to what effect? As previously noted, the CON process can be streamlined by no longer subjecting certain applications to undergo full review. The thresholds should be periodically re-examined

for each CON level, with the goal of maintaining realistic standards that could further streamline the process.

There are opportunities to streamline the application preparation process, as well, by examining the schedules to determine if they're all needed, use of exception reporting rather than full reporting for certain items, providing on the DOH website samples of completed CON applications and otherwise better documenting CON requirements up front.

The application review functions should also be examined to identify other opportunities to streamline processes such as expediting time-consuming DOH staff reports, particularly character and competence reviews, and also, reviewing the respective responsibilities of the SHRPC, the Public Health Council and the CCRC Council to maximize the value of the external review function while minimizing duplicative functions.

And are there aspects of the process that are duplicative, unnecessary or of marginal benefit? The underlying intent of the character and competence review, we believe is important,

but the current application is rather limited in its effectiveness. We're concerned in a related way about the effect of the character and competence process on volunteerism in public -- I'm sorry, not-for-profit facilities and agencies. It is already difficult to find qualified, willing and capable individuals to serve on volunteer boards. However, current policy dictates that if such an individual has been on the board of a nursing home that within the last ten years, had certain types of survey issues, he or she is effectively disqualified from serving on the board of a facility undergoing character and competence review.

Further discussions are needed on this issue, as well as the emerging standard for competence to operate a health care facility or agency.

And how should CON weigh the financial impact of a project? Although it's important to consider the financial implications of a project, this can't be done without evaluating other equally important deliverables such as access and quality. In other words, the less expensive of two projects may also produce less

value in terms of access and quality than the more expensive one does.

We also note in our testimony that equally important, Medicaid access regulations as applied to nursing homes should be repealed. We think they are a policy artifact and are a solution to a problem that no longer exists.

We're also raising concern in our testimony about the concept of instituting regional competitive reviews for certain CON applications. Competitive reviews could place undue emphasis on financial considerations at the expensive of quality and access and inappropriately result in the rejection of worthwhile proposals.

Should need methodologies be modified to reflect increased utilization of community-based long-term care? We believe the State should periodically re-evaluate the need for existing CON-related moratoria and/or limitations on developing additional home and community-based services and any moratorium should be revisited regularly to ensure it still represents an appropriate policy response.

So in conclusion, we believe CON reform

can be in the development of a policy framework for health and long-term care service delivery in our State. Our State, like most of the country, has struggled to meet the growing and changing need for services in the face of resource constraints and growing complexity.

We think CON reform has balanced a lot of complicated trade-offs, including encouraging a market-based approach versus exercising greater regulatory control.

With that said, I want to thank you very much for the opportunity to speak before you today. NYAHSA and its members stand ready to assist as this process moves forward.

MR. KENNEDY: Thank you. Questions for Mr. Heim? Yes, Dr. Berliner.

DR. BERLINER: Mr. Heim, at the end of last year, SHRPC spent -- actually, this committee of SHRPC spent an awful lot of time re-evaluating a bed needs methodology for skilled nursing facilities. Do you think that was a worthwhile exercise, given your remarks? Or should we approach a new way of looking at nursing home capacity?

MR. HEIM: Thank you, Doctor. I

believe that the exercise was a worthwhile one. However, I would argue that there were certain alternative services that we were not fully and appropriately accommodating for in that discussion. And we alluded in our testimony that we have a whole different method for Medicaid and non-Medicaid services that are provided for in long-term care throughout the State, and evaluating the need for one particular item, you need to fully take into account those other service settings. So I do believe there was a value. I do think there were other very interesting ideas for long-term care relative to short-term rehabilitation and lots of other system changes that we're seeing, and we will need to systematically and periodically re-evaluate those two methodologies.

MR. KENNEDY: Mr. Kissinger.

MR. KISSINGER: Dan, I have one question. I want to ask whether you think there should be CON at all for community-based long-term care services?

MR. HEIM: That's a good question, Mark. It's not one that we have presented to

our membership in those terms. I really think there are different schools of thought in that area, and I will say, if I was there, there could be concerns about woodwork and dynamics of that nature. I don't believe necessarily that promoting home and community-based services is synonymous with having, not having some degree of control over those services.

MR. KENNEDY: Dan, what has the impact been from your view on the Berger Commission in terms of the kinds of collaboration that you have seen within the last year or so among your members? Has it been a positive impact?

MR. HEIM: I believe that the Berger Commission exercise -- I think it was good from the standpoint that it did promote a different perspective among our members and other providers, and I do think there are positive discussions going on in a number of communities. In terms of the actual practical effect of Berger as it relates to affiliation and those types of exercises, frankly, we don't see as much evidence in long-term care as you might see in primary care. So not to the same

degree.

MR. KENNEDY: Okay. Thank you, Mr. Heim. At this time, I would like to introduce Daniel Sisto, who is the President of the Healthcare Association of New York State.

MR. SISTO: Thank you. Chairman, members of both councils, on behalf of our 550, we appreciate the joint council effort to focus both on health planning and CON reform.

In the interest of time, the CON recommendations that were just laid out by Dan, we concur with, essentially, in their entirety. Some nuances, but essentially, we propose those, plus additional ones that are in the testimony. And with respect to conceptual approaches to healthcare, as in Mr. Tallon's testimony, there is very little in that that we would have a problem. In fact, nothing I heard constituted a problem. So I think it is very important to keep these two issues separate, CON and regulation and health planning. I think, while our members would be almost 50/50 diversion, there are certain things in which they would automatically respond, essentially. One thing they would want is a level playing field,

whether it's competitive or whether it's regulatory. A level playing field, not just across similar types of providers but across the entire spectrum of health care services. And that is something that is lacking now.

Many people say the bottom line is CON. I think you've heard a lot of recommendations by Dan and in our testimony on that, and the Department has already begun to address that, but the original focused so much on Berger during the administration, it's really kept a lot of the attention on how to unlock that. I'm very encouraged by this opportunity to speak to it.

I think this was touched on by Mr. Tallon, that we certainly try not to recreate the past. There is really very relatively little and I'd say almost no interest in redrafting of a new generation of health systems agencies or comprehensive health care agencies, per se. In fact, many of the functions that were instituted by health planning agencies have now been absorbed by others. For example, I remember when I was at the HSA, one of the things we would be asked to worry about is

workforce planning. Here in Albany, the Center for Health workforce studies is a tremendous job, not only Statewide but also on a regional basis. This is projecting workforce needs. We have quality oversight of all sorts of different types of responsibilities that will improve quality. Today, you have numerous agencies, volunteer, academic, business oriented, media oriented, all involved in the mission that we need more standardization rather than another entity there. So each of these agencies and others have filled many, many of the gaps that HSAs once were asked to do, but are not necessarily integrated. It's not necessarily coordinated and it's not necessarily being applied in a cohesive fashion to talk about the health system as a broad whole. And that's where the opportunity for generational conception truly lies.

I'm all the way up to page five. I'm fast forwarding.

Models for health planning do exist. These elements were used to develop Healthy People 2010. For example, identifying and engaging community partners, setting health

priorities, identifying and securing resources, obtaining baseline measurements, managing and sustaining local and statewide processes, communicating health goals, building foundation, leadership and structure are all basic elements of health planning.

Health plans should have its power generated out of its credibility. My observation in this kind of field is that -- and I'm sure it happens with myself -- is that while initially, an agency is asked to do health planning, they're so afraid two years later that frankly it will just sit on a shelf, and they begin to say, Well, gee, we have to get more authority. Let's work with the State and review CONs. Let's file for federal grant applications. And over a period of time, it morphs a regulatory agency. There are workforce studies that I just mentioned. There are planning agencies who generate their authority out of credibility of what they do, which speaks to Jim Tallon's issue about data and how objective, analytical, comprehensive data that spans the spectrum of healthcare that can be measured, identified, packaged, made sense of

and facilitate conversations that result in change, that's where the power should lie. And, I think it's very important when we talk about being now segregated from the regulatory process, which brings me, of course, to the Berger Commission, which I don't think we should confuse in any way, shape or form a frankly provider issue, legislatively mandated, base closing division with two and a half billion models to implement these recommendations with a comprehensive voluntary or regional statewide health plan. It accomplishes many good things, but it is not health planning. And so we all have to view as maybe it's a spring board as we think about the next generation, but it is certainly not the prototype or the model that we ought to be putting in our heads as we move forward.

Nevertheless, page seven, there is a legitimate public interest in the size and scope of the health care delivery sector to insure adequate capacity and service availability in geographically accessible ways. Identifying gaps in services, the effects of new technologies, forecasting the implications of

mega trends, new science, technology assessment, these are all focus areas that health plans, State or national, really need to appropriately engage.

My interest here is health planning. When I think of health planning, I don't think about the local community. I think about my interstate competition. Frankly, my international competition. And I hear about regional utilization statistics and length of stay in rural areas. Sadly, that doesn't take into account the fact that I have dramatically different variations in my occupancy in the summer versus the winter. I don't want to hear about regional formulated descriptions when staffing for my institution, so of course, they have very, very dramatic differences when they start hearing about formulated descriptions.

To put the burden on the proper place, the Commission recognized the dilemma that its scope was limited to institutional providers while the impact or role of non-regulated segments was affecting safety net services and needed to be addressed. It didn't have the portfolio or the time to do that. The

Commissioner also recognized that health system restructuring could not occur without a concurrent change in payment structure. This issue is being addressed as part of the outgoing reimbursement reform discussions, but I think it's important to note that those discussions only relate to paying differently for Medicaid fee-for-service beneficiaries and do not include, even as a Department goal, to cover the cost of those services.

Despite everyone's best efforts to incorporate local input and local recommendations in the Commission's findings, the Department rightly had to adjust a variety of determinations based on subsequent information, local concerns and financial feasibility.

There are numerous plans and functions that could provide a constructive effort to the State and providers alike. And let me get into those a little more.

One, long term capacity and service need planning. The most traditional of health planning activities, projecting service needs based on population and utilization trends,

remain at the core of health planning work. There is significant benefit to credible data collection and up-to-date analyses to project health care needs and service requirements.

Two, service gap analysis. Page ten. Highlighted in the Berger discussions, identifying the gaps, in particular, in the continuum of long-term care services, is crucial to the development of an efficient delivery system.

Assessment of the impact of new technologies and science and proactive interest in innovation. What we're suggesting here is several years ago, the State Hospital Review and Planning Council created an ad hoc Emerging Issues Committee to consider the merits of new or emerging services or technologies. There remains a concern that the current process and CON rules inhibit innovation rather than stimulating new ideas. There are other service configurations that are not so new. The State continues to resist transitional care units and long-term care hospitals. As hospitals struggle to move clinically complex patients efficiently and effectively through the continuum, the State

has consistently resisted using service configurations that are in wide use nationally.

Proactive development and use of health information technology, HIT. New York is far ahead of the country in providing seed funding for certain types of HIT applications, but only certain types. That activity needs to be integrated into the health planning process with support for both organization-specific investment.

MR. KRAUT: You have five minutes.

MR. SISTO: Evolution of physician/hospital relationships. The challenge of out-migration of certain services is a much-discussed element of this subject. However, a broad-based health planning effort needs to discuss the rapidly changing environment of physician-based services and physician-hospital relationships. This includes the impact of increasingly larger multi-specialty group practices, formed in part to respond to payer challenges, but also able to dictate terms with hospitals. It involves a discussion of the growing separation of many primary care and specialty physicians from roles

in hospitals, including willingness to be on call in the emergency department or provide coverage services elsewhere.

The development of a better health planning database. As the focus appropriately shifts to ambulatory care, service information is lacking. Insurers have access to the missing ambulatory care elements, but it is not collectively available for State or local health planning consideration. There would be significant value in discussing opportunities to aggregate both the public and the private insurance data into a single health planning database.

Workforce implications. The current health planning process acknowledges, but does not directly focus on long-term workforce issues. Coordinated local efforts are needed to identify workforce needs and promote educational solutions.

Page twelve, clinical integration. There are public benefits to horizontal and vertical clinical integration, horizontally and vertically between hospitals and physicians or between hospitals and continuing hospital and

continuing care providers. The potential benefits are both economic -- it's a more efficient system -- and qualitative, with more consistent use of clinical standards by physicians and organizations. Providers are hampered at almost every turn by antitrust and competitive issues.

And third party insurer consolidation. This growing influence affects the configuration of the health delivery system as the focus may shift more toward economics and less on access to care.

So many of these topics are relevant to the State health planning activity, whether or not the system is more market driven or regulatory. We tried to highlight topics where local input would be most relevant: Service gap analysis, long-term care system gaps, workforce needs and promotion of service innovation.

Again, there are two pages on CON and there are three more pages on detailed implications, as well. This gives me time to answer questions.

MR. KENNEDY: Thank you. Questions for Mr. Sisto? Dr. Berliner and then Mr.

Robinson.

DR. BERLINER: Mr. Sisto, you bring up, I guess, a contradiction that is at the heart of what we're here to discuss today, at least on the CON side. On the one hand, you say that most of your members seem to be leaning towards more of a market based way of going toward less regulation. At the same time, you argue that we, the health planning apparatus of the State, should be more critical to those kinds of new services that, in fact, reflect the market but that hurt hospitals, that hurt the institutions that already have CON protection.

MR. SISTO: I think there is a conflict. On the one hand, we say we're going to promote for competition. For example, more choice. And so we're going to provide more information about price, we're going to provide more information on quality, and hospitals should go out and compete on the basis of quality and price. When hospitals start to compete with one institution against another, we say, Wait a minute. We really need to leave that safety net, or we say, We want more competition, but we're going to continue to

regulate the institutional structure, and maybe in that two or three-year range, we're not going to get anything approved. But the providers that are able to just do full service can set up anything they want within a couple of months and go at it. We need one level playing field. One set of rules that applies to all. We don't care if it's all regulatory.

