STATE HOSPITAL REVIEW AND PLANNING COUNCIL

PLANNING COMMITTEE

James Kennedy, Chair

New York State
Department of Health
90 Church Street
New York, NY 10001

Thursday,
September 18, 2008
1:50 p.m.

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3 State Hospital Review and Planning Council

4 Michael H. Barnett, Esq.

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1 STAFF PRESENT:

2 Neil Benjamin

Karen Lipson

3 Thomas Jung

James Welsh

4 Charlie Abel

Norman Marshall

5 Christopher Delker

Mary Ann Anglin

6 Doug Reilly

Fran Weisberg

7 Julia Richards

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P R O C E E D I N G S

MR. KENNEDY: Welcome to the September 18th meeting of the Planning Committee of the New York State Hospital Review and Planning Council. My name is Jim Kennedy and I'm Chair of the Planning Committee.

To my left is the Vice Chair of the Planning Committee, Dr. Howard Berliner, and

to my left, also, is the Chairman of the State Hospital Review and Planning Council, Mr. Jeffrey Kraut. Next to him is the Director of Division Policy, Karen Lipson and who was here before was Mr. Neil Benjamin. I want to recognize all of them for without their minds and collective leadership, we would not be engaging in the level of discussion that we certainly have had today in the previous committee meeting, but also in terms of this, today, the second round of hearings that we are having on the Certificate of Need.

We also have with us two members of the Public Health Council, Mr. Stolzenberg, Peter Robinson and Mr. Friedman. I would like to welcome them, and also I would like to

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recognize my colleagues on the Planning Committee for the work that they have been doing in participating in these hearings. Mr. Robinson, I know, is returning for a second

round this time.

The first round was on July 18th where we hosted our first public discussion among healthcare stakeholders from around the State in Albany. The Department of Health, State Hospital Review and Planning Council, and the Public Health Council were there, where we talked about reforming the CON process. Today's second meeting is an opportunity to continue that discussion.

Over two months ago the Department announced that its implementation of the Berger Commission recommendations concerning hospital and nursing home closures and restructuring is now complete. This announcement capped a nearly three-year, in-depth review and reconfiguration of New York's health delivery system under the auspices of the Commission and of the Department. Now that the first stage of the Commission's recommendations have been

implemented, we now begin to focus on the fundamental delivery service challenges that were identified by the Commission.

The Commission's report criticized the State's delivery system for its over development and inpatient hospital and nursing home beds, its uneven distribution of healthcare resources, and inadequate investment in preventative care as well as the continuation of a medical arms' race among hospitals. The CON process is but one tool that can be deployed to alleviate these concerns. In the decade since our CON process was first conceived, New York's healthcare delivery system has undergone a dramatic change. Our CON process needs to respond to those changes. The Department, SHRPC, and the Public Health Council are committed to an improved CON process that promotes the alignment of healthcare services and community health needs and supports the overall development of patient centered care and a

high performing healthcare delivery system.

We are committed to a CON policy that stimulates competition on the basis of cost

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and quality, but not over the acquisition of duplicative technology and construction of excess beds. With input from a diverse group of stakeholders in the healthcare field, from our July 18th meeting, today, as well as in other forums, we intend to make improvements to the CON process that advances all of these goals.

We are looking forward to hearing the views of the stakeholders who are invited to present today. First, let me lay out a few ground rules to follow, to make this a productive meeting for everyone.

First, I would like to remind Council members, staff, presenters and the audience that this meeting is subject to the Open Meetings Law and is broadcast over the

Internet. There is an additional room behind me where those who cannot find a seat in here can sit and also view the presentations. The webcast is accessible on the Department's website. The high demand webcast will be available no later than seven days after the meeting, for a minimum of 30 days, and then a copy will be retained by the Department for

four months. Because they are synchronized, captioning is important, and people should not speak over each other. Captioning cannot be done correctly with two people speaking at the same time. So please be recognized.

The first time you speak, please state your name and briefly identify yourself as a Council member, SHRPC, or Public Health Council or a DOH staff member. This will be of assistance to the broadcasting company in recording this meeting. The company here today is Total Webcasting, Inc. Please note

that the microphones are, quote/unquote, "hot," meaning they pick up every sound. I, therefore, ask you to avoid the rustling of papers next to the microphone, and also to be sensitive about personal conversations or side bars, as the microphones will also pick up this.

Each presenter is allotted approximately 15 minutes for both his or her presentations. Mr. Kraut is going to act as a timekeeper, and this includes questions and answers. I will ask all participants to be mindful of this time limit so that everyone

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has sufficient time to present.

Also, because of the extended Project Review Committee meeting that we had, I would ask presenters, particularly those who follow later on in the proceedings, to be mindful of ideas, concepts, suggestions that have already been suggested, and while we ask you to feel

free to allude to them or emphasize them, please know that since we are running late, there is a likelihood that many ideas, I.E., the level playing field, will be spoken to again and again. So in terms of our time limits, please be mindful of that.

I also know that a couple of our members do have to leave early to catch flights or have other appointments, so I just wanted to make you aware of that. So, please, try to be as efficient as possible in your remarks.

I would like to welcome our first presenter today, representing the New York City Health and Hospitals Corporation, Ms. LaRay Brown, who is the Senior Vice President.

MS. BROWN: Good afternoon, Chairperson Kennedy, Members of the Planning

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Committee and colleagues of the healthcare bill. I am LaRay Brown, Senior Vice President

for Corporate Planning, Community Health and Intergovernmental Relations of the New York City Health and Hospitals Corporation. HHC is a public benefit corporation created by the State legislature in 1970 to operate the City's municipal hospitals. It's the largest municipal hospital system in the country. We operate facilities in all five boroughs and provide comprehensive, quality care, ambulatory skilled nursing facilities, and behavioral healthcare and a wide variety of specialized patient care services throughout New York City.

I am not going to go through any more of what we do. Most people in this room are familiar with the Health and Hospitals Corporation.

Our system-wide initiatives include enhancing quality and patient safety, using transparency to drive performance improvement. We look at the patient's experience in implementing patient, provider and strategic management collaboration. On behalf of HHC

and President Alan Aviles, we are grateful for the opportunity to provide comments and recommendations regarding the Certificate of Need process reform, and appreciate the reform goals, developing a patient-centered, high performing healthcare delivery system that offers accessible, affordable, and professional care.