DR. BERLINER: But wouldn't that argue to find a different way to protect the essential services that you believe that hospitals offer that non-institutional facilities can't offer by definition, and then let the competition go after the services that both could offer equally well?

MR. SISTO: Sure. The problem is that the multiplying, decade-long financial system of complex cross-subsidization of services lies in a rubber band ball that's been wrapped so tightly that it is extremely difficult to unwrap, and frankly, I would like to see, since we approved a hundred and some odd ambulatory surgery centers four or five years ago on the assumption that doing so would lead to lower costs, and per unit, it probably does.

You can provide it cheaper in a physician-based ambulatory surgery center than in a hospital, unless the hospital has an interest in the center. I don't dispute that. But what I do dispute is that when both are in short supply, when you take that existing institution and you break it into multiple sites, when you take a limited amount of capital and allow for technological expansion in unregulated sites, that, in the aggregate, is several negative things. First, decreased per unit cost and increased aggregate costs. Second, broke down by increasing the fragmentation, which is what you said you wanted, which is a system that is cohesive -- I think the competition is right here, and institutions, hospitals, nursing homes are really reflections. These institutions will do what it is that public policy dictates and where financial incentives are, and as long as you offer financial incentives around things that you want, you're going to get a behavior that you don't want.

MR. KENNEDY: Mr. Robinson and then Mr. Cohen.

MR. ROBINSON: Thank you. That was

my question, so thank you.

MR. KENNEDY: Mr. Cohen.

MR. COHEN: May I use the microphone or not?

MR. KENNEDY: I can hear you fine from there.

Mr. Sisto, there was something in your testimony that has peaked, and that is the need to renovate hospitals as time goes on because of the current age of the infrastructure. And as I look at the other alternatives, I see that they are also burdens on the taxpayer. So I'm wondering what your view is or your root view is as a solution for your membership?

MR. SISTO: I think it would be a solution -- I believe that if you look over the last twenty years, whether it's at hospitals -- and call me crazy here, but also insurance companies, what you find is that for-profit entities behave like for-profit entities. They will go where the money is. They will also go where the markets are. New York State has to take on an incredibly social mission in that they have to basically deal with all the social problems in this State and institutions by

reinvesting back in State hospitals at a time when both the State and federal governments -- although there are rate hikes, we cannot expect a whole lot of Medicare and Medicaid additional support. It means that -- I believe it means an acceleration of the disparities of care. If you look at the differences around the country, and I'm not saying all not-for-profits are beautiful and pure, but most -- most of them in this country track directly back to the HCAs and the -- I forgot. I just have no -- any sense of any local control. You talk to people in -- I've talked to many, many COs who started in New York and went to Florida, and they basically talked about the fact that, yeah, they streamlined the system real quick and then they polled the resources in the community back to where it always was. So that would be the last thing that would probably happen. It would be my last day, because I will not help present it.

MR. KENNEDY: Thank you. Thank you, Mr. Sisto.

MR. SISTO: Thank you.

MR. KENNEDY: At this time, I would like to introduce Mr. Paul Macielak, who is the

President of the New York State Health Plan Association. Please.

MR. MACIELAK: Today, I'm appearing as the head of the Health Plan Association, and we represent twenty-six plans in the State, full spectrum. Some are large for-profit entities. Some are regional non-profits. We have managed long-term care and a number of Medicaid PHs, as well.

In light of this hearing, I went back and talked to the membership about planning issues. The first and foremost question that came back to me, What is the purpose of CON today? People understood it from ten, twelve years ago. People don't understand what the mission of CON is today. And I had more questions about that than I had about any of the other issues. I think that part of this discussion is to define what people expect from CON, not only for the public, but for SHRPC, as well.

I want to focus on an important issue, and that is -- I would say hard to do -- is there needs to be a recheck or resetting of the role of the Department, Department staff in the

CON process. I went back and read the 2002 Certificate of Need New York State "A Program in Transition" before submitting my remarks. Most of you, I don't believe, were on SHRPC and were here when this was developed. And when I went through it, I found some interesting points that I believe still apply today.

First and foremost, from use of an orthodox analytical regulatory model to streamlined review, the goal of the Board is to assist and approve and accept CON applications. And I think that also goes to an -- I also believe, and I put it in my report, that applications -- a number of applications have been denied, have been reduced over the years, those voluntarily withdrawn or those that were under prodding from program officials.

The other point that was made in the report that was particularly significant was that except for a few certain categories, such as organ transplant or cardiac surgery, and nursing home beds is another one, that negative findings of need really based on need methodologies is not necessarily consistent with department practice. And need methodology needs

a tighter regulatory review. A lot of the other CON Article 28 -- it's looser and a more flexible methodology, and ultimately -- SHRPC has its own data need methodology, and "need" is becoming very, very intuitive of the CON process. That is no longer really part of the process. It focuses more on conceptual considerations.

Projected service utilization or cases/population standards are employed by DOH in assessing CON community "need." How are they set? When were they last updated? How old are they? Is there any universal standard that's used? Any national standard? Is there some sort of need standard or methodology? Why is there one imposed on cardiac surgery or in cardiac cath labs?

And then the final point is really unmet need in the community or is the service provided elsewhere? All too often, we see CON applications that look to create a need, when, in fact, that need is really the best service provided. Perhaps service is provided in a different city. The need is not the true need methodology that I think people associate with a

CON. We've moved away from that.

In terms of the HPA reform -- and it's something that Fred has brought up on many occasions, and that is we need to look at CON access, not just on service need, but also ultimately on cost. When I say "cost," we sit around the table when we talk about cost as it applies to the Medicaid system. That is a good review. I think that explains the rigid rigors of Medicaid methodology.

We have the more flexible need technology today and more community costs. That is the cost that's ultimately attributed to business and employees, and that's why we disagree with Dan Sisto's analysis. He talked about the merger of health plans regarding the economies and finance of projects versus the true need of service. I would say that the full process today, both on need and deliverance of services, is an inadequate consideration of the cost of what that means in terms of affordable access. You might have service, but if nobody can afford that service, you don't have access to it.

Our reform agenda that I laid out in a

few points really goes to the need of updated CON need, and we need -- whether it's a planning committee, we need to address that. I think we also need to really look at the financial status of the applicant and the application. There needs to be more weight put on the review of that data. I think I would also advance -- when I was at the Emerging Issues, Jeff got up and said as part of its conversion, it should be held to certain standards in terms of quality and there should be a penalty for both. So if they want to convert, there should be certain quality standards -- customer service -- and if they don't have those standards, they should be penalized financially. We should look at some of these CON applications in terms of responsibility by the applicant to meet the standards of the application, in particular, services, volume and unit cost. If that applicant, today, before the application is presented -- well, what does that actually deliver in terms of service units and the cost? And the revenue generated is another story. When I heard this, we go to the table and negotiate hostile. For example, the following

is not there, the service is not there. We're looking to make up that shortfall and spread that cost.

I would say, for an application, you need to look at some sort of certification as in the methodology, as in the numbers. Secondly, we need to look at some sort of standardized reporting back for that service, whether we have those numbers. They would give some sort of better standards, and ultimately, if that service didn't meet their own projections, there ought to be some sort of penalty imposed in terms of future applications. That is what we need to consider if we're going to improve the process and we're going to improve fiscal responsibility in terms of that process.

In this Rockefeller report was a recommendation to pursue more batching, and batching of services in the community offered a true analysis of community hospitals versus academic centers, and that would help identify and point out some of the costs and some of the service units projected and would better highlight for these guys, our guys, really what the comparison is and what the need is in the

community and what would be best and most efficient provider of that service, particularly the issue about academic health centers, as it should show in the numbers, the higher cost basis that an academic center starts out with versus a community hospital. And that should be reflected in a batching methodology. That's in our narrow agenda. And are there any questions? Thank you very much.

MR. KENNEDY: Thank you, Mr. Macielak. First of all, can everyone put their microphone off? There seems to be several over here that are on, so push the bottom down towards the base. That might be part of the problem that we're experiencing today. Any questions for Mr. Macielak? Dr. Streck.

DR. STRECK: Paul, this strikes me as taking some advice from Warren Buffet's hostile takeover playbook here in terms of the commitment to a real review process, and it seems to me that this is about as strong an endorsement for sustained and enhanced regulation based upon need that we've heard in a while. And since it is predicated on need, I'm sort of curious on -- curious to your thoughts

on how the need will be defined.

MR. MACIELAK: I don't know. I don't have the formula or the methodology, other than what we've used over the years here in terms of need methodology, so I'll go to need, in terms of actual service or unit or caseloads or recommended caseloads. But I know that for something as simple as cardiac cath lab capacity -- I mean, I know that is something I know I've asked about, the update on that, for years, but we're still operating at a 1200 service units per year per cath lab. The cardiac or some of those high tech services, I don't know when they have been last updated, but I think that goes to just the service needs side. The financial side of it, I think material is requested of applicants. I'm just not sure of the rigorous level of review that exists of that financial data and how that might compare to -- I'm not sure what other standards might exist either regionally, nationally, other states, but I think its something we need to look at. So I'm not sure calling for really more regulation as opposed to just a more rigorous regulation of what currently exists.

MR. KENNEDY: Mr. Kraut.

MR. KRAUT: Okay. Paul, you heard Jim and I guess Dan also make reference to the need for health planning data and democratization of that data. Does the membership, your membership, have an opinion as to their willingness to share what we're talking about as to the episode for care? We have a lot of inpatient data, but the willingness to get together with Medicare and Medicaid for the commercial payers to share a data set that would take a look at that episode of things that happen outside of the hospital.

MR. MACIELAK: I don't think they are there yet, and I know from a few years ago they weren't there at all. So there has been change. I would say that, in part, varies very clearly between national plans and regional plans. Regional plans are more willing, I think, to share. National plans, looking at things truly from a national platform or perspective, having a different view. But to that end, I would just say that the Health Plan Association, we got pay for a performance grant from the Department of Health, and the main

focus on that grant, from our perspective, was to aggregate that among multiple payers. It's something that doesn't exist. And we see it as critical just to pay for performance. Think about a physician. If you're going to get a pay for performance instead of CDPHP and MVP and Health Now, and there are different measurement criteria, you're not going to change practice to become better quality, more efficient. If you have critical mass, you can hopefully gender that type of change. And we are trying to work at creating that infrastructure for the aggregation. I will tell you, it's been extremely painful, extremely difficult to work out, but that is something that we are working on, and perhaps that might offer a base for further conversation.

MR. KENNEDY: Dr. Reed.

DR. REED: Paul, both you and Dan have referred to the cost of health care and have actually very different views, as I interpret what you're saying. If we were to do away with the CON process in New York State, do you feel the cost of health care would go up or would go down?

MR. MACIELAK: It would go up.

DR. REED: And why do you feel that?

MR. MACIELAK: Because what you would have -- and I heard it back from a number of our provider relations people -- more capacity equals more utilization, and where the utilization even remains relatively constant, the cost per unit then starts to increase or it gets rolled into the per diem, lump sum amount of the institution. And while Dan referenced health plan merger, et cetera, clearly, hospital active passive parent models have also created some merged -- relatively merged day-to-day use from a negotiated standpoint, too, and that all goes to increasing that cost base, as well.

MR. KENNEDY: Mr. Robinson.

MR. ROBINSON: Just a quick comment on around leveling on the CON playing field. Your views on that.

MR. MACIELAK: We have spent, from when amb-surge -- I was here when amb-surge passed its regulation, and I can't believe it's that many years later we spend as much time as we do on amb-surge. We can sit, all of us,

around the table, and we can have a hospital project rolled down the tracks, a 50 million dollar renovation where the numbers don't jive, don't make sense, and we all vote intuitively yes. We can have an amb-surge center following right after that, and we can spend an hour debating it and have a holy hell of a fight about whether to allow the amb-surge center or not. I think that there can be some leveling of the playing field in terms of some of the office-based services, and I think some of that is occurring now with some of the office-based surgical certification that is in process. I think that's the first step. I think the medical community, which, as always, envisions its office as sacred and nobody can check in on the four walls and what's happening, may have started to move down the road of recognizing quality perspective from a certification perspective, that there is a State right or role in terms of having some of that data. So I think that moves it more towards a level playing field. I think it will be a gradual process, as well.

DR. BERLINER: Paul, given that

your -- the different plans that constitute your organizations, each have a responsibility for the patients that are enrolled in those plans, shouldn't the plan be the actual planner for New York State? Shouldn't each plan be deciding what the constellation of service in New York State is versus who they contract with and what they decide to contract for?

MR. MACIELAK: That's a yes and a no, as well, as in relation to the marketplace. If a plan -- one of the regional plans, here, goes up to the north country and you go into one hospital town, your ability to selectively contract for services or to determine how you're going to contract is extremely limited. You go downstate and where there's a hospital on every corner, you have a different ability to negotiate there. The problem you have there is it's in downstate, where you had a New York Presbyterian, Sinai network, you've had growth of major networks where the networks take a strong negotiating position in terms of what services will be in the package, and it's a negotiation, so it's limited ability to pick and choose on that plan.

MR. KENNEDY: Thank you. Thank you, Paul.

MR. MACIELAK: Thank you.

MR. KENNEDY: At this time, we'd like to hear from Glenn LeFebvre, Vice President of Public Policy at the New York State Association of Health Care Providers, and then, after his testimony, we're going to take a five-minute break.

MR. LEFEBVRE: Good afternoon, Chairman Kennedy, distinguished members of the planning committee, State Hospital Review and Planning Council, Public Health Council and guests. My name is Glenn LeFebvre. I'm the Vice President for Public Policy for the New York State Association of Health Care Providers that are known as HCP.

HCP represents approximately 500 offices of licensed home care service agencies, certified home health agencies, long-term care programs, hospices and other home and community-based providers in the State, so we have a broad and diverse membership that deals in long-term care in community settings.

We are very grateful to be here and have

this opportunity to meet with you and offer you some of our recommendations for reform of the Certificate of Need for home care providers in particular, and so those are the areas in which I will try to confine some of my comments.

We do commend the Department and the State Hospital Review and Planning Council, firstly, for undertaking this important evaluation of the CON process to insure that the process facilitates the appropriate alignment of health care resources with community needs and avoids another forced downsizing of the system. We support your goals, as well, in developing a patient-centered, high performing health care delivery center, and obviously, the goals should be accessible, affordable, high quality and cost-effective care in settings, most importantly, that are appropriate to the needs and preferences of the health care consumers. We are also strongly in agreement with the high performance of a health care delivery system that contributes not only to individual health, but also the health of the community as a whole, which I know is one of the hallmarks and one of the important areas that the council wants to

focus on in looking at the impact of the CON system.

HCP believes that home care and policies that promote home and community-based care are a fundamental part of the range of solutions that are needed to develop a patient-centered, high performing health care delivery system that you are seeking to help foster. In 2007, the administration, the Health Department, in particular, took the lead and noted that one of the fundamental strategies that they wanted to pursue was to support better home and community-based long-term living options that reduce the need for expensive and difficult to get nursing home care. We must also work to provide options across the full range of long-term care options that are available in the community.

As health care policy recommendations are made by this body and other policymaking bodies in the coming months, we strongly encourage you to make every effort to insure that this sector of the health care continuum is given the policy attention and dedication of resources that it needs to insure that it can be

there to provide some of the solutions and meet the challenges of the State and that this council is attempting to address.

Why do we have to promote home and community-based care? The redirection of the long-term care policy from an institutional setting to focus on home and community-based settings has been occurring more rapidly over the past five or ten years. There have been many factors driving policy in that direction, including an increased consumer awareness, desire to utilize services, lawsuits that challenge the degree to which care recipients could choose the manner in which they want to receive services, cost effectiveness of home and community-based care in the face of rapidly rising home health care costs in both the private and the public payer markets and rapidly changing technologies that make it possible to deliver efficient care in these settings.

It has become increasingly apparent that chronic conditions can be managed more cost-effectively at home. An analysis of the studies investigated that the use of home care as a cost-effective substitute for acute care

services found a statistically significant relationship between home health care use and reduced use of inpatient hospital care. All very worthy goals, I think, for this policy analysis.

Now, specifically -- let me just touch briefly on some of the recommendations that we have with respect to the CON process. First, we recommend the elimination of the CHHA public need methodology to help establish what we believe is a level playing field for home health care delivery, permits increased competition, with a prospect, we believe strongly, will enhance efficiency, quality and access to these services.

There have been dramatic changes in the health care system particularly in home health care delivery over the years that are not accounted for, we believe, in the current CHHA public need methodology. There have been public policy shifts that have -- increasingly have demonstrated the need for home care as patients are discharged from hospitals sooner and quicker and require post-acute care. In addition to delivery of chronic care at home, the programs

such as Personal Care, Long Term Home Health Care Program, Managed Care and other integrated service delivery programs, they also encourage the delivery of care at home, which is not reflected in the current formula's "normative use" methodology.

Technology advances have made it even more possible during the last decade to administer treatment in a home environment that previously had been confined to very intense acute care settings. These include services like telehealth services, which the State is, wisely, I think, attempting to promote through its policies, as well as other more labor intensive services like infusion therapy that can be delivered at home now.

Also, the delivery systems for home and health care have become more efficient and effective as home care providers have focused on patient outcomes. Unlike hospitals or nursing home beds, the number of CHHAs has no impact with respect to controlling the utilization of home health services. Because the need for capital in the establishment of a CHHA is relatively small, there is no need to

demonstrate that there is an adequate demand for home health services in order to secure financing.

So we believe that the needs test that has currently been set out for these facilities is an arbitrary restriction to the market that is antiquated and flawed. Eliminating the need criteria that is used to determine CHHAs should be done, because it needs to appropriately respond to these dramatic changes in the evolving healthcare delivery system. So we support increased access to both public and private markets for home care providers as long as they can demonstrate the essential things that the Council and the Department seek, which is character, competence and financial feasibility and delivery of services.

Entities like licensed home care services agencies have the expertise, the interest and the capacity to become and deliver services in the same way as CHHAs, but they are unable to do so because the existing public need methodology basically hampers that. So elimination of that methodology would establish a level playing field for home health care

delivery, permit competition with a prospect of both efficiency, quality and access.

On character and competence, one of the areas of review I know the Council was reviewing was the idea of looking at a more specific, sophisticated character and competence test that looks at health care experience. We believe and we would recommend that you retain, at least for home care, we believe, a current character and competency standard and do not agree that the addition of specific additional requirements that include looking at health care experience are applicable or appropriate for home health care service providers.

Owners of home care agencies have appropriate staff, requisite experience in place to manage their agencies. They should be judged to meet the character and compliance requirements if they comply with all these existing standards. The experience of the owner becomes irrelevant so long as they meet all of the regulations and the requirements for the operation of their agency. The adoption of new requirements that emphasize health experience will only serve to limit the potential pool of

these operators who would be otherwise qualified and will not guarantee that there is any demonstrable impact on the delivery or the quality of care that are provided by providers.

I want to turn to CHHA charity care requirements. I know that this was an area that was subject recently to a report by the Department of Health with respect to certain CHHAs are required to comply with the provision of charity care for patients in this State.

As is clear from the report, most CHHAs are not in compliance with the current charity care requirements. CHHAS are unable to meet the level of charity care required by the Department for many reasons, including the narrowly drawn definition, which makes it difficult to find patients that meet that technical definition of persons with the appropriate financial need. This difficulty is further compounded by the fact that you have public programs that have, in recent years, been significantly expanded, including Medicaid, Family Health Plus and Healthy New York, Child Health, just to name several, that reduce the amount of charity care that can be feasibly provided by these agencies.

For many years, for instance, hospitals have been authorized by law to establish community service plans in order to promote, publicize and help implement the community mission of these providers. Many certified home health agencies are also mission-driven providers that we believe should be allowed to provide care and meet some of this requirement through the adoption of a community health plan.

MR. KRAUT: You have five minutes.

MR. LEFEBVRE: Thank you. The Senate has introduced legislation just this year which, in fact, would allow for the addition of that.

Quickly, also, we recommend simplification of the CON process. These are topics, I think that were touched on by other speakers which really go to the heart of the complexity and the cost and the difficulty that providers and others face in negotiating their way through that process, and so we would endorse the idea of a thorough review to help to speed and make it more efficient for all of us involved in this process as the way to produce CON applications.

We also have recommendations dealing with transfer of ownership, which would provide for CHHAs and LHCSAs, standards that are currently available in Article 28 for hospitals, which will also make it more efficient, because those kinds of transfers can be dealt with in an expedited way that preserves your right for oversight and accountability while, at the same time, allowing providers to proceed through the process in a more efficient way.

We'd also ask that you look at the change in the membership of your body, the State Hospital Review and Planning Council, to better reflect diversity in the State's health care system and re-examine the CON process to determine how that should be worked with the Council's role.

Local health planning is something we would support. These initiatives have to be fair and equitable and not include the addition of political considerations at either the State or local levels, and we are certainly supportive of the concept of reviewing the need for additional local health planning, but recognize that will add to the time and the complexity of

the process that you're about to change.

Finally, public notice is something we believe -- and I think this echos what other speakers have said, as well -- is something that the process for public notice for being able to track and keep up with the applications that are made by providers really desperately needs to be simplified to make it easier for us to be able to have input and meaningful, I think, opportunity to provide you with what you need to make your decisions in this process, and that can't be done if providers find themselves entangled in a web that makes it so difficult to find their way through this process and track their applications.

Finally, we would recommend a CON work group that would be established with representation from health care sectors to help provide for detailed reforms that relate to many of the issues I think that I just outlined. This kind of process would provide the opportunity for the industry to provide that level of expertise to you, the Department and policymakers, to help you with your efforts to streamline and improve this process.

I appreciate the opportunity to appear before you this afternoon and I welcome any questions that the council members may have.

MR. KENNEDY: Thank you, Mr. LeFebvre. Mr. Kraut?

MR. KRAUT: I just want to return to one of the comments you made about the competency issue of ownership of directors of the agencies, and let me stay with the ownership, where the Board sits. It runs somewhat counter to all good government practices for health care, for profit and not for profits. So if you just could comment on that.

MR. LEFEBVRE: I think we're looking at perhaps the experience we've had in the health care system to this date, and I think what we need to probably step back and do, if we decide that you want to somehow significantly change that requirement, is to look at the value of that requirement, the impact that will have on the system and whether that additional accountability or that experience brings something to the system which is so essential that it has been missing before. And I think

that's where we have some questions in that regard.

MR. KENNEDY: Other questions? Comments? Yes.

MS. CALLNER: Perhaps you could clarify for me your statement number four that says unlike hospital or nursing home beds, the numbers of CHHAs has no impact with respect to controlling the utilization of home health service. Were you meaning to say that regardless of the community need as to the extent it can be established, that the number of CHHAs that are allowed to exist would have no bearing, no impact?

MR. LEFEBVRE: Our opinion would be that it doesn't have a bearing in the same way that it does, for instance, for the more capital intensive kind of providers like hospitals and nursing homes, because we don't have a public need methodology, for instance, that applies to licensed agencies, and we do have one that applies to the more limited number of certified home health agencies, and given that experience and given the fact that a level playing field in encouraging greater access to home and

community-based care, this makes sense, I think, to go back and evaluate how that need criteria has been applied to those providers, whether or not it actually accomplishes what the State's goal has been in this and why it has been treated the same way as perhaps other providers where there is a tremendous capital investment that's associated with their CON.

MS. CALLNER: And are you suggesting that given a reasonable or perfected need methodology, that there should be some process, not that its just an open market?

MR. LEFEBVRE: I think -- we would argue there should be an open market, and it doesn't mean necessarily that all providers that are currently not providing certified home health agencies would choose to do that, but we think there are many licensed agencies in the State, for instance, that can and ought to be able to do that, but because of the current need methodology and the way in which it controls access to certified agencies, they're not able to deliver that care. And we're all looking for ways to better provide home and community-based care.

MS. CALLNER: Thank you.

MR. KENNEDY: Anyone else? Thank you, Mr. Lefebvre. At this time, we are going to take a five-minute break. We'll be back here at five minutes to three. Thank you.

(Whereupon, a brief recess was taken.)

MR. KENNEDY: At this point, we'd like to hear from Gary Fitzgerald, President of the Iroquois Healthcare Alliance.

MR. FITZGERALD: Good afternoon members of the Public Health Council, State Hospital Review and Planning Council and Department of Health staff. My name is Gary Fitzgerald. I'm the President of the Iroquois Healthcare Alliance, a membership organization representing fifty-five hospitals and their affiliated organizations in thirty-one Upstate counties. I want to thank you for the opportunity to speak briefly on the subject of health planning. IHA's membership is diverse in that it comprises thirty-two rural hospitals including eight Critical Access Hospitals, which means it represents the smallest hospitals in the State as well as some of the largest teaching hospitals in Upstate New York.

In anticipation of this discussion, we formed a local health planning advisory group. This group is made up of fifteen hospitals, and many of these hospital representatives responded to the questions that we distributed with the notice of these public hearings. Their comments have been included in an attachment with this testimony. This group will continue to meet throughout the process and will provide us with feedback which we'll provide to you as we go forward.

I will use my time, then, to comment on the more broader issues and concepts of health planning.

As you listen to the testimony regarding health planning, you will undoubtedly tire of hearing people talk about a level playing field. It's been mentioned a few times already today, obviously. I have to tell you a little story about level playing field. I had the opportunity to work with the senior manager from General Electric Corporation in Schenectady in the early 1990s. We worked together on development of critical pathways of care for nineteen hospitals based on concepts used in

GE's manufacturing operations. This individual often chided me about the hospitals whining and complaining about an unlevel playing field when it came to competition by other providers. He boasted that GE had competition from companies around the world and had to constantly adapt and innovate in order to remain profitable. He suggested that hospitals in New York could learn a lot from the private sector. I certainly was impressed with this man from GE, as I was just starting in the business, and thought for a while that he was right until I watched how GE and other for profit companies, quite frankly, acted in response to competition. GE, at that time anyway, had almost unlimited capital. GE could also lay off six hundred people in a week and shut down its operations in Upstate New York. GE could then move its operations to another state or another country. GE does not have to sell light bulbs to individuals who can't pay for them. Obviously, our hospitals do not have those options. Some of the hospitals that I represent have been serving their communities for over 150 years. Some have gone through bankruptcy and are still providing care

in their communities. All have suffered inadequate government payment rates, and most -- most have survived the Berger Commission. As of today, none have moved their operations to India or any other countries for that matter. Hospitals, therefore -- and I think that obviously speaks to Dan's question about for profit versus not-for-profit. Hospitals, therefore, have a right to insist on a level playing field when it is their mission to accept all patients regardless of their ability to pay and provide access to quality health care in their communities without regard to their financial condition. The new CON policy must encourage access by rewarding providers who are willing to accept all patients. Physician organizations, surgery centers and other practitioner-based services must comply with the same CON requirements as hospitals. Free-standing organizations must take Medicaid and Medicaid patients and must be willing to have a charity care policy similar to the recent mandated hospital charity care policy. If the Department of Health does not have the resources to monitor these requirements, local health

planning organizations may collect this utilization data as part of a new local health planning data set. Providers who have consistently demonstrated their willingness to accept all patients and provide community services even when they lose money in providing those services should be given preferred CON status. In establishing a new health planning policy in New York State, resources, or more accurately, the lack of resources should be given serious consideration. Given the current State's fiscal problems, it is highly unlikely that the Department of Health will see an increase in staff resources to handle CON applications. This reality is not likely to change in the future. This is a unique opportunity to simplify and eliminate non-direct care patient items from the CON process. The updating or replacement of equipment changes or location of services within a system or the establishment of a physician practice by an Article 28 facility are just a few examples of items which could easily be eliminated from the CON process. We will provide you with a more comprehensive list of these items in the very

near future.