I would like to direct my first few comments toward issue item 4, the CON submission and review process. In subquestion A, the issue item number 4 asks: Is there a way that the CON review process could be streamlined and to what effect?

We recommend that the Department take a page from the college common application process. Many of you are smiling. I am sure you have probably been through that effort, the process where technology is used to streamline the application, and currently

there are electronic fillable application forms that would allow the Department to especially have a back-up review copy of what has been submitted in hard copy. However, taking this functionality one step further, to

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a design implementation of a web based information form, the technology would create an opportunity for greater satisfaction, transparency, efficiency and accountability throughout all the steps of the CON process.

Concretely, this would facilitate better tracking and information sharing of the project milestone and, most importantly, the responses. For example, the form would allow providers and Department of Health Project Management staff to review metrics that show the number of days of response outstanding on 30-day or 60-day letters and it could facilitate a more timely response. It's just the staff and cuing projects for review.

The subquestion B of item 4 asks: Are there aspects of the process that are duplicative, unnecessary, or provide minimal marginal benefits?

For the past several years, HHC and several of our provider colleagues have reviewed 30-day letters on CON applications requesting a business plan. Much of the content, we believe, of a business plan is also requested in existing CON schedules, and

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to those who request it can appear to be duplicative. However, if, in fact, the Department wants a business plan to address specific concerns, then we ask and recommend that the Department incorporate an expected format and minimal content into the CON application, which eliminate the Department's need to request this information as a 30-day letter and, thus, shorten the review period.

Subquestion C of issue item 4 asks:

How should the CON process weigh the financial impact of a project of services on Medicaid and other payers, and ultimately consumers and taxpayers?

An element of the New York State Department of Health's stated vision is to make New Yorkers the healthiest people in the nation, but as we all are aware, New Yorkers fall into all income categories, including those that are low income and uninsured. Therefore, the CON process must balance maximizing the short and long-term revenues of a project with weighing the value of those projects in addressing the needs of all New Yorkers, including those who are most

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vulnerable.

Frankly, this is not in my testimony, but we are sometimes frustrated in the need to address a business plan, particularly in light of our mission and, often, frankly, we have

very difficult conversations about particular projects and how they may impact the Medicaid program, but also how might we assure that people who don't have Medicaid or who have special needs are also assured access to healthcare services.

So, again, the CON process must balance those two very important public policy concerns. We encourage the State Department of Health, as it is doing with Heal 9, to continue to resource local collaborative planning efforts, but I emphasize resource, because while there is the dire need for local collaborative efforts, it is not going to happen unless there are resources directed towards it. Frankly, in those communities where a collaboration is most important because there may be small, not so rich providers, and a lot of need and a lot of community organizations and a lot of folks who

might be disenfranchised, they are the ones who need the most, in terms of collaborative planning efforts to take place, to assure that there is an effective and fully accessible healthcare delivery system, and they would have the least amount of resources.

So we encourage you to do what you are doing more, in terms of Heal 9, and at the same time, we are also encouraging that the Department should hold these collaborators accountable for identifying and generating metrics that would measure the efficacy of their interventions over time, understanding that efficacy can be measured over short and long-term periods.

As to issue item number 1, project services and equipment: We recommend to increase in the minimum cost thresholds for both limited and administrative review applications involving construction.

The current cost thresholds were updated at least ten years ago. According to the Dormitory Authority of the State of New

York, construction costs in New York City have increased 300 percent over the past two

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decades, and in the past two years, the cost of new construction has increased at a rate of 12 percent a year. So, essentially, a limited review application of 10 years ago, with the same project scope, could be bumped into administrative review levels today because of the rapid increase in the cost of construction. The same example would hold for an administrative review project and its current threshold, less than 10 million dollars.

This concludes my statements on behalf of New York City Health and Hospitals corporation. I will be happy to take any questions.

MR. KENNEDY: Dr. Berliner?

DR. BERLINER: Thank you. Let me ask a somewhat direct question: Do you think

that the CON process as it is currently constituted in this State helps poor people and uninsured people?

MS. BROWN: No.

DR. BERLINER: Would you recommend any specific improvements to it or changes in it?

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MS. BROWN: I recommend, I believe maybe it was several years ago, maybe even decades ago, there used to be a requirement that applications had strong information, a strong component of information about how does that project improve access to healthcare services. What I meant, in term of metrics, that if, in fact, the State resources collaborative planning that, number one, the value or strong principle of that collaborative planning should be the outcome of services available to all. Therefore, metrics related to, how is that achieved, at

the end of that collaborative planning process.

But to get back to your specific question, I don't see the CON, the current format that's used, being strong enough in requiring that applicants, number one, justify not only the need for their program as it relates to a bottom line and how much dollars, Medicaid dollars are being expended, but more over, how quantifiably they are going to assure access to everyone. Now, I might be passionate about this because of where I have

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been for 21 years, but I do think that the State is responsible for healthcare for all, as well as responsible for balancing and assuring accountability with public health dollars.

DR. BERLINER: Thank you.

MR. KRAUT: LaRay, you head up what is arguably the planning efforts of one of the

largest healthcare systems in the country, do you think that the corporation should have, because it's a system, because it's integrated, should it have special kinds of powers to move things around within the network, that would not necessarily require CON? Are there things that could be provided so you could do a better job of providing access, I guess?

MS. BROWN: Is there a way in which the CON process could facilitate our being able to be a flexible, integrated, delivery system? Yes, I do believe that's the case. I do think, that as our colleagues of the State are considering need, I think we apply, for example, for the development of a skilled nursing facility that happens to be located in

the Lower East Side of Manhattan, that there needs to be consideration that there is not limited access to that facility, that it's not

limited to residents of the Lower East Side of Manhattan. Although we try to be community centric and neighborhood focused, because we have a large, acute care system, we are also looking to leverage the capacity that we have in our entire long-term care system. Therefore, when we apply to expand a skilled nursing facility that happens to be in one locale, consideration needs to be given to how that capacity is not only going to address that neighborhood, but also the patients who are observed throughout our system, and how, frankly, our goals, which I think are shared goals in terms of the public hospital system and the public health and state health authority, as to how people can move from one level of care to another, and if we assume responsibility for their full range of care, that that consideration needs to be given as we submit individual or discreet projects; the overall systemness of the Health and Hospitals Corporation needs to be considered in that

evaluation.

MR. KRAUT: Thanks, that's a good example.