Serious consideration should also be given to an approval time requirement. Certain CON requests which are routine, if not completely eliminated from the CON process, should be deemed approved if action is not taken within sixty days. A major goal of health planning obviously is the control of new costly technology. Who decides how many of the latest high tech diagnostic machines should be approved and where should they be located is the key question. During the past eighteen years that I have been working in health care in New York State, we have successfully avoided creating a two-tiered system of health care; that is a system which has one level of care for Medicaid patients and the uninsured and a different level of care for patients with private insurance. And that goal has been reached and we've done a great job with that, certainly in our hospitals. As we consider making changes in health planning, we must be careful that we not create or perpetuate another two-tiered health system. That is, a rural system versus urban system. One version of a plan that has been talked about

that would deal with the proliferation of new technology would have the latest technology located in urban areas and have rural or small community hospitals affiliate with tertiary hospitals to access that technology. That model may work in some cases, but should not be seen as the only answer. People in New York State who choose to live in rural communities should not be denied access to the best health care available, and they should not have to drive three hours to have access to that health care. The CON process should encourage the rural to urban model as well as a rural to rural model in which rural providers are allowed to create organizations which could own and operate high tech health care services.

The new CON process must be able to address regional needs and be flexible. Upstate New York is currently experiencing a severe problem in recruiting and retaining physicians. This problem has been well documented. Hospitals in Upstate are increasingly hiring doctors as employees and setting up practices or purchasing physician practices. Without the support from the hospital in many Upstate

communities, the physician shortage would be much worse and the access to care severely limited. The new CON process should encourage this behavior, not discourage or delay these transactions as it currently does. At present, these transactions are delayed for months because the relationship requires the establishment of a new Article 28, given the hospital's involvement. This requirement has caused physician and hospital relationships to fail and has exacerbated the physician shortage problem in Upstate New York.

CON policy should be much more flexible to address the problems of access in a more timely fashion, not etched in stone to be addressed or changed every ten years or so.

Finally, I'd like to address the subject of local health planning data and local health planning organizations, or what we really are referring to in our association as local health planning data organizations. Health planning must occur at a local level to recognize the needs of the local community, obviously. In discussing the Department of Health's recent RGA regarding local health planning, it became

apparent that there are many different sources for local health planning data. There are also huge holes in that data. Census data, Medicaid data and SPARCS data can be used to predict current health care needs and population trends. Predict. Not accurately predict, but just predict. That prediction is only a guess, as I said, and a great majority of that data is on inpatient hospital activity only. Very little data exists in those public sources on outpatient activity or physician activity outside of the hospital. To accurately plan any local health services, the outpatient and physician data is essential, and that goes back to a question that was asked earlier about that kind of data. There is no way you can have local health planning done accurately without having physician data in the local health planning data set, and we don't have that now. Hospitals have some of it. Medicaid has some of it. Medicare has some of it. But the payers, the private payers have the rest of it. And if Paul's members are not ready to give up that data, then they should be mandated to give up that data, much like the State -- the hospitals

are mandated to give their data up through the SPARCS system. A local health care planning data organization must be truly local. NYPHRM regions and Berger regions are not local health planning regions. They're just too big. Local planning organizations must represent community stakeholders equally. An example of one of these organizations -- and I'm going to stretch this a little bit, but I hope you'll indulge me -- we have created -- and it's not just that I was a co-founder with Paul Macielak that I'm mentioning this -- we've created a REO in the capital region which is called HIXNY. It was founded four or five years ago by IHA and the Health Plan Association. The State of New York is investing tens of millions of dollars in REO development in every portion of our State, Buffalo, Rochester, Syracuse, Albany, mid-Hudson Valley and New York City, to name most of them. Also, a few in the North Country and Southern Tier. Many health dollars are being spent to develop this relationship. Our REO organization has nine hospitals, four payers, six physician organizations, a consumer rep and soon to be an employer person on the board. It is not a

perfect organization by any means, but we took a lot of time and a lot of effort to make sure that the board of that organization has equal representation and equal voting power from all those different partners, and so far, it has worked. Our data will start to flow in October of this year. You, as a State, have a perfect opportunity to use those organizations, when they become up and running, having health planning data right there at your finger tips. It has medical data. It has physician data. It has payer data. It has hospital data. It can have county public health data, all on line, all have access to that data. Why create another set of organizations that would be duplicative of what's already being done in those organizations? It's not there yet, but those of us who believe in the technology believe that it's only a matter of time. And I think the State believes it's there, it will happen, given all the money they're investing in those organizations. Just a thought. Thank you again for your time and opportunity. I hope that during your deliberations, you will seriously consider the issues that we have discussed with

you today. The members of the Iroquois Alliance are certainly looking forward to working with you in making sure that quality, affordable health care is accessible to all citizens of New York State. And certainly, I will take any of your questions.

MR. KENNEDY: Thank you. Questions? Yes. Mr. Cohen.

MR. COHEN: There was something you said that I was unsure about, because I had an understanding, and now, I'm not sure after listening to you. My understanding is -- I'm from Western New York. You have a rural and urban setting over a nine county area. It is not expected that the rural hospitals provide all level of services so they can accept every patient. In fact, they would be expected to refer some of the patients. And the telemedicine has been set up to deal with that issue. So I'm not sure about what your point is about rural to rural. Is it just a matter of degree or are we going to have a system that acknowledges that centers where there's more volume and better expertise are actually better for patient care?

MR. FITZGERALD: It depends on the service, obviously. Intelli-stroke has been a successful program, and we're certainly involved in that, but not all technology needs to be centered in the urban areas, that if a group of four or five rural hospitals in the North Country could certainly have enough volume and enough expertise to have a certain diagnostic piece of equipment, which seems to be the hottest item that we're discussing these days, and the concern that those million dollar equipment purchases will be all over. Each hospital will have one. There is a concern among the rural members that I represent that there is that forcing to move all of the high tech equipment to urban centers and that they would be forced to make sure their patients got there, and it's three hours in most of the North Country to Albany, to Syracuse, in some cases, so that is a concern. And there are examples across the country where rural networks have come together and have been successfully able to be -- to use equipment and to do many of the services that can be done in some of the larger hospitals. Not everything. Not everything.

But its important that that option is certainly not totally left off the table.

MR. KENNEDY: Dr. Lechich.

DR. LECHICH: I think just to follow up on that, the technology is an issue that puts across higher and higher, like an arms race, to the exclusion and sometimes deprivation of primary care service. So if we keep facilities open because of the impact on the outcome, we really have to look at that, and I think the CON will, however, be deemed that to be a review has to be a consideration of technical cost, because they are really running wild in comparison to primary care.

MR. FITZGERALD: I understand.

MR. KENNEDY: Yes, Ms. Callner.

MS. CALLNER: Mr. Fitzgerald, you've probably thought about it, so can you elaborate a little bit more on how you can see your HIXNY system playing into the CON process or how you would see that your system that you're developing utilized in the CON process?

MR. FITZGERALD: Not as much the CON process, but the information gathering process. You have all the players in this

organization sitting at the table who have access to all the data that is required to do health planning, and they own the organization as a group of partners, if you will, and they're all equally a part of the organization. Their votes are all counted equally. So you would avoid the problem, the political problem. In some parts of the State, we have payers that dominate local planning organization. In some parts of the State, we have other organizations that dominate. You already have equality. All the group would do -- you already have these groups exchanging data electronically between each other, patient data. You could easily add public health data, health status data from a community level into those data sets, and you could report that data back to the State and back to the decision-making bodies. We are not suggesting that they be decision-making bodies, but just data flow is already happening or will be happening soon. And when I get back and have my next meeting with HIXNY, they'll be very upset that I suggested this, because we are so -- right now, we're so close to turning this on, but we're also in a situation where we haven't

done it yet, so to add another layer of burden on them would be probably too much. But I'm saying you have the potential around the State for the data flow to be there through the organizations that you want to get the data from.

MS. CALLNER: Thank you.

MR. KENNEDY: Dr. Reed.

DR. REED: As a member of HIXNY, I'd -- on the planning side of things and this whole question of HSAs, and I'm hearing Dan and Jim and everybody say that HSAs are not the way to go, and you're suggesting that perhaps a collection of organizations like HIXNY might be a way to go. On the other hand, I also know all the political realities you went through during the formative stage of that and find it very hard to picture myself and other people ever coming to terms around that table on who gets the next MRI and who gets the next free-standing amb-surge center, and I'm really troubled on the whole planning side. What is the organization that we -- not that planning isn't a great idea and not that the first step in that planning has to be the appropriate data base -- and we really

have to have agreement as to what that data base is, but I still struggle in knowing the struggles that you went through in forming HIXNY, is what is that group that takes the place of that HSA and how do you keep it from getting politicized, which I understand is what killed the HSAs in the first place. So if you look at that group, how would we solve that with that HIXNY group and so forth?

MR. FITZGERALD: Well, again, it would be a data collection agency. I avoided the politics because I don't see it as making recommendations, but I know when I look at the RFA from the Department, as much as they talk about it being data collection, I see little pieces of recommendations from the local organizations jumping out at me, which scares me a little bit. I think the recommendations need to stay at the State level or else you're going to have politics -- I was there in the State Legislature when the HSAs were unfunded and watched the politicians basically go nuts over certain HSAs behaving in certain ways, and it really became ugly. And I can't guarantee that wouldn't happen with these other organizations,

but what I was hoping for was we've got to get the data first, and not consultants who will charge us all a lot of money for a black box which puts data out and predicts things, but real data from real transactions. And having Paul's people involved in this, I feel will get them closer to giving it up. But I thought about this, also. How do you change the HSA model to make it work? I don't know how you make it do that. I don't know how you can get the local groups through -- first of all, it's one more step in the planning process, which slows things down and drove people nuts because of that, and then there are local politics with who was on the board, who was running the thing and where they were getting all kinds of influence from that created -- it would work its way up to senators and assemblymen who then decided at the last point that they couldn't take it anymore.

DR. REED: So let me ask this out there as a potential solution, just to stimulate the discussion a little bit. Paul, when he was speaking, said -- he used the example of consolidation in health care as basically a bad

thing because that was going to push up the cost. As we form these larger health care organizations, they have more bargaining power or whatever the speculation was. But wouldn't that solve your problem? Rather than having fifteen of us sitting around the table with our own turf, what if, in fact, what happened in health care in New York State was what happens in most industries in the world and that is to improve cost structure and so forth? There is consolidation, which is also exactly what's happened in the HMO industry.

MR. FITZGERALD: Yes, and I disagree with Paul on that. In the North Country, let's take the rural areas, where if -- Paul mentioned rural areas, where if a payer goes up there, basically having a hard time negotiating with one hospital in one town because that hospital is the only hospital in town, that is not what happens in realty. A Blue Cross Plan goes into a rural area and says, This is my rate. You take it or leave it, because they happen to be the only payer in that area. So in order to change that, you have to allow hospitals and physicians in rural areas to

negotiate as a group. The legislature came very close to allowing that to happen in a rural health network situation that was developed a few years back, and there is actually language in there that allows the beginning of that, but it never really went anywhere. That would allow those groups of hospitals to be able to be more efficient in their use of data -- equipment or technology. It wouldn't mean that every rural hospital would have to have the latest piece of equipment or come here to ask for it. And that's what I said about urban -- excuse me -- rural to rural partnerships. It would also allow for physicians and hospitals to negotiate with payers and keep those community hospitals in business and the docs, as well.

DR. REED: And isn't the perfect example of that is you give the history of HIXNY and what finally got it off the ground was when you brought the most consolidated physician group together in this region, CCP, with the most consolidated HMO in the region, CDPHP, and the most consolidated health care system, which was Northeast Health, together and got those three in the room and all of a sudden, things

started to click.

MR. FITZGERALD: It took off. Yes. I'm sorry. I went over my time.

MR. KENNEDY: That's all right. Just a little bit. Thank you for the discussion, Mr. Fitzgerald. And I also want to commend the past few speakers who have been cognizant of giving us highlights of their presentation, and that's really appreciated. I just want to remind the other speakers that fifteen minutes includes your presentations as well as possibly to anticipate questions and conversation with the Council members.

At this point, I would like to introduce from the Family Planning Associates of New York State, Susan Pedo, and I'm not sure I'm pronouncing your last name correctly, Vice President of Family Planning Advocates of New York State. Please correct my pronunciation.

MS. PEDO: It's pretty close.

MR. KENNEDY: Thank you.

MS. PEDO: Good afternoon, Chairman Kennedy and members of the Committee. My name is Susan Pedo and I'm Vice President of Family Planning Advocates of New York State. I will be

serving as the interim CEO of Family Planning Advocates. And with me today is Ronnie Pewelko, our general counsel.

Thank you for the opportunity to present testimony on behalf of New York's Family Planning centers. Family Planning Advocates represents the State's planned parenthood affiliates, hospital-based free-standing family planning centers and a wide range of organizations providing health care services to women and men throughout New York State. We welcome DOH initiatives to develop a more patient-centered health care system and improve health care quality, and we look forward to working with you to establish those goals. An essential step to achieving our common objectives is addressing the CON process, an existing regulatory structure as it pertains to access to reproductive health services in New York. We have been engaged in ongoing discussions with the Department of Health regarding many of the issues we will touch on today. We are optimistic that there is a concerted effort to improve many aspects of the process, and we thank you for your

responsiveness in these areas.

The main concerns the Family Planning centers repeatedly raise about the CON process are: First, the time it takes to have a CON approved; second, confusion about applicable state standards, and third, constraints that regulations place on our ability to deliver family planning services in innovative ways. As you know, the lengthy project approval process can significantly drive up costs. Providers have also found a lack of coordination and even consistency among the various parties involved in the process required to construct or renovate a health care facility.

We understand that DOH is moving to an updated architectural standard and we are optimistic that this will help end some of the confusion and lack of consistency regarding applicable standards. As the State works to insure that there is more uniformity in the interpretation and enforcement of regulations, we will move closer to establishing one consistent set of standards. At the same time, it is imperative that flexibility for innovation be maintained as providers seek to expand

services and reach the many people who are in need of family planning services. Too often, health centers are confronted by regulatory barriers that prevent the innovative delivery of family planning services. Although many of the existing regulations offer a degree of flexibility and applicable requirements, there is a lack of guidance on what is minimally acceptable. Some the constraints that limit provider's abilities to seek new ways to serve patients are delineated in our written testimony. The main challenges involve lack of specificity that can result in problems in surveillance, how to address changes in service provision that may take place during the lengthy approval process and how to accommodate part-time health centers to enable them to serve larger populations, particularly for providers that serve geographically large rural areas. Regulations should be reflective of the level of care provided, not the number of hours that the site operates, as the degree of complexity does not increase measurably with the number of hours a particular clinic is open.

Many providers have expressed particular

frustrations about the lack of standards applicable to mobile care vans. This is another area where we are hopeful that DOH's adoption of updated standards can be useful. We encourage the Department to consider incorporating these standards into regulations. Another very specific area in which our providers have asked for clarification is in defining what constitutes a health fair and what services can be provided at a health fair.

The centers that FPA represents provide critical health care services. They include family planning counseling, pregnancy testing, prenatal and post-partum care, health education and treatment and counseling for sexually transmitted infections. Clients are primarily young women of child-bearing age in medically underserved communities. Reproductive health services are an essential component of primary care. They play a critical role in the State's efforts to reduce New York's distressingly high rate of infant mortality. Pregnancy planning and spacing leads to healthier birth outcomes. DOH should be commended for its commitment to family planning programs, but there must also be

a commitment to insure that family planning services are integrated into the State's health delivery system and not stigmatized as being unsuitable for provision in conjunction with other health services. This is not only an issue of respect for women, but quite simply, family planning clinics cannot meet the entire need for these critical services alone.

We have watched in dismay as hospital mergers between non-sectarian and religiously affiliated hospitals have caused a loss of reproductive health services that include not only abortion but contraception and education. Because many reproductive services have been singled out for elimination by some providers, it is important that community need for reproductive services be carefully considered when evaluating a proposal to consolidate health services. We recognize that it is difficult to address the very real conflicts that arise when religious doctrines conflict with access to comprehensive services, but as the health care system consolidates, the State's focus must be on insuring that patients have access to complete health service. In the

patient-centered health system that New York envisions, family planning centers play a crucial role in ensuring the delivery of quality reproductive health care.

We thank you for your support for family planning, for your willingness to work to expand access to those in need and for holding these hearings to discuss specific challenges in the CON process that provide an opportunity to improve our health care delivery system.

MR. KENNEDY: Thank you. Questions for Ms. Pedo. Dr. Berliner?

DR. BERLINER: Yes. Hi. I'd like to ask a question on the written testimony about what happens in Connecticut and Vermont and what it means to seek -- to become an intervener or party status in CON hearings?

MS. PEDO: Ronnie Pewelko has done a lot of work on that one.

MS. PEWELKO: We pointed to those two states as states where they allow for some involvement by the public or other interested parties if they can show that they are adversely affected, usually by a loss of health care services or a change in the way they deliver.

The people that want to become parties to the proceedings will apply to the state. Connecticut has a rather complicated structure, which you can find in the citation. Vermont has a really simple one where, if a party can show that they're adversely affected by a loss or a change in delivery, they can become part of the review process. And the way Vermont does it, they hold a public hearing which is really limited to the parties. If you can become an intervener, you -- the one I watched, the parties were given twenty minutes to present their objections and the state needed to address those concerns in their review. And this way they were able to kind of get a perspective that wasn't present there in the CON application in a way that was limited and controlled and the interveners were able to have their concerns addressed. And the one in Vermont I watched, there wasn't a change in how the -- it was a CON that was disapproved, and they went back to the drawing board and came up with a better plan. So we cite that as a way to -- not to replicate HSAs, which our providers did have problems with because of just the intense involvement from

people who didn't want to see the services added. This way, we felt people had an opportunity to -- who really would be affected adversely in their own health care, to have a say that made sure those concerns were at least considered.

DR. BERLINER: Thank you. I think our problem has not been allowing people -- what you would call intervener status. Because at our committee hearings, people who feel themselves affected, whether adversely or positively, can come forward and testify. Our problem has really been how to find those people and get them to know that this is something they should be involved in, so if you could address that.

MS. PEWELKO: I know in Connecticut, they have a public notice requirement where I think there is a notice placed in the local paper, and then, also, the CON application and all the material are made available at the local library. I've seen other states where they had much better internet access in the applications, but it is a problem, I think, in the ordinary citizen finding notice.

The little legal notice in the paper doesn't necessarily meet it. I've seen, in some states, where they actually provide notice to like the town board, if it's like in a small town. I know in Connecticut, that seemed to work well. Vermont, I think they note -- I'm not sure how they notify people, but there is some public notice requirements.

MR. KENNEDY: Yes, Mr. Barnett.

MR. BARNETT: We do have a website, and then there is opportunity for people in the community, either individuals or organizations, to comment either for or against. I'm not quite sure what you're --

MS. PEWELKO: I don't think there's any clear standards of how people can comment, and I think that really is the beauty of Vermont and Connecticut. There is a procedure where people can apply, but I still think the website is very confusing. If you look at your website, you look on the right and there's a little button that says "hospitals" and then you need to click to -- I think CONs and then you can look to CONs distributor or CONs approved, so you can see what's been distributed. You get a

two-sentence description of what it is, but that's all the information, and there's no way to know when it's up for public review until the notice of the meeting is published a few days before. So I think there's just not enough information, unless you're really an insider who knows who to call to find out what's going on.

MR. KENNEDY: Other questions? Yes, Neil.

MR. BENJAMIN: I heard in your testimony and written here, and I will read it: "We have watched in dismay as hospital mergers between non-sectarian and religiously-affiliated have caused the loss of reproductive health services that include not only abortion, but also contraception provision and education, and sterilization in hospitals and health centers across the state." My question is: Do you have evidence that has actually occurred, that because of these mergers and consolidations, that people who are in need of these particular services are actually going without care?

MS. PEWELKO: Well, I'm not saying they're going without. They're needing to travel a lot further. So I guess you could say

that has been the end result, when the loss of hospital-based services are unavailable. Amsterdam is a good example, where there are no hospital-based reproductive services.

MR. BENJAMIN: So maybe loss is not the word. Inconvenience, maybe.

MS. PEWELKO: I guess you can define it in many ways. Loss in the community.

MS. PEDO: And for many people, when you add those additional barriers, it does result in a loss. There is only so many things that individuals can overcome before they forego the health care that they need.

MR. BENJAMIN: I'm just curious, do you have actual evidence of that?

MS. PEWELKO: I'm not exactly sure what you mean. That people are going without services?

MR. BENJAMIN: People are actually not being served because of these mergers between religious and non-sectarians. I'm just curious, because, as you know, the Department takes these things seriously, so we'd be very interested if you have any evidence of that.

MS. PEWELKO: I do have stories of

women who were unable to have a sterilization at the time of birth because of an inability to access that service within -- close to their home. I mean, they can go have a second operation later, but there has been that problem. Neil, I know this -- you've worked very hard at this, and we're not really making any specific recommendations, only that we need to be careful.

MR. BENJAMIN: This is for other situations I want to learn, as part of this whole new process, as it's important.

MR. KENNEDY: Dr. Reed.

DR. REED: No comment.

MR. KENNEDY: Mr. Barnett.

MR. BARNETT: As part of the process, people from the public can comment at any Project Review Committee meeting regarding a CON. They can speak up for or against. I think there is that access. Maybe it's not the best system in terms of notification. The website could be improved, but is an open meeting.

MR. KENNEDY: Thank you Ms. Pedo. Yes. Ms. Conboy.

MS. CONBOY: Could you explain to

me the difference between Planned Parenthood and the Family Planning Associates?

MS. PEDO: Sure. Planned Parenthood is actually the non-profit organization that is a national organization and it has specific affiliates throughout the United States, and in New York State, we have eleven Planned Parenthood affiliates. The Family Planning Advocates represents, in addition to those eleven Planned Parenthood centers, free-standing family planning clinics, as well as clinics that have associations with hospitals and health centers.

MS. CONBOY: So you are affiliated with Planned Parenthood?

MS. PEDO: Yes. We represent them.

MR. KENNEDY: Thank you. Thank you, Ms. Pedo, and thank you for allowing us to move along by summarizing your testimony.

Next we'd like to hear from Richard Herrick, who is the President and Chief Executive Officer of the New York State Health Facilities Association.

MR. HERRICK: Thank you. Good afternoon. My name is Richard Herrick,

President and CEO of the New York State Health Facilities Association. I appreciate the opportunity to present the following thoughts, ideas and proposals to the Planning Committee of the State Hospital Review and Planning Council. NYSHFA has approximately 275 members and represents both skilled nursing facilities as well as assisted living residences. Although our members are primarily proprietary, we also have voluntary as well as county facilities in our membership. As a state-wide association, we are also the New York State affiliate of the American Health Care Association, which represents more than 10,000 nursing homes nationally.

I have included for your review my comments, as well as an attachment. My comments today focus on the CON process and related programs for skilled nursing facilities, realizing that they can impact and influence the entire health care delivery system. For that reason, we feel it is important to continue our open dialogue with the Health Care Association of New York (HANYS), New York Association of Homes and Services for the Aging (NYAHSA), as

well as other regional associations across New York State. Additionally, being an affiliate of the American Health Care Association provides us an opportunity to access information from other states across the entire nation as it might relate to the subjects that we are discussing today. Before addressing specific proposals, I think it's important that a review of the goals and objectives of the CON process be revisited so it is clear to all parties at all levels of the CON process as to, one, what should be the expected outcome, two, what should be the expected time table to achieve that outcome, and three, do both of these meet today and tomorrow's needs in a rapidly changing environment.

Proposed reforms to the Certificate of Need process: We all agree that we are in a rapidly changing health care delivery environment. One would think that the value and timeliness that are achieved by the CON process must be a significant benchmark to measure the performance of any system that is accountable to those who use it as well as those who are impacted by it. We are faced with a significant

challenge, and that challenge revolves around that we are in a rapidly changing environment, which is a highly-regulated environment. Those two factors are at opposite poles and are working against each other. In order to effectively deal with these conflicting demands, we have the following suggestions: Establish and clearly disseminate the rules and expectations of the process prior to applicant submission. Current applicants need to be grandfathered when changes are called for. Establish a list of timetables, perhaps by category of applicant, which will hold all parties accountable for achieving the desired outcome in a timely fashion. For example, throw out change of ownership. Can it be done in ninety days? Delegate some of the processes to professionals for self-certification, i.e., architects, CPAs, attorneys. Establish competitiveness among proposals so that innovation, cost effectiveness and ultimately value can be achieved and acknowledged. Eliminate "policies of the day" hurdles which -- both unexpected and inequitable, that result in unintended consequences, i.e., giving up beds

after a contract has been signed.

While revisiting some of these issues, it is important that New York look outside its box to see what programs and tools are being utilized in other states, in other parts of the country. That would help it achieve its intended goal and desired outcomes. A national consulting firm, Larsen Allen, which I mentioned today, which has worked in other states to create new demand models, known in New York as a bed need methodology, which we feel considers many other important influences to consider today and tomorrow's needs, should be reviewed. In addition to looking at demographics, which is the traditional approach for bed need, it also considers the wealth of the community, the workforce availability, the financial commitment or lack thereof of alternative long-term care services, and also, the pattern of practices of the major referral sources to nursing homes.

We are aware that this model is being examined in Western New York, and we would suggest that that experience may well benefit the entire State.

While we applaud the update to the

capital reimbursement limits for replacement of new facilities, we also think it is very important and of great value to encourage modernization of existing facilities and revisit those policies which, up to this time, have discouraged a cost-effective approach to meeting today and tomorrow's needs. A discussion must continue in areas of character and competence, management agreements and other areas around governance of operations, so that the best and the brightest are encouraged to participate in the leadership of these organizations in the future.

In conclusion, I would like to bring your attention to the attachment from the Kaiser Foundation, which shows the nationwide occupancy by state of nursing homes, which may lead you to the conclusion that New York -- in New York, the CON process, up to this point, has worked quite well. And while we might concur, it begs the question, why was it necessary to have Berger right-sizing and the apparent ongoing discussion about voluntarily giving up beds? Regardless of our opinion of the past, the question we are addressing today is: Will the system serve us

well in the future and bring value to those that we serve?

I want to thank you for giving me the opportunity to share my views and thoughts, and I'm open to any questions.

MR. KENNEDY: Thank you, Mr. Herrick. Questions? Mr. Kraut.

MR. KRAUT: Mr. Herrick, in the character and competence applications, particularly from your members, we've had an issue with discussing -- can an eighteen-year-old member or board of director member of a nursing home, who is eighteen years old, be competent to serve as a director of a nursing home? And we're just trying to figure out what it means for character and competence. Can you comment on that?

MR. HERRICK: I can answer it as a parent, but I guess I'd better answer it as --

MR. KRAUT: Frankly, if you were able to answer it as a parent, I don't think we'd have a conversation. I think there would be unanimity.