DR. BERLINER: LaRay, if I can follow up: Do you think that the ability within an integrated health system or any of the large health networks or systems, that any of those systems should be allowed to move resources around within the levels already approved by the State through the CON process?

In other words, is that not just for you but --

MS. BROWN: Frankly, I think, all integrated systems, including HHC, we should be held accountable for what we are spending and the outcomes of the care that we provide, and there should be metrics. Anybody who, whether it's a public or non-public integrated delivery system, meets those metrics, then they should, therefore, then be allowed to work as a system.

So the CON requirements should be facilitative of that systemness, facilitative of achieving those outcomes and, again, we should be allowed to work in a partnership

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with the State to achieve the end results.

Therefore, individual projects, that may happen to come up, need to be reviewed within the context of the larger organizational structure and responsibilities of that organization.

MS. LIPSON: LaRay, I don't want to put you on the spot.

MS. BROWN: I am used to it, you are not in City Council, so ...

MS. LIPSON: You, Lauren and I talked a few months ago about some of the local planning initiatives that HHC is involved in with the New York City Department of Health and Mental Health and the other providers and stakeholders in and around New

York City, and I am wondering if you can share some of those initiatives with the group here.

MS. BROWN: I think there are some witnesses who are going to talk about that, but I will give a recent -- I have a couple of examples to provide. Let me start in Staten Island.

On Staten Island, about three years ago, Health and Hospitals Corporation,

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frankly, at the encouragement and strong opinion of local elected officials, as well as others, was asked to develop a planning process that would review what was considered to be a significant unmet need, in terms of healthcare access for the residents of that borough. At the same time, there were some critical issues presented, evolving, that related to at least one of the acute care hospitals, but in fact there were some challenges for the other hospital. So the

genesis of that concern was that there was not an HHC hospital.

We tried then, and we continue to try to frame our efforts around healthcare access and not whether there's a hospital response to that, but whatever level of care is responsible for that, but to start from what is the need of a population and what are the gaps.

So we convened a pretty large stakeholders' group, included every single elected official from Federal, State, to local elected officials and their designees. It included the two hospital systems on Staten

Island; it included every single special population provider, mental health, HIV, every single organization that works with any possible immigration organization or immigration groups, as well as several other non-Staten Island-based organizations like the

Primary Care Developed Corporation, et cetera, to come up with a Staten Island-driven healthcare plan and, frankly, to help inform HHC, as well as the City of New York as to what short-term and, long-term investments we needed to make.

One result of that, one outcome of that work, and we are still doing that work, was the development of a community health center, which now has FQAC look-alike status, and the goal is for it to be a federally qualified health center. So the result of that process was the agreement that what was extremely important and a huge gap in service was access to primary care services in a particular portion of the borough, and with a particular focus on immigrant populations and low-income, uninsured individuals, and that was first.

Other things that have come out of

that, frankly, was the creation of other services or expansion services that HHC had; in fact, shifting services in our child health clinics, to be able to provide greater access of those clients to specialty and other services at the hospital. So tightening up those back-up plans and making them more into service integration plans. That's one example.

Another example is at the request of --

MR. KRAUT: LaRay, you have one more minute.

MS. BROWN: Okay. At the request of the City Council Speaker and the Mayor's office, HHC was asked to develop a community health assessment to help inform the decisions in terms of investment in primary care. We convened a very, very diverse group, including health providers, the City's health agencies, but more importantly, community based organizations who provide not health care services, but support services in different

25 locales, frankly, driven by what we know are

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1 medically under served neighborhoods. We also
2 engaged 14 CBO's in working with us to
3 actually do on-the-street interviews of
4 individuals as to what their access issues
5 were or challenges and access to healthcare
6 services; what their access or concerns were
7 in terms of health insurance, as well as a
8 myriad of focus or discussion groups, of very
9 specific populations who might not get an
10 opportunity to voice their concerns in what
11 would be considered the governmental planning
12 process.
13 I could go on, but I think I have
14 used up my time.
15 MR. KENNEDY: Thank you, Ms. Brown.
16 Also, thank you for setting the tone for the
17 presentations today.
18 Next up, I would like to ask,
19 representing the Greater New York Hospital

Association, Ms. Susan Waltman, Executive Vice President and General Counsel, and representing Memorial Sloan Kettering Cancer Center, Ms. Cynthia Maccallum, Associate Hospital Administrator. For their combined presentation, they will be allowed 20 minutes.

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Thank you.

MS. WALTMAN: Thank you very much. We will divide this up for purposes of today's presentation, as I have a little more systemic presentation and Cynthia Maccallum will be a more private-oriented presentation.

I'm Susan Waltman. I'm Executive Vice President for Legal, Regulatory, and Professional Affairs, and General Counsel for the Greater New York Hospital Association. With me, as indicated, is Cynthia Maccallum, the Associate Hospital Administrator at Memorial Sloan-Kettering Cancer Center.

We very much appreciate the

leadership of the State as you undertake this review of the Certificate of Need program. We have submitted detailed written comments. I will review for you today just a summary form of those comments. We have attached to our comments an extensive chart, however, that Greater New York has put out and updated over the years. It shows the complexity of our program. I am not someone steeped in the way the program works or filing applications, and looking at this for the purpose of today's

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comments, it looked like something I would have to learn in organic chemistry, but it is a program that has evolved extensively over time to meet the needs of, obviously, the different types of equipment that has evolved. We do feel very strongly, however, that it is a program that needs to be overhauled, which is exactly why we are undertaking this.

We have looked at this very hard, and

we have concluded that the program does not effectively further the goals that the State put forward with respect to cost control and quality access. It's in great part due to the evolution of our healthcare system and the other dynamics in the marketplace, so to speak. We, therefore, think that there is no way to describe the program, other than that it has become overly complicated, expensive, and burdensome, not because of any of the individuals who handle it necessarily, but just because we think that it doesn't serve its purpose, that there are other means of meeting its goals, and the cost, obviously, outweighs, we think, the benefits.

In essence, in summary, we think that

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the program should increase its cost threshold very significantly. It should exempt non-clinical projects entirely. It should streamline the process that is left.

On the issue of out migration -- I'll give a little more detail on what I just said, but on the issue of out migration, we feel very strongly that the State should take steps -- and many of you heard this morning, this debate, obviously -- to stop the proliferation of free-standing, non-hospital-based ambulatory surgery centers that threaten the ability of hospitals to deliver care, needed care to their communities.