MR. HERRICK: It is a very challenging question and it's a very important

question. Obviously, your initial reaction might be to say eighteen years old and so forth, lacking, if you will, life's experiences and so forth, would raise questions and so forth, but its not, in our view, quite that simple. In the particular case where there are families that have long-standing experience and for one reason or another, they want to pass that particular asset, take the extreme case where the principal owner passes away and he may leave his only asset in his estate to that which may be that nursing home, by basically saying that that situation has to be nullified because of character and competence and force that facility to be sold, there is a whole range of equitable -- inequitable issues that you have to deal with. And we certainly have had discussions with the Department with regard to this particular subject, and I'm not saying we came up with any profound answers to it, but in the ideal world -- which none of us live in -- but in the ideal world, you would like to see the operator of a facility have vast amounts of experience, ideally be a licensed administrator, have a considerable amount of wealth, a

considerable amount of experience and not have any particular health care delivery issues, deficiencies from the survey process and so forth. I would suggest to you that that particular applicant doesn't exist. And in many ways, if you have a significant amount of experience in this business, and in my prior life, I operated nursing homes for twenty years, I would basically say to you keep in mind you're in the problem business. You are going to have problems. You are more than likely going to have deficiencies because of the survey. It's more how you deal with those problems, how you manage them and how you correct those problems and move forward, if you will. So it is not an easy question to answer. I could also basically suggest to you that perhaps twenty-one might also not meet that particular test, and I think at the end of the day, we're going to have to come to a particular position where, when you look at the settings in the nursing home and realize that there is a requirement in a nursing home that has a licensed nursing home administrator run that particular facility and be accountable for the rules and regulations,

the quality of the facility and so forth, to whomever the owner is, that does make a difference. It should make a difference. I would also suggest, you saw in my remarks, my opinion, if you will, as it relates to revisiting the issue of management agreements, so that in the event that that occurred, that example I just gave, that that estate could reach out to a competent, experienced operator to act on behalf of the estate, and ultimately that heir, to operate that facility. It works very well in other areas, in other settings. So I may not have the total answer for you, but I think there are some areas that can be explored to deal with it.

MR. KENNEDY: Mr. Abel.

MR. ABEL: How can the CON process be improved to improve quality of care in nursing homes?

MR. HERRICK: I think you may have seen me use the word "value," and we talk about cost, we talk about quality. I think one of the things missing from healthcare is value. It is not necessarily -- we all want -- no one is going to testify that we need less quality. No

one. I would like to think no one would do that. And we always talk about cost. At some particular tipping point, the services that are being delivered at a particular cost have got to equal to value. I think my major reference is the timeliness of the whole process. And I've suggested ninety days, just as a talking point, if you will, for change of ownership. In this environment that we're in, it's a rapidly changing environment. For example, if you had a CON applied a year ago and you're reviewing it today, I would think you'd all know that the banking environment has changed substantially in twelve months, and it may well affect the ability to get that particular transaction done. So speed is important. We're all being asked, basically, to adapt to change, either culture change or everything else, but timeliness is a very, very important issue. When you look at the Berger Commission, the Berger Commission, whether you agree with it or not, it basically had a time frame connected with it by which it had to be done. The measure of performance with Berger was not only the number of beds but the timeliness of getting it done, and I think the

opportunity is there to basically time frame around it, and I'm not saying that just to make -- because the Department has to work harder, work quicker and so forth. The applicants who have a responsibility to bringing a completed package to you, so that either it's an aye or nay in a given period of time. There would be a -- basically, a definition, if you will, to the process, because as you certainly know, the approval process is just one part of getting many of these projects through. There's lending. There's local permitting that's necessary. There's environmental issues that have to be addressed. And having experienced it quite a number of times, this is only part of it. So putting timeliness onto the particular applications, I think, would hold all parties accountable for getting it through the particular process.

MR. KENNEDY: Dr. Garrick.

DR. GARRICK: I just had a question about your opinion regarding the CON process and the unevenness of the playing field.

MR. HERRICK: Dr. Garrick, I don't think I used the word "unevenness of the playing

field," but predecessors did.

DR. GARRICK: I'm not sure if they're gone or not, but the question was -- one of the things that was commented on by other speakers was that CONs, in some institutions, are not necessary for the acquisition of certain high tech equipment, whereas that same equipment would require a CON if it was being acquired by a hospital. And I was wondering what your thoughts were and whether or not that is something that you'd be able to address.

MR. HERRICK: Well, it is a little bit off of my primary concentration, but it would seem the CON process, if nothing else, provides the dialogue that's necessary to talk about these issues in a public forum. Whether that becomes a strict rule of approval or whether it becomes the basis of sorting out what is best to meet the particular community need, we certainly do think that it's an important process. But there are many other influences in the community today that we need with regard to providing the needs for the community. Why I referred to the consultant's report is I had an opportunity to sit through the determination

need process that was put on for Minnesota and Florida, and they've expanded it to look at the community wealth as being the indicator of where some needs are. If people can pay for it out of their open pocket, they may not need the CON process, but those that can't may need to have those services there. The workforce is there. In our best instance, we can basically say there are services that we would fully acknowledge can be provided in the community rather than a nursing home, but if those services are not there or if the workforce is not there or if the financial commitment is not put in place to put them there, you are still going to need the nursing homes, be it for a safety net for the system or whatever it may be. That's our point with regard to kind of looking at the new influences as they're out there.

MR. KENNEDY: Thank you, Mr. Herrick, for your presentation. At this time, we'd like to hear from Michael Alvaro, Executive Vice President of the Cerebral Palsy Associations of New York State.

MR. ALVARO: Good afternoon. Thank you very much for inviting us and including us

in this presentation today. We have a number of affiliates across the State. We have twenty-four -- I want to tell you a little bit about us, first, because I think after listening to a number of the acute care providers and the nursing homes and all of the other groups, they're a lot more developed than we are across the State. They've got different issues. And I want to tell you a little bit about us today, because we do run Article 28 clinics across the state in twenty-two sites, but we serve a significant component of the health care spectrum and we are part of the health care continuum. Our agencies were founded sixty years ago by families who weren't able to find services elsewhere. The services that they looked for were basically therapies. Eventually, we developed schools and other programs, but they're basic health needs that the hospitals were unable, unwilling and physicians were unable or unwilling to offer the people who had children with cerebral palsy or other significant developmental disabilities. Our Article 28 clinics have grown over time or came out of that initial -- filling that niche,

that part of the health care delivery system that wasn't there, and for almost forty years, we provided health care services that fit a special place in the health delivery system, and we now have providers who are continuing to provide those services and trying to provide those services and have gone through the Certificate of Need process for anything from a change of address to addition of another service and have met with resistance, largely because the needs assessment process really looks more at the acute care system, and rightly so. It's a lot -- if you look at the numbers out there, it makes sense, but they don't always take into account our folks, the true needs that we've got. If you show an area that has gynecological services or other services that are in abundance, they may not be there for people with disabilities. There's a real specialty component to the services that we provide. We have a group down in New York City, our affiliate down there, the UCP of New York City. The medical director there is working with New York University Medical School, and they've developed a program as part of their training

component to make sure that physicians going through the medical school now have an understanding of the specialty needs and the specialty services that are necessary. So as that idea of the specialty practice has developed, we really are working across the State with all of our medical directors and all of our clinics to make sure the community, at large, understands who we are. The SHRPC and I know the Department of Health, over time, doesn't always -- their needs assessment process and the CON doesn't always take into account those special things we do. So I will be very, very brief today.

We have a number of very specific recommendations that you'll see about the process that -- they may be considered minutia, but basically they echo what you heard already. There's a timeliness issue. There's a lack of clarity in the instructions or instructions in the process, and the point of contact for our folks isn't always clear. They're getting different information from State versus the local Departments of Health in terms of CON applications, and we'd like to see that so it

makes more sense for our providers. We have, you know, a couple ideas about streamlining the process. One of the things that was mentioned earlier is financing isn't always necessarily tied to the process. It doesn't make sense. Our providers are able to somehow finagle some kind of financing. They're not usually the robustly-funded organizations that some of the others out there are looking for, their Certificate of Need applications, and we are not always able to maintain that approval for financing based upon the untimeliness and lack of speed in the approvals for our services. So what I'd ask simply is that as you're looking to approve, streamline or otherwise change the Certificate of Need process, you'd keep in mind some of the specialty services that are out there, the clinics that we have across the State, and anyone else who really is filling a niche that otherwise isn't met or a need that otherwise isn't met in the health care continuum. And given that today's meeting happens to take place on a very significant day for some of us who live in Saratoga Springs, I will end right there. So I'll see if there are

any questions.

MR. KENNEDY: Dr. Berliner.

DR. BERLINER: Thank you. A question. Are there any data sources about people with disabilities that would be available to review in terms of when we do analyses?

MR. ALVARO: It is very difficult to find data sources. We have a medical directors' group that meets regularly, and they, themselves, really are the strongest group to talk about evidentiary or evidence-based information. Whenever they get together, they complain about the lack of information and the resources. So I don't want to say it needs to be an anecdotal, but there are providers and there are forty-one clinics in the Cerebral Palsy developmentally disabled grouping, the reimbursement grouping in the State. There's forty-one of those clinics. Those clinics themselves really would be the best resource for information on needs of people with disabilities.

MR. KENNEDY: Thank you, Mr. Alvaro, for your time and your presentation. At this point, we'd like to hear from Tim Bobo, who

is the executive director of the Central New York Health Systems Agency.

MR. BOBO: Good afternoon, Mr. Kennedy, Dr. Berliner, members of the Hospital Review and Planning Council and Public Health Council and Department staff. My name is Tim Bobo. I'm Executive Director of the Central New York Health Systems Agency, or CNYHSA, and I'm pleased at the opportunity to provide input on the topic of CON reform on behalf of CNYHSA. Our agency has been involved in CON review for over thirty years, and I believe it is important to maintain and enrich the CON process at the local level. There is a real advantage to linking CON reviews to local planning, which has a potential for collaboration and development of projects that grow out of the planning and consensus building process.

There is considerable value in local input in the CON process. Local participation fosters credibility and legitimacy. It needs to be broad-based and reflect the interest of different parties. It brings with it a better understanding of local needs and factors which may be unique to the area. This is confirmed by

our experience with reviews over the last several years. In dialysis, where a hospital and private practice application were clearly duplicative, the local process was a major factor in a resulting partnership approach. A community dialogue component of our review of the Upstate Medical Children's Hospital proposal dealt with concerns from outlying hospitals for more active participation in the collaborative regional approach to pediatric services. A hospital review brought out the dynamics between hospitals and private practice approaches in radiation oncology and the need for a single integrated solution focused on the continuum of cancer treatment services. In one hospital, cardiac catheterization review documented hospital size and utilization as a major factor for approval. Another review highlighted the need for cooperation with neighboring hospitals and physicians.

A local CON process can and should be focused, selective and concentrate on proposals that have high impact on the community, relate to technology diffusion or specialty care, are politically sensitive or controversial,

represent obvious duplication, are based on poor or inflated documentation of need or may be inappropriate for the type of facility.

CON reviews can be improved by more population-based as opposed to provider-based approaches to understanding of need. CNYHSA work in this area has included radiation oncology, where we created an Upstate database by using Finger Lakes HSA data, a local CNYHSA provider survey and telephone interviews with Northeast New York providers. In cardiac catheterization, we downloaded data from the State CON and operating certificate files and discovered that the hospital under review was one of a few with over 200 beds that didn't have the service, while a high proportion of smaller hospitals did.

In chronic dialysis, we abstracted data from a Statewide report, found a population-based zip code database unknown to the Department and used national survey on age and race-specific trends.

More updated population-based methodologies for examining need should also be pursued and allow for dialogue and debate

between State and local planning interests on ways to measure need. Very little research on need methodology topics has taken place in the last fifteen to twenty years.

These recommendations are consistent with the Department's objective to promote population-based planning, which I heartily support. I note, however, that the recent SPARCS annual report multi-year posting has dropped all population-based tables.

For public notices purposes, the Department should consider development of an online CON database that is searchable and selectable by provider, date and location. A one-page CON form might even be required that summarizes all aspects of a proposal. That can be a viewable, downloadable PDF attachment, much like surveillance reports are prepared for facilities or disciplinary actions for physicians. The design should also allow stakeholders and others to submit comments electronically. We currently use our own website in a limited fashion for CON notifications and feedback. In expanding our CON activities, we might also issue "interested

party" letters to solicit input.

The Department's local health planning request for grant applications is a substantive step in promoting collaboration. The mix of local projects anticipated under this effort may provide a good means for testing "best practices" in support of collaborative efforts. The projects would also benefit from a partnership with the Department to concentrate resources on high-potential collaborations, building on the Berger Commission implementation experience and use of CON as a tool to promote coordination. Providing access to data and promoting discussions involving local stakeholders and provider entities are two additional things the Department can do to support these efforts.

On health planning models, speaking from experience in Central New York, my bias is for a model that incorporates or builds on the basic characteristics of a health systems agency. These include a regional focus and responsibility, a Board structure that is diverse and representative of major stakeholders and not tied to any single interest group or

association, a process and criteria for carrying out CON reviews and access to data and an analytical capability, with professional staff resources, to carry out planning and review functions, needs assessments and special studies.

The administrative review process and application form should be streamlined to have real administrative reviews and perhaps allow for administrative disapprovals. Recent changes in forms now require the same information and schedules as a full review application. The concept of a limited review might also be expanded to a class of proposals involving minor renovation, simple service relocation or other relatively minor changes. What would remain is Department oversight on architectural, reimbursement or site inspection requirements related to the project.

Financial impact is a difficult issue given the relatively small, marginal impact of almost any single project or service on the overall cost of care. How it should be applied in CON review could first be explored through development of standards, guidelines and

principles of cost effectiveness. Finally, it is appropriate that need methodologies be modified to better reflect factors which include the unique needs of rural areas, promotion of growth in community-based long-term care and health disparities. Some type of scoring or weighting might be applied to account for these types of factors.

In closing, let me emphasize that the CON process is wholly justified to the extent that it contributes to improved health care and health care outcomes, access and quality, and at the same time, results in cost-effective investment decisions and cost savings. In the end, it should promote more proactive rather than reactive outcomes, ones that are less institution based and more reflective of collaborative efforts on a community-wide basis.

That concludes my remarks. I'm glad to respond to any questions.

MR. KENNEDY: Thank you, Mr. Bobo. Any questions? Tim, I have one. There have been several remarks characterized in traditional health systems agency planning as being politicized. In your view, since the

whole process has been deregulated or unmandated, can you comment on that in terms of the existing -- well, in terms of your existing HSA?

MR. BOBO: I can only speak for our agency. In our case, I think there were a number of safeguards that have been used to really minimize the amount of political inputs. I'm not saying that the system is immune to that, but there are ways to minimize it.

MR. KENNEDY: Ms. Lipson.

MS. LIPSON: You mentioned in your testimony that the need methodologies should be revised to respond to the needs of rural areas and issues such as health care disparities. Do you have particular suggestions in that regard?

MR. BOBO: I don't have any specific suggestions with me today, but it is important that particularly, the issue of health disparities, service in rural areas and access in those areas, that that be given special attention. And I'd be glad to work with the Department to scope out some of those ideas.

MR. KENNEDY: Any other questions? Okay. Thank you, Mr. Bobo.

MR. BOBO: Thank you.

MR. KENNEDY: At this point, we'd like to hear from Al Cardillo, the Executive Vice President of the Home Care Association.

MR. CARDILLO: Thank you, Mr. Chairman, members of the committee, Department staff and ladies and gentlemen. I'm here today on behalf of the Home Care Association of New York State, and we are pleased to provide our comments and recommendations to the committee and to the representatives of the State Department of Health regarding your examination of the Certificate of Need process.

The Home Care Association is comprised of over four hundred health care providers, allied organizations and individuals involved in home care in the State of New York. We represent the full range of those who participate in the home care system. Certified home health agencies, long-term home health care programs, managed long-term care programs, licensed home care services agencies, hospices and AIDS home care programs, and that's along with other ancillary providers.

The Certificate of Needs process is

unquestionably critical to and intertwined with the State's framework for health care policy, financing and State and local system operation, and so HCA especially appreciates the importance and the potential opportunity and possible consequences of this effort that you've launched, and we do very much appreciate having been invited and earlier on, having had some briefings with Department staff on this initiative.

You've heard today from many speakers representing facilities clinics. I know that my counterpart from the other association described home care, but I think it's important that we emphasize that home care services are certainly distinct from most of the projects that come through for your review, because our agencies are not facility based. Our services are delivered in patients' homes and in the community. So therefore, our capacity, the capacity of our services, the local resource and the needs are not tied to bricks and mortar or to beds or facility size. They are tied to the staffing resources available to the agencies, as well as to the characteristics, strengths and

challenges of our actual service delivery environments. Home care is also distinct in that we're one of the primary areas targeted by State policymakers for a positive shift in the movement of the health care system. We believe that home care is the ultimate model in service flexibility because it can grow or contract in response to -- in accordance to the needs and resources, and without the need for either construction or demolition, as the needs fluctuate. But in order for home care to truly be what it is and to be able to serve a function and meet the need, there needs to be an investment in a responsive State support of our system through the Certificate of Need process, a positive policy framework, which is imperative to providers' ability to function and adequately meet State and local health planning needs. We commend the council in the breadth of the questions and issues that you asked us to explore. We'll address a number of them in our comments today, but we are also continuing to vet those questions and issues that you gave to us. We intend to supplement the more cursory comments that I'll make today with more details

in terms of suggestions and issues, and we look forward to doing that, but at this time, I'll offer comments and recommendations on a number of priority concerns.

The first is really more global. One, streamlining of the entire Certificate of Need process, and you know, this is a theme certainly you've heard from many speakers today. That the current process imposes layers of review or cost thresholds between the administrative and full review and other elements which complicate and delay the process with consequences for all concerned, the Department, this Committee and the Council, the applicants, the community, and ultimately, the patients who would benefit from the proposed project. In addition to just simply moving a project through, the fact that the State has an over-arching policy to shift the emphasis toward community-based care, a decision which directs the states to ensure that there's capacity for care in the least restrictive, most appropriate settings, and ranging to things like disaster preparedness and service in large rural areas. Some of these are additional concerns that would certainly compel

a streamlined process in the Certificate of Need review. So we recommend that the Council and the State really undertake a complete review of the process, which we know you are doing and which we greatly appreciate, to look for the associated benefits of reduced administrative burden on all levels, reduced cost, reduced time frames for decision-making and the like. We believe that the opportunities could begin with some targeted areas, if across-the-board changes will take some time to implement. So again, our first recommendation is more globally in terms of the process.

A second area that I'd like to speak about is really very specific and very technical, and it probably represents one of the more problematic areas for our membership. I mentioned that we service long-term home health care programs, also known as the Nursing Home Without Walls Program. We represent the better part of the 108 providers of long-term home health care in the state. They are the only statewide home and community-based service which has a rated capacity or slotted capacity for each provider. And as when the nursing home is

approved and it's approved for a number of slots, these programs are approved for a number of slots, as well. This issue of the slots for the program really has its roots in the originating statute which was enacted thirty years ago and again, was an attempt to analogize and make the program analogous to the nursing home sector. But that was at a time, also, when the system was still very much taking shape as we know it today and when the overall policy of institutional alternatives were also just coming into their own. So since that time, the other sectors have evolved, so that side by side with the long-term program, there are -- whether it's certified agencies, personal care licensed agencies, there are no capacity limits on those programs. So what it means is if you are the provider of a long-term home health care program and you're at your census, you have to apply to the Department, through the CON process, to serve additional patients, so that means you have to wait for that process to go through.

The Department has a requirement that in a county -- that the census of all of the providers in a county have to come up to

eighty-five percent of the total capacity in that county before an application for an expansion will be considered. So that means if you've got a program and you have one hundred patients and your census is one hundred and you have ninety-five, if somebody else is not at that point and you're not at eighty-five percent, you have to wait for an expansion until that other process comes into place. Regrettably, we're aware that some of our providers have waited three and four years, and we currently have them in a hopper for an expansion. Given the length of that kind of review, it really impairs the ability to serve additional patients. It impairs the freedom of the choice of the patient, because they can't access the provider, and it generally has a very delicate affect on the referral process on an agency that's stuck for three years and can't admit other patients.

So we have some very specific recommendations that we would like to make to you in this regard. First, we would like you to consider eliminating the need for these capacity expansions to go for full review and to consider

it more as an administrative function of the Department. Secondly, we would ask that you consider a change in the policy so that when a provider reaches capacity, their census reaches capacity, that you allow for flexibility over the capacity. As long as they file the application and they're awaiting approval, you allow for them to admit additional patients in the interim. Now, the Department of Health has a policy which allows the provider to go ten percent over capacity, but that's mainly so that when a patient is on the program and they're discharged from the hospital, there's a place for them to come back to. So we're asking that for the Department and the Council, in your recommendations, to consider a broadening of that, perhaps to twenty-five percent or twenty-five patients. And that proposal was reflected in a legislative proposal by Senator Hannon, which he introduced this session.

We would also suggest that the entire process of whether this program ought to be singled out for limited capacity should be re-evaluated for justification in 2008. It might have made sense in 1997, but it may not

make sense in 2008. And then finally, we recommend that the eighty-five percent threshold is eliminated for some of the reasons that I mentioned, in terms of the effect on both patients and providers.

MR. KRAUT: You have five minutes.

MR. CARDILLO: Yes, sir. Thank you. So moving to another category, we also recommend a streamlining in the Certificate of Need process in certain particular areas. With respect to the cases of the merger, the consolidation or the closure of home care agencies, often, there certainly is a great deal of change going on within the system among all health providers, and principally, in home care. A big change has occurred in the public system of -- the public health system of home care agencies. And so in order to adapt when an agency either needs to close or needs to scale back its services, very often, large communities are really at risk of not being fully served. There is a provider right now in a county of the State, in a very rural county, that's in the process of closing, and the next provider that would try to move in and service this county

also serves two other rural counties, so you really have a situation where it's important that the process be put in place which expedites the arrangements for being able to maintain services in those communities. And I would also add that when an agency is troubled and is perhaps considering decertification, that we would hope that the Department would attempt to reach out in an attempt to maintain that agency if it's a benefit to the community and the system to do so.

The next issue relates to the compatibility of the Certificate of Need process with the Berger Commission recommendations. As most of you know, most of the Berger Commission recommendations are predicated on the availability of home and community-based care to take up the slack for contracted hospitals and nursing homes. So we ask that in your examination of a review of the Certificate of Need process, that the provisions be compatible where home care agencies in those areas have to expand to fill the demand.

We also ask for consideration of a flexible process where providers have innovative

proposals to either improve the quality of care or make the system more efficient or to improve access. Again, a similar theme of trying to support that meritorious process that benefits the State and the communities.

The one area where we think is very important to examine is in the case of new models, which are routinely being established, but not all of which are part of the Certificate of Need or public need process. In those circumstances where there is not a citing process for these new models, there's a destabilization in the community when suddenly something comes up and is established which has not been established by the same ground rules as perhaps another initiative. And so we recommend that as a course of policy, that any new initiative which is going to have an effect on the infrastructure be assessed in terms of its impact, be assessed in terms of perhaps the merit of utilizing the existing infrastructure before it's just cited in the community.

One of the areas that you asked about very specifically was collaboration and care of special needs patients, and I want to just take

a second to talk to you about a policy that the State currently has to live within that emanates from restrictive policies from CMS, in that if you are -- CMS has very restrictive policies for serving patients from two different wayward programs, and as many of you know, more and more, we're developing waivers to create flexibility. Well, if a patient could be meritoriously served through the collaboration of two providers, CMS has very restrictive policies in that regard, and the Department fairly much has a directive which precludes that joint service. We would ask you re-examine that policy. There are patients with AIDS, mental health conditions, pediatric cases, throughout the State that are unable to be served in a collaborative manner because of this restriction. We've had a number of meetings, our association, with CMS and the congressional delegation, New York Congressional Delegation, to bring this to their attention, and I would submit to you that a process which precludes that level of collaboration is really akin to saying to an individual, If you need a psychiatrist and you need a physician, you can't

have both. Pick one, 'cause that's what the patients are asked to do. Pick one or pick the other and let that provider serve you in total. So we ask your review of that.

Finally, we would say that --

MR. KRAUT: We are at fifteen minutes, so if you just want to make a summary statement.

MR. CARDILLO: I will. I will. In summary, I would say that we, again, appreciate the opportunity to have presented to you today. We also support the issue of local input as long as it is from an unbiased mechanism and a mechanism that doesn't bottleneck the process, and we look forward to working with the Committee and the Department as you go forward in this process.

MR. KENNEDY: Any questions or comments for Mr. Cardillo? If not, I'll thank you. Thank you, Mr. Cardillo. And then welcome Mr. Rick Abrams, who is the Executive Vice President and Executive Director of the Medical Society of New York State to come forward.

MR. ABRAMS: Thank you, Mr. Chairman. Thank you very much for the

opportunity. My name is Rick Abrams and I'm the chief staff officer for the Medical Society in the State of New York. We are a Statewide physicians' organization in every county of the State of New York, representing every specialty within the State. At the outset, our president, Dr. Michael Rosenberg, had hoped to have been here today but could not do so. Therefore, I'm going to try and pinch-hit effectively for him.

Our testimony has been provided to you. Certainly, you can refer to that testimony. I will be outlining it, but what I'd like to do is I'd like -- I've been here for about ninety minutes. I know you've been here for much longer, but I'd like to address two themes that I heard as I sat in the back or I stood in the back waiting to testify. And the first is something Dr. Reed -- that you had raised and some others have raised, and that is whether consolidation of health care services, health care delivery is good for -- is the right policy for the State of New York. And the medical society, State of New York, I, personally, wholeheartedly agree that it certainly is, because when one looks back at the history of

our Certificate of Need process in the State of New York -- quite frankly, I spent many years working in the State of New Jersey, and the public policy goals of any health planning or Certificate of Need process are laudable ones, and in my mind, there are three. Certainly it's cost containment, it's providing efficient and effective health care services and it is providing robust access to, in this case, every New Yorker, regardless of where they live and regardless of their socio-economic status. And when we look at the whole concept of consolidation of services, both horizontally among physicians, if you will, and vertically, by way of example, hospitals and physicians, I believe firmly that two of these three very laudable public policy goals are easily accomplished, and with attention and focus and hard work, the third will absolutely be accomplished. The two that are easily accomplished, in my opinion, are cost containment and efficiency. It is access and assuring access to care, especially in our rural areas or in our depressed urban areas. We're going to have to look a little more closely and

really focus on those, but with collaboration, decentralization, localization, if you will, that, too, can be achieved. So Dr. Reed, in direct answer to your question, the Medical Society of the State of New York absolutely endorses the whole concept of consolidation of services, again, both horizontally and vertically.

The second theme or the second issue that I've heard in the ninety minutes that I've been here is the whole concept, if you will, of, quote, "leveling the playing field," and I would suggest to you, ladies and gentlemen, that when we talk about leveling the playing field, I think we're a little off on where we should be. In my opinion, when we talk about leveling the playing field, the focus is on the provider of service and not where it should be, and that's on the New Yorker and on the patient. Okay? And again, I certainly mean no disrespect to anyone around the table, but when I read the letter and I read the law and all that has been written, certainly we all need, from Governor Paterson on down, need to focus on the creation of a patient-centered health care system that

provides the best quality of care we can at the lowest possible cost that we can, in the most -- in the least restrictive environment. So when we talk about patient centeredness and we talk about leveling the playing field, in my mind, the way that we accomplish that is that certainly, we need to embrace new technologies, we need to embrace new ways that we can deliver care efficiently and effectively and in the most community-based setting possible. However, at the same time, if indeed, the ramifications or the resulting effect of doing that is, if you will, to starve the safety net -- in this case, let me give you the example of providing office-based surgery and the impact that perhaps that may have on our acute care hospitals. While I, for one, absolutely would endorse the continued progression and evolution of office-based surgery, on the other hand, we can not ignore the very, very important role that our hospitals and that, at least to some degree, our nursing homes, our sub-acute facilities play as being a very, very important safety net for people who might not have access to those office-based surgeries.