Finally, we call upon the State to work with us to develop creative and meaningful mechanisms for accessing capital in order to ensure that we move forward, post Berger Commission recommendations, to meet the needs of our communities.

Many of you are aware that there have been studies and that many states have actually looked at the efficacy and value of their Certificate of Need programs. I have outlined some of those studies in my

testimony. There are, clearly, conflicting conclusions as to whether, over time, these Certificate of Need programs across the country have met their goal of cost control, some saying they have historically; some saying they have actually increased the cost of healthcare. One Of the most often quoted, still quoted studies concludes that even where it may have historically controlled costs, there has not been any rush to increase capital expenditures when the program is actually eliminated.

New Jersey has been a state that has recently looked at its program. They know that a report that went into the New Jersey version of the Berger Commission actually recommended elimination, total elimination of New Jersey's Certificate of Need program. The full Commission, headed up by Uwe Reinhardt, did not embrace that particular conclusion, but did recognize that the New Jersey program needed the total overhaul and focused very

clearly on the fact that it may have a very important role as it related to the quality of services; where there is a relationship

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between volume and quality, perhaps it has a meaningful goal.

It's against that backdrop that I made my recommendations on behalf of the Greater New York Hospital Association, with respect to the Certificate of Need program. We outline in detail why we think that the program not only doesn't meet the current goals as it relates in particular to cost control, but why there are so many other mechanisms in play at the current time that really serve that purpose, from the State's regulatory and licensing authorities, to your day-to-day oversight from the standpoint of quality.

You have taken bold steps, I believe, to encourage us, to require us to pursue best

practices, to undertake healthcare in a transparent and accountable way. You have put forward very, very creative financing mechanisms in order to incentivize or disincentivize certain behaviors. It's the same array of external factors, I believe, that fulfill these functions of cost control access and quality.

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And then there are the costs of the programs. Cynthia will speak to some of them. The State itself has outlined them, for example, on the State register when the State last increased the thresholds, actually picking through the costs that the program brings to providers in terms of delays in the application process. It did not, however, go into what you heard earlier from Ms. Brown, and that is the cost of construction as we await the Certificate of Need application. Indeed, there are studies that indicate that

the cost of delaying construction by one year is 12 percent, and that the cost goes up over time. So as the delays occur, the cost of construction goes up along with it.

When you take those different factors that the studies look at, does the program further its goals? Are there other ways to meet the goals and what are the costs? I do think the conclusion is that New York's program, notwithstanding the good efforts of everyone, does not effectively meet its goals and, therefore, requires the overhaul that we have outlined.

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It has been ten years since the State increased its cost threshold in 1998. They were actually in two steps. They increased the thresholds the first time in a small step, and a second time because there were too many -- it didn't pick up enough of the projects that it wanted to take out of the Certificate

of Need program, but it very much, at that time, indicated that they needed more flexibility because of the forces in the marketplace in our healthcare environment. I would suggest that we have even more stronger intensified forces today to really take care of the issues of cost-control access and quality.

Therefore, as you see, we recommend very much tremendous increases in the cost thresholds, to take into account the experience that we have for increased cost of construction, raising the administrative review thresholds from 3 million to 10 million; full review from 10 to 25. We also recommend, as I indicated, entirely non-clinical projects. I say that because I recognize the value of the Certificate of Need

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program, as many studies in other states have, as it's mainly related to quality, and where

quality involves the importance of competency of the provider for high-tech services, but no one today is embarking on non-clinical projects unless they are absolutely needed, and it should be left to the discretion and authority of management to budget for non-clinical projects the same way it does for other types of expenditures.

I also think, and you will hear a little bit from Ms. Maccallum, that the program that will remain needs to be streamlined. We made some specific suggestions. We know that the State agrees with some of these suggestions, in terms of the need to make it more streamlined for the benefit not just of the applicants, but for the State itself.

On the out-migration issue, Greater New York has long advocated for a moratorium on free-standing non-hospital-based ambulatory surgery centers. We are very concerned about their negative impact on hospitals and their ability to undermine the healthcare they can

provide to their communities. That is our sole concern with respect to this. You would expect us, as our public does, to provide high quality care to our communities and expand our access which is being undermined by the out-migration services, the more profitable services.

We recognize that there are questions raised about the ability of the State of New York to look at that impact. I make you aware that we filed an amicus brief in the South Shore case, when there was an Article 78 proceeding against the Public Health Council in which we took a position, but the State, all of you, have the authority and the responsibility to actually look at the impact of these ambulatory surgery centers on hospitals. We recognize that you think you need to only just look at the criteria that are listed in the regs, I would suggest that

every single one of those specific requirements take into account the impact of that ambulatory surgery center in terms of referral patterns, access, et cetera, and you cannot just look at the positive aspects of

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those criteria. You also must, I would suggest, as part of the planning, the law and the regulations, you must look at the impact that they have on hospitals.

We have a brief section in our comments on community health planning. We are very much supportive of what the State is doing with respect to community health needs' assessment, collaborative planning. I am a big supporter of the State's prevention agenda. We are working with the New York City Health Department, the implementation of that agenda locally, and we look forward to the data that are becoming available to help us in that process. We do not want you, however, to

lose track of the value of our academic medical centers and very tertiary teaching hospitals and undermine them in that way as community need planners.

Our final point in there, as I indicated, is the need for capital. We have long suffered from limited access to capital for a lot of reasons. We are perhaps the most unfortunate, hospitals, nationally, when it comes to looking at financial indicators. The

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State of New York's own requirement, that we have to arrange for credit enhancement in order to go out to issue bonds, for example, and other factors, limit our access to capital. We call upon the State to work with us to develop meaningful access to capital so that we can serve our communities better.

MS. MACCALLUM: Good afternoon. Thank you for the opportunity to append testimony to Ms. Waltman's.

I'm Cynthia Maccallum from Memorial Sloan-Kettering Cancer Center, and I'm speaking today as a representative provider who is very familiar with the CON process. We file about six CON's a year on average; we have filed more than three dozen since the new Millenium.

I would like to just preface my remarks today with the comment that we have a great deal of respect for our colleagues at the Department of Health, and that my comments today reflect the frustration that, I think, is shared by many of them: That we are trying to do too much with suboptimal resources and are doing it in a way that is less efficient

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than it might be. I hope that the comments that I make today will assist the Department as well in streamlining the process in the face of budget cuts and hiring freezes. We are all trying to do a lot more with less.

We do all of our own CON preparation. We do not hire consultants who are attorneys to assist, and so all the burden and the cost falls on the existing hospital staff, all of whom have day jobs in addition to preparing CON's. So what happens when we set about to prepare a CON? We're faced with upwards of 20 schedules and many, many departments who have input into filling out those schedules. The schedules aren't always relevant to the project at hand. This is particularly true of information systems' projects, but many projects have schedules required that actually don't add a whole lot of value.

There is no way to keep standing information on file with the State, so we end up refiling the same information up to six times a year. The schedules that we don't feel are relevant and instructions often tell us not file, we leave out, only to then get a

phone call asking us to please file them anyway. The schedules don't allow for footnoting or flexibility or ways to explain information that might be puzzling, and although we include that information in the narrative, the connection isn't always made by the individual reviewing the schedule in question.

So after we spend weeks on end pulling together what we believe to be an optimal CON filing, we are then faced with the request that we submit the original with eight copies and/or drawings, and that in order to prove receipt, we need to send it by either registered mail or UPS. So we have a Xerox-a-thon that goes on in the hospital administration copy room, where we create this mound of tree-killing material, which is then boxed up and tubed up and hauled up to the mailroom. I looked at our UPS bill to the Department of Health, and it's hundreds of dollars every year to get this stuff to Albany. I honestly don't know where all nine

copies go, but I have visions of this box getting torn open and some poor person

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stuffing this all into envelopes and routing it through the Department.

Then we begin the process of trying to find out if it's actually been logged in and gotten a log number, which involves many phone calls and eventually we get an acknowledgment letter. Sometimes it takes a couple of weeks; sometimes it's taken up to a month or two. Then we have a log number and we begin the process of calling and annoying very busy people by trying to learn what the status of the CON application is, who's got it and what more they need to know. In looking over the past three dozen filings, it takes approximately eight months to get our initial approval letter, and that invariably is an approval with contingencies, and then the process of responding to the contingencies

begins.

Then, we produce more information which we box up and send off to Albany. Then, once all of the information is assembled and we receive an "all contingencies met letter," then we actually have to initiate a process where we request approval to begin

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construction, which doesn't make a whole lot of sense because of course we would want to begin construction, so we are not sure why that process isn't automatic.

Then, we are about the thirteenth month, on average, and we begin construction at last. Once we do that, we get through the project, which may take a few months, perhaps up to a year or two for complex projects, and at the end of that process, we then begin the process of working with the regional office here in Manhattan to get a surveyor to come to a preoccupancy survey.

The surveyor arrives on site after what can sometimes be a difficult scheduling process. They're very taxed and there are very few of them, and often they arrive and have disparities with how the plans have been approved in Albany and they have different interpretations of code. So then we have a back and forth, if that happens, with Albany, trying to get resolution of what the code interpretation should be. At the end of the survey, invariably, additional information is requested from the area office. So we then go

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about the process of filing that with the area office manually, often having been hand delivered, and at the end of that process, it then has to be reviewed by the surveyor, who is usually now out in the field surveying a different project.

So anywhere from 10 days, often longer, later, we finally get the response

from them as to whether the information we have submitted has met their needs, and the process of actually getting the letter that allows us to occupy the space we have constructed begins. At some point, usually within a month that letter arrives and we are now ready to open for business.

So why does this matter? Well, that's a total of 14 months on average, not including the construction time. It is not good for patient care. The construction projects we undertake are to make thing better for our patients, to improve access, to cut wait times, to create a better patient experience. Additionally, we are losing revenue for the services we are unable to provide.

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Susan referenced ambulatory surgery centers, I would also add private imaging centers. Often times, as we are trying to

increase our imaging capacity -- cancer patients use a lot of imaging services -- we are having to send patients out to private centers in the community and we don't have the same quality checks on the work that is done there. The revenue goes to a private practice and they have to get copies of their films brought in and scanned into our system.

Meanwhile, as Susan mentioned, the bids expire, our costs escalate, we have to rebid projects. We often have to lease space and pay the rental costs, which are not reimbursed, in order to keep the space available for when we do get project approval and can begin to build. At the end of the day a lot of staff time is used after DOH, and at our end, that probably could be better used in different ways.

What is the fix? Susan referenced many fixes like increasing the limits for CON's, reducing the number of projects that require them. I would also add that many of

the need methodologies, particularly for imaging and high-tech services, need to be reformed to reflect current technology and not technology of 10 and 15 years ago. Most of all, I would beg, as a provider, for automation of this process; for a web-based process, where we can submit the applications on-line; where they ought to distribute to the people who need them; where we can go on line and see which bureaus are reviewing them and what the status of the review is; where a request for additional information can be transmitted electronically in both directions, including our responses; where we have contact information in each bureau, knowing who has got our project; where approval letters could self-generate from each bureau. That way, when we've got a financial contingency, we can be addressing that even if EAEFP is still reviewing their part of the project. At the end of the day, when all bureaus have approved

it, it could generate an automatic approval letter. We think that would go a long way to making all of our lives a lot easier and spending our time a lot better.

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I thank you very much for the opportunity to speak to you today.

MR. KENNEDY: Thank you.

Dr. Berliner?

DR. BERLINER: Let me start with Ms. Waltman, if I may. So why keep CON? One can easily imagine other ways of controlling the quality of care and the cost of care that don't revolve around limitations of access to capital or equipment. Other states have tried that, don't see markedly differences in outcomes of quality of care or, in fact, spending. So, why, given the critique that you made out, which I think is very salient, why not just get rid of CON in the State completely?

MS. WALTMAN: What I have seen, and I am sure you have read those studies too, is that it is concluded that it does have a role, a favorable impact in terms of promoting quality. Admittedly, which is probably where you are going, it becomes a door, it's an up-front barrier, so to speak, whether it is someone establishing a new service or an existing provider actually providing something

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that might be very sophisticated or high tech. What the studies would indicate, as I understand it, is that where there is a correlation, perhaps, between the volume and quality or the competency of the provider, that it does serve a role.

DR. BERLINER: You can easily imagine a system that exists in Florida for cardiac surgery where, if there were no controls on setting up a system but after X number of years, two or three years, if you

don't meet particular volume requirements or quality requirements, the state refuses to reimburse you any more.

MS. WALTMAN: I understand. That's another alternative. I would suggest, however, we have such a delicate balance in New York with respect to healthcare. I am only speaking to hospitals, that's what I am here for. There are so many of our members who remain financially stressed, for example, notwithstanding the implementation of the Berger recommendations. I want to say this: It was Greater New York, together with other partners, who actually recommended the need

for such a Commission, because of the financial pressures facing the hospitals and because we wanted a planful, thoughtful way to strengthening the system.

We have implemented some of them. We are very worried about some of the remaining

hospitals. There are so many that have closed, it has not solved the issue for a lot of our other hospitals that are very needed by our communities, not just for tertiary care, but the care that they deliver. I would suggest, and it has a flavor, admittedly, protectionism, but if you open those doors and you let anyone start to deliver services, whether it's the ambulatory surgery centers or it's the imaging centers, it will pull more and the more of the services out of our existing hospitals. They will become weaker, and I think it's a very valuable element, that that degree, admittedly, of protectionism, some people would say, provides support and strengthens New York's healthcare system because it keeps in place those who deliver many types of care already.

DR. BERLINER: Thank you for that

response. I think that's actually the

dialogue we are hoping to have out of this process, precisely the issues you are addressing.

If I can just ask a question of Ms. Maccallum: I am not sure that reducing the number of packets you have to send from nine to eight is going to actually make the difference.

MS. MACCALLUM: I would like to go from nine to zero, submit electronic applications.

DR. BERLINER: I'm not sure it's not going to take you 20 packets the next time you put an application through, but I will leave that to my colleagues.

The question I have is about the process you are recommending for a more transparent computer-based, web-based system. I am wondering if you have thought about having that system open to the public, at least at the initial stages, so that everybody in the public could actually see your application, see what you are proposing, and

25 also be able to comment along the way. One of

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1 the complaints that we have is that people
2 don't find out about this until the night
3 before and have no idea what anything is
4 because there isn't much information posted
5 about it at present.
6 MS. MACCALLUM: That would be fine
7 with us.
8 MR. KENNEDY: Dr. Zinberg?
9 DR. ZINBERG: Ms. Waltman, I wanted
10 to follow up on your use of the word
11 "protectionism." One can't help but be struck
12 that you are really here, in a sense, one
13 speaker is cynical, it's a protection racket
14 for your constituent members. This is a way
15 to keep competition away from them, a way to
16 keep what someone might argue is a failed
17 hospital in business, when, perhaps, a more
18 efficient way of delivering care, not
19 necessarily even just more efficient but more

patient-friendly way of delivering care is available.

I can't help but be struck by the fact that every time an ambulatory surgery center comes up for consideration, a local hospital is there complaining, "This will

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drive us out of business." When you peel back the layers of the onion, like I think we did partly this morning in the Bronx Ambulatory Center, the hospital involved is probably not running a very good operation. They are running an operation which is grossly under utilized, yet they are trying to expand in the hope that they are going to suddenly, miraculously, by some unknown mechanism, start to attract doctors from the community, when, in fact, there may be instances when these are services that hospitals just are not very good at delivering. It may be much smarter to move them into a more efficient setting.

If you could answer the question, why isn't it better to, perhaps, recognize which services hospitals don't do very well, move them into a setting -- by the way, we have shifted a lot of things. Years ago, all sorts of things used to be done as an inpatient, now they're done as an outpatient. One might argue that the next step is to move them out of the hospital altogether. So why shouldn't patients have the option of getting care where they want, in perhaps a more pleasurable

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setting, in a more efficient setting, and why shouldn't physicians have the option of practicing where they would like? After all, if you ban all the surgery centers and --

MR. KRAUT: Excuse me, I'm sorry, but we are running a little late, so if you could finish the question.

MS. WALTMAN: I think I understood the question.

DR. ZINBERG: I think from the point of view of physicians, though, you are locking them into practicing at one particular place, which may not run very efficiently and they may not want to work there.

MS. WALTMAN: Having spent a lot of time on this, I am the first person to understand the competing issues here, but I hope, I really hope, that when we talk about this issue of out migration, that what we really are focusing on is the fact that the State of New York cannot afford, on behalf of its public and our patients, to allow us to become, as a hospital system, any weaker than we already are. That's what it is.

I put the word "protectionism" out

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there because I knew that's where you were going, and that's part of that debate, but we have to face the fact that we are not protecting us as hospitals, but protecting us

as providers of healthcare, providers of meeting community needs as we deliver these services. When that physician or ambulatory surgery center opens, the State of New York must look at the impact on the rest of the healthcare system. Yes, it might close some doors to that physician or to the patient who might chose to be in another setting, I absolutely appreciate that, but we can't afford, I believe, as a State, to undermine the hospital system, the healthcare, which is right now the underpinning of a lot of community services at this point in time.

The Berger Commission went through a lot of effort to identify hospitals that were not deemed to be meeting their community's needs or where those needs could be better met somewhere else.

MR. KENNEDY: Thank you.

Dr. Garrick, and then Mr. Sloma and then we will wrap up.

DR. GARRICK: Thank you for a wonderful presentation. I just wonder if you could comment on something. It has always puzzled me a bit that when new high-tech services come along, that physicians could buy them, put them in their office practices with little regard for CON's or for anything else within their scope of utilization. I wonder whether or not it might be feasible for high-tech, largely radiologic and radiation medicine and some other interventional activity, to first be moved into a hospital setting to make sure that it actually is safe, effective, and appropriately utilized before it moves into an office practice setting?

You mentioned something in your presentation about the concept of needing to put in CON's for high-tech services. I wonder if you would comment on what your thoughts are about the way we currently address high-end technology in this State.

MS. WALTMAN: I am not a clinician;

however, I will say that as part of our talking to our members, some of our members very much will say, "Maybe we need more review

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of certain services." It is not all about "let's not review, let's see how much we can get out," but "let's look at what we should review." I think there is a good argument for certain high-tech services, that they should be controlled in this fashion, as you suggested initially, and then maybe even more review than we are giving them now.

One thing I suggest in the testimony is that if you increase the threshold to take up a non-clinical, we still should go through all of the projects, the types of services that are left, as well as considering maybe whether there are ways to actually have more review for certain types of procedures or services that might fall into what you suggest.

MR. KENNEDY: Dr. Garrick, I am going to defer now to Mr. Sloma. We are way over.

MR. SLOMA: My comments will be real quick.

In support of Ms. Maccallum's comments around CON, I've filed my fair share, I think she was right, 100 percent right on the money.

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The Department of Health has right now an HPN network, the Health Provider Network, where there is like a two-way way to communicate between providers and the Department, whether it's things like viruses or bird flu or anything like that, but you can also submit things like Medicaid cost reports, so it appears that there is a vehicle already in place, that if it was slightly modified might work very nicely.

MR. KENNEDY: Thank you Ms. Waltman and Ms. Maccallum. I appreciate your time and

your interest.

I would like to introduce Ms. Fran Weisberg, Executive Director, representing the Finger Lakes Health Systems Agency.

MS. WEISBERG: Thank you very much. I am Fran Weisberg, the Executive Director of the Finger Lakes Health Systems Agency. Chairman Kennedy and Vice Chair Berliner, thank you for inviting me here today to provide input into the evaluation of the Certificate of Need process.

As I am sure many of you know, FLHSA as one of the only vestiges of the Health

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Systems Agency world, is an independent, regional health planning organization that serves nine counties in the Rochester and Finger Lakes' region. We trace our roots back, in fact, to the invention of community health planning in the early 1960's, and I have a wonderful history of health planning --

actually, it started in Rochester, New York, with Eileen Folsom, who was a critic at the time. When I started doing a lot of research about what I was working on, it was so amazing, what was going on back then and what is going on now, how similar it really is.

Over the decades, FLHSA has provided local and regional input into the State's review of thousands of CON applications. We provide technical assistance to the Community Technology Assessment Advisory Board, known as CTAAB, which reviews local projects and makes recommendations to area health insurers about the services they should cover; in fact, we call it private CON. CTAAB is a locally based and control decision maker. It extends the State's capacity planning effort without expanding regulatory authority or the CON

process. It is a model to keep in mind as the Committee continues to do its work.

Part of our role in the review process is to collect and analyze data from multiple sources -- payers, providers and government -- that are then used to inform State decision makers, but it's one of the only two health planning agencies left in the State. This HSA takes a much broader look at everything. In fact, we deal with all aspects of cost, quality and access. Our professional analysts help stakeholders interpret health data, to make informed decisions that improve community health.

What I also think is most important about the work we do is that we provide a community table where key stakeholders in the region come together to address critical issues facing the healthcare system. What I think of us now is that we are a coalition of coalitions, and it's very rich. Hundreds of people come through our office every day and the glue that holds them together is the data and the analytics where we do studies that say what is going on in the community.

Right now we have the Ryan White Network with us; we have the LED coalition with us; we have two very vibrant coalitions working as African American Health and Latino Health; each of those coalitions can have 40 to 50 people on them, representing every walk of life in our community, folks that are from doctors to people in the pews, to community-based organizations that all come together to analyze data and then inform the data so that we can inform the State. We have an obesity project, so, as you can imagine -- but there's a lot that links them together.

Shortly after I became Executive Director two years ago, my board and I took on the challenge of developing a new strategic plan. Our goal was to review our mission and create a new Twenty-First Century model of community health planning, because one of the things I did learn more than anything is that

very few people I talked to, and I didn't know much about this, wanted to go back to the "old HSA's." We did do a White Paper, "Needed, a Healthier Approach," redefining community health planning for the Twenty-First Century.

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Under our new model, HSA continues to do work in capacity management, but what is most important is capacity management is only a tool. We are expanding our mission beyond the supply side of work. We would rather focus on the community engagements I just talked about, which is very key, that talks about lowering the demand for hospital services. Our goal, all of our goals, should keep people healthy and not using the higher healthcare services.

Our goal and our role is to facilitate an original healthcare system that focuses on patients who are personally more accountable for their own health. You know,

health literacy, informs patients with the knowledge they need to make better decisions, reduce the demand for expensive inpatient care and prevention and primary care. Of course, it ensures that it uses information system technology to help providers effectively manage, prevent, and care for a chronic illness. Lastly, and most importantly, it has built in a commitment and collaboration for multiple community stakeholders from inside

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and outside their healthcare system.

I believe this approach is in perfect sync with the Department of Health's commitment to a patient centered, high performing healthcare delivery system that has been talked about all throughout today. In fact, a renewed commitment to partner with the State is central to our strategic plan. It is about giving people, as we all keep saying now, the right care, at the right time, at the

right place.

The State plays an essential role in setting policy, managing system capacity through the CON process, and supporting access to care. If it's effective regional planning, we can also play that pivotal role. We help to inform State decisions and tailor solutions that fit the unique healthcare needs of our local and regional communities.

As we look at the CON process and discuss possibilities for withdrawing, it is essential for New York to continue to have some kind of CON process, and you will see this when we talk about our 2020 Commission. The process isn't perfect, but it works, and

it is far preferable than having no check at all or market forces regulating the supply of essential medical services. As the calamities in the financial markets are unfolding this week, I've noted that Republicans and

Democrats alike seem to agree that a little regulation can be a very good thing.

Through the CON process, hospitals and healthcare systems put forth their proposals. Communities provide local input into those State decisions. The State Health Department conducts its review and gives the final say, informed by community comment. In our region, HSA and the State Health Department do have that symbiotic relationship. Again, DOH collects data on health and disease and I think our local group makes that data sing. I think that because we put it into our community lens. We helped to craft solutions that meet local needs, even, for example, on the inception to State policies, when we can demonstrate that they could adversely affect the local population.

One reform that is obviously clear through this, through the whole CON process,

is to support the expansion of regional and local health planning throughout New York State.

Today's discussion is quite timely for me and the Finger Lakes, because I can share a real life story with what happened today, and I'm sure that for many of you, this will be a redundancy, so I will try to go quickly.

As you know, this morning, our community, three hospital systems, had three CON's all done at the same time before you. HSA reviewed the CON applications from the three major hospitals. Each hospital is critically important to our community and each made a strong case for modernizing very out-of-date facilities. Each proposal was excellent from the institution's perspective, but collectively, the three proposals would have added 278 beds to our community and an increase of more than 22 percent of capacity of med/surg, and, as we talked about, a great deal of money needed for modernization.

So, in order for to us to look at what was going on in our community, we

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convened the first ever Community Health System 2020 Commission. The group's purpose was to look at the hospitals, through a community lens, examining what our region needs, and what we can afford. The Commission was composed of 17 community leaders who offered a diverse healthcare perspective. They enhanced our role and our review and ensured involvement by all stakeholders in the review. The group's unique approach is to support the supply-side need for facility modernization and expansion with requiring hospitals to support community initiatives to reduce demand for acute care beds in the future.

The 2020 Commission, I believe, can serve as a model for CON reform in the future. It transforms CON from the typically reactive

mode to a more proactive effort. It shifted the conversation from bricks and mortar into a comprehensive, community-wide dialogue about what is needed for a high-performing healthcare system in our whole region. Our local process, which informed the State about what DOH has recommended at the Project Review

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Committee this morning, was actually truly historic. We were thrilled to note that it was a unanimous decision this morning as well. The three hospital CON's were batched -- and that was very critical -- by DOH, and assessed on their collective impact to our community, as well as their individual impact.

An important principle was to have three strong Monroe County hospitals still standing, while not jeopardizing the survival of the rural hospitals in our region. The review process was highly collaborative and was collaborative in our community and with

the Department of Health.

The hospitals -- I hope the key stakeholders and the community at large -- commissioners conducted a transparent public process; input was solicited from the CON applicants, physicians, nurses, to business community rural hospitals, minority community, labor and business. Ultimately, the Commission reached a unanimous consensus on its data based recommendations -- unanimous: They supported facility modernization at each hospital, while reducing the collective

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requests by nearly 50 percent. The Monroe County hospitals will now collaborate with all the stakeholders to improve the measurable elements that quantify the health system's effectiveness. HSA will facilitate the collaboration and monitor progress. There will be a metric. The metrics that we will be monitoring will help to focus initiatives to

improve the health of our community while reducing the demand for care. These metrics include PQI-related hospitalization, emergency room utilization, Code Red frequency, the supply of primary care docs, and length of stay. By the way, if we don't move the performance needle on these issues, that number is going to have to go up. So it's in the community's interest that we really work together on those.

These recommendations include a trigger mechanism that streamline expansion of the applicants' inpatient capacity if demand increases beyond the projections despite improvement, meaning that if, in fact, in 2012 or later, these beds are needed, because we can't really see into the future as accurately

as we would like, that those be an expedited process. The linkage is clear in recommendation; hospitals are being encouraged

to modernize and expand based on data-growth projections, but they must also engage with the community to improve system performance. Again, that's where the supply and demand and the CON work together.

If the State looks at ways to reform the CON process, it can hold up this Commission, I believe, as a model. This process worked well because it was community driven. It examined individual proposals, but as a community. I also think the process showed how local communities can and should have a very strong voice in State decisions that impact their local community systems.

So I think there are many other ways that I could talk about. I think the role of data, local health planning, it does take money and resources. The State CON process and the need for regional health planning, remain as relevant today as they have been, especially in light of the Berger Commission. That Commission was created because market

forces alone had failed to control healthcare systems' size and cost. In the end, the Commission's work will be seen as just the beginning. The Berger Commission reports concluded, and I quote: Speed of change in healthcare, driven by changing technology, populations and finance, make it essential that the work of reforming the system and the regulatory framework must be continuous."

MR. KRAUT: Ms. Weisberg, we are about three minutes away. If you could just leave some time for questions. If you want to make a closing statement?

MS. WEISBERG: Just to say that this worked completely because it was a community effort aligned with the Department of Health and using CON to have everybody work together as a community. Thank you.

MR. KENNEDY: Thank you.

Dr. Berliner?

DR. BERLINER: Ms. Weisberg, my

experience on SHRPC has been that on the rare occasions when we actually get an application that has been reviewed by an HSA, if the HSA is for it, the State is recommending against

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it; if the HSA is against it, the State is recommending for it. The actions this morning, I think, are historic in more than one sense, but it raises the question of that contradiction between local health planning at the very basic level and the kinds of things the State is required, by law and statute, to do.

The things that are going to be monitored in Rochester: PQI, length of stay, occupancy, those things are things that the State can monitor just as easily as you can monitor. There are things that the State can't monitor because they are not there, but you can. I am wondering if you could talk a little bit about the kinds of things that you

can provide at the local level that the State, just by nature of it not being local, can't provide.

MS. WEISBERG: Let's use as an example emergency room. I am going to leave this document for you that we presented for two of our coalitions about why people -- you know, you are not going to really get in there and spend the time to say, "Why are people

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using emergency rooms for primary care?" "Why are they going back over and over and over again?" And "Why are people ambulatory sensitive admissions?"

What we think is by getting multiple stakeholders together to do the research, to find out what's going on that, collectively, as a community, instead of fighting we're going to decide together how we move the performance needle. Then we and you monitor together if it's working, but we are also

going to have solutions now, and the good thing is -- no offense, I don't have a clue about how the old HSA's worked and all of those fighting. I do have ideas about why this worked, and I do think that our communities owning their own care -- and I always say the right and the left can really understand; this is about supply and demand, and have people understand their own healthcare and own it together. Then we say to the State: "Our community is committed to really changing the paradigm."

You can't do that. We are also going to decide what issues are the worst and decide

together what to set priorities on and what to focus on. We don't want to boil the ocean. I don't think you want to do that. We want your data. We want you to set the vision that we all want right care, right time, rate place, but getting it done, I think, can be local.

MR. KENNEDY: Thank you. And thank you for your presentation.

We are at the halfway point. We are going to hear from Ms. Judy Wessler, who is with the Commission on the Public's Health System.

MR. KRAUT: I want to apologize. I believe I called Ms. Weisberg "Ms. Wessler" before.

MS. WESSLER: Actually, I like what she said.

MR. KRAUT: That might shorten your presentation.

MS. WESSLER: No.

MR. KRAUT: Please go ahead.

MS. WESSLER: Thank you. My written testimony is being passed up, it's a lot longer than the time that I have, but I just want to highlight some of the pieces of it

and, clearly, we come from quite a different

perspective, a community perspective.

There are two things I want to start with: One is, you are asking about Certificate of Need, CON. The last word is "need," yet the definition of "need" is, the way that we understand it currently is, the code is very troubling, has nothing to do with people or people needs, so that's a very good place to start from and look at. We also feel very strongly that CON and health planning have to be looked at together; that they should not be done in isolation. That's why I particularly liked what Ms. Weisberg said.

I just wanted to go into some of the details that we have in the testimony and stress one particular piece. When we talk about "need," we talk about people need, community need, consumer needs, not institutional needs, not financial needs, and there is a real big difference in what you do and how you look at what we think you need to look at, as opposed to what is currently