You know, when I was in New Jersey, a very, very long-serving State official who ultimately became the State Commissioner of Human Services, Bill Waldman -- Dr. Berliner knows Bill Waldman, I'm sure, very. Very well. But in a budget hearing one year, Dr. Waldman was asked -- he said -- Commissioner Waldman -- he said, Well, as we move mental health services out of the institution and into the community, that will save money, correct? And Commissioner Waldman said, Absolutely not. Ultimately, ultimately a community-based system may very well result in a cost savings, but as you continue to run two systems at the same time, and that is, as you bring down, if you will, the facility-based system and transition into that community-based system, for a time, it may very well cost more money to achieve that long-term goal of patient satisfaction and cost containment. My point is, ladies and gentlemen, again, that focus on patient centeredness, the focus of allowing new technologies and new ways to deliver care, we should embrace that, and the Medical Society of the State of New York stands with you and all of our colleagues, both

consumer and health care deliverers, to try to achieve that goal, while at the same time, we need to make sure that that safety net is maintained.

At this point, I've probably used about half my time addressing those two points, but I think they were absolute themes of this hearing, at least to the degree that I heard them, and I think that as you move forward, I think they are very, very difficult but certainly important issues that we need to grapple with.

As you review the testimony, what you'll find is you'll find a very, very comprehensive -- and I give kudos to my staff who put together this testimony -- I think a very, very comprehensive assessment of the history of Certificate of Need and also the upside, if you will, and the downside of our current Certificate of Need process. But I'm going to focus, really, on some of the points that we make at the end, and that is observation, some of which I already made, but also, recommendations. And what I'd like to say is really make four points, some of which I've already alluded to. First, I think that what's

critical as we move forward in really trying to serve the needs of all New Yorkers is that the system, to the degree that it is not so already, be decentralized and localized. Tip O'Neill, as well as many others before him, and I know after him, talk about politics, all politics, as being local. I would submit to you, ladies and gentlemen, and the providers and professionals around the table, I think, would agree with me, that health care delivery is even more a local endeavor. Therefore, the localization of health care planning and the determination of the needs is absolutely critical. Now, in saying that we've got to localize and decentralize, certainly the providers of health care have to be at the table. The consumers of health care have to be at the table, but ladies and gentlemen, I believe the group that we have too long left out a lot of the time is the payers of health care. Now, my payers, I don't mean the insurance companies. Okay? Because they are the payers to the providers of health care. What I mean by the payers are the businesses, and to a degree, the individuals who pay the bills, who pay the health care premiums to

provide the payments to the health care providers, and business has absolutely got to be at the table, ladies and gentlemen, because from my perspective and from my experience in Albany, in Trenton, New Jersey, and in Washington, D.C., when you ask the business person about health care efficiency, they talk about cost containment and the discussions stops. We have got to educate the health care community has a responsibility to educate the business community that efficiency in the delivery of health care is a heck of a lot more than just cost containment. It's about robust access for people, their employees. It's about the quality of health care delivery, again, in the most effective, most cost effective and least restrictive environment for people, and unless we can pull business to the table in a decentralized structure, we're going to be continually impeded and continually engaged in what I always call the knife fights behind the scenes, and that impedes progress and we don't have time for that. Secondly, it's been alluded to --

MR. KRAUT: You have five more

minutes. You have five more minutes.

MR. ABRAMS: I can do that. Thank you. Secondly, and again, it's been alluded to, collaboration is essential. In the four and a half years since I've come to New York as the Executive Vice President of the Medical Society of the State of New York, we have made -- we have made strides before, but I could tell you that one of the focuses of the time that I have been here is to work without partners in health care and to work with consumer groups. So what we have done is we have established very, very comprehensive and tight coalitions with HCANYS, the Health Care Association of New York State, the various regional hospital associations, having come from the long-term care -- facility-based long-term care profession, Dick Harrod, Bob Murphy, our good friends, and really, with the recognition, again, that the challenge and that the goal is that it's all about the patient, ladies and gentlemen. It ain't about the doctor. It ain't about the nursing facility, and so on down the line. And a nursing home owner told me over twenty-five years ago, when I got into health care, 'cause I

asked him -- his name was Bob Friedman. I said, Bob, I said, How do you provide such good care to people in your facilities? And he said, Rick, he said, the formula is very simple. He said, If you provide quality care and you focus on the patient or the resident of your facility, everything takes care of itself.

So my point, ladies and gentlemen, with collaboration, is that if we can continue to work together, that is, policymakers, hospitals, all providers and professionals of health care, and focus on the patient, we can get -- we can push over the finish line in grand fashion.

So the second point and the second principle is the critical need of collaboration. The third point that I would want to make -- and really, it talks about a new and innovative model of care is the whole concept of clinical integration. Again, it's very, very closely related to collaboration, but through clinical integration, groups of physicians or groups in hospitals, really, they come together and they provide protocols of care and quite frankly, negotiate for payment of care. The great and the very, very exciting thing about the whole

concept of clinical intervention is that finally, what we have the opportunity to do, again, whether it's hospital, physician, physician, physician, again, vertical or horizontal, is that we can bring together -- we can bring together, ladies and gentlemen, the important concepts of quality and outcome measurement with fair payment. So from the standpoint of the Medical Society of the State of New York, we believe that in moving forward, we stand ready to work with all of you with a focus on decentralization or localization, collaboration, new concepts like clinical integration, and we believe -- we believe that by focusing on concepts like this, you can, one, be true to the historical purposes of health planning and Certificate of Need. That is, robust access, efficiency in cost containment, while at the same time, deliver the health care and be responsive to the health care needs of all New Yorkers in the 21st century.

So with that, I'll conclude my remarks. Thank you so much for the opportunity to be part of this great public hearing. And in my remaining time, I'd be happy to answer any

additional questions that you all may have. Thank you.

MR. KENNEDY: Thank you, Mr. Abrams. Any questions or comments? Yes. Mr. Cook.

MR. COOK: Another theme here today was the importance of information and data as we assess this. I'm wondering where you are on providing us information and data on physician offices?

MR. ABRAMS: In what respect, sir?

MR. COOK: Claims, the types of work that's going on. As we assess the market and have to make decisions about planning, much of the discussion here today is we really need good information, but we don't really have good information as it comes from physician offices.

MR. ABRAMS: We would -- I will tell you that we have not -- one of the areas, frankly, where we fall short is collecting on a continual basis, operational data within physicians' offices, certainly within the parameters and the anti-trust and other things, but we would stand ready to respond in any way to any requests that the -- that this council

would have in a very, very transparent fashion.

MR. KENNEDY: Dr. Berliner.

DR. BERLINER: Thank you for your testimony. A lot of the discussion today has really been under the code word "leveling the playing field," which, to some extent, means the fact that institutions are regulated and non-institutional facilities and services are not regulated. How would the Medical Society feel about the regulation of services provided in physician offices, to put it bluntly?

MR. ABRAMS: Dr. Berliner, let me go back to the microphone. I just didn't want to have the -- again, I tried to address that before. You know, I would submit to you, sir, that, at least to a degree -- and again, I'll use the office-based surgery example, physician services are regulated, and again, to a degree, at the call of the predecessor Commissioner of Health, the physician community along with the Department of Health, as well as others, put together what I thought were very, very comprehensive guidelines that are going to govern office-based surgery, that are going to require office-based surgery suites to be

certified. The presumption -- it could be presumed that each and every physician that provides office-based surgery is going to automatically get his or her suite certified. I can tell you that there are physicians, quite frankly because of a lack of finances, who are not going to do that or who choose, because of the heightened requirements, not to do that. As I said before, in trying to address the point -- and I think it was a fair point on the leveling of the playing field, I would say that a blanket regulation trying to compare apples and apples and paint everybody with the same brush is absolutely not the way to go, and I think would basically have our health planning system fall way behind what the needs of New Yorkers are. As I said a few minutes ago, and I'll repeat that, is that what we need to do is recognize and embrace the new technologies in the way to deliver health care, insuring that they are done in a way that, again, does not stymie the entrepreneur and the provider of care, while at the same time, protects the health, safety and welfare of the patient, while, on the other hand, again, recognizes the critical safety net

of our hospital partners.

DR. BERLINER: So should the technology -- the technologies that are regulated in institutional settings be similarly regulated in non-institutional settings? If an MRI has to go through a CON to be approved for a hospital, should it also have to be approved for a physician's office or a clinic?

MR. ABRAMS: I would say that so long as we can develop a grandparenting mechanism for providers of current equipment and services, and the system is a nimble one that can be responsive to the needs of the community, the answer to that question is yes.

DR. BERLINER: Thank you.

MR. KENNEDY: Any other questions for Mr. Abrams? Yes. Neil.

MR. BENJAMIN: I was just curious. Looking at your paper, you talk about current regulated cites and unregulated cites. We don't go past ten years or so with CON. On the regulated side, it appears that more and more what we hear is the public good paying for the public good services, and the argument that comes back to us is how can you drive a system

that has it both ways. It allows for the migration services, whatever, into the unregulated side, the private practice side, and yet continues to burden trauma centers, 24/7 emergency rooms. In the collaboration discussion, does part of your response to that include a way for the private side to distribute care to hospital patients?

MR. ABRAMS: You know, I think that's a great question, Mr. Benjamin, and it's something that we would absolutely be willing to look at, but with that, let me just say -- and again, I'm repeating myself, that again, I think that the development of community-based services, whether they're physician services, I think that's a good thing and we shouldn't impede that and saddle those providers with the very, very appropriate, necessary safety net services that our hospitals have to provide. And to your question, as far as helping out, if you will, but we will stand ready to assist in trying to address the needs of all of our hospitals with the trauma services and the uncompensated care services, but I would hope that that wouldn't be done in such a way that,

again, would impede the development of what I think are high-quality, very, very efficiently -- both from a standpoint of high quality and cost efficient services that are provided in the physician offices. It's a delicate balance, but certainly one we would welcome the opportunity to work with you, our hospital colleagues, on and to work with all of you on. I think its a very fair question, sir.

MR. KENNEDY: Mr. Cohen.

MR. COHEN: I'd like to make an observation, 'cause to me, and I'm sort of surprised by your answers, the fact that facilities could be providing services that could be provided in a hospital, and they do it risking their own capital at less cost, sometimes better, more efficiently and at higher quality, to me, it's an advantage to the patient-centered goals --

MR. ABRAMS: I agree.

MR. COHEN: But more importantly, that provider also pays taxes. A not-for-profit hospital, of course, doesn't. So there's justice here. He pays his charitable contributions, and he may not have the active

role, but he certainly has a responsibility to do it. So I think you need to look at this a little wider, with a much greater scope than -- that's not really the question. Its a whole social question that we need to look at, and I don't think we should stack it with something that works well and can be very good just because we haven't taken the scales and actually evaluated each provider's contribution to society.

MR. ABRAMS: Mr. Chairman, if I may?

MR. KENNEDY: Go ahead, Rick, and then Dr. Garrick.

MR. ABRAMS: I -- perhaps I wasn't clear, but I think my statements were consistent with what you said. Thank you. I'm sorry, Mr. Chairman.

DR. GARRICK: Having listened to some of our debates, I actually heard something a little differently when I asked my question earlier, and that was I think sometimes when new technology comes into place, the regulations follow, and then, over time, the regulations should be lifted. So it might be that neither

hospitals nor physicians nor ambulatory surgery centers or anyone else should have to go through CON after time to get a four-phase CT. Maybe in the beginning, it was reasonable for new technology to come before the Board, but everyone would be deregulated if we put accessibility into the right studies, and then, after a time, neither hospitals or other practitioners should be regulated. At the moment, it's cumbersome and complicated, I think, to explain why hospitals have to have a CON process for four-phase CTs is complicated. So I was actually thinking that maybe the group could look at ways to address this that may make technology more accessible and not keep regulations in place in a burdensome way for any part of the health care system.

MR. ABRAMS: If I may?

MR. KENNEDY: One quick comment and then any other questions from the members of the council.

MR. ABRAMS: I think that's an excellent suggestion on how one keeps the public policy nimble and forward looking to accommodate and address the needs of all New Yorkers. I

think that's an excellent point.

MR. KENNEDY: Thank you, Mr. Abrams.

MR. ABRAMS: Thank you, Mr. Chairman. I appreciate the opportunity.

MR. KENNEDY: At this time, I would like to thank all the council members who are here today from the Planning Committee and the Public Health Council. This, and to those of you who have provided presentations and who are here attending. I just want to remind you that the next series will be on September 18th in New York City. I think we're going to title those "How we level the playing field" with respect to CON.

I would also like to recognize the Chairmen of both of the councils who were part and parcel of this happening, and in particular, the staff, Karen Lipson and others, who have been involved with the providers in developing the presentations today and having some, as I understand it, some very, very long and constructive discussions about the response to the CON. Those of you who remember that it was Dr. Berliner, the Vice Chair of the Planning

Committee, who presented on CON, almost two years ago, and today really is a culmination of, I think, that discussion that was started then, but also with the work of the planning committee and certainly the staff in tandem. So with that, I would like to thank all of you again for your participation and involvement. The transcript, as I understand it, of the presentations today will be on the web at some point. Thank you again.

(Whereupon, the Hearing concluded at 4:52 p.m.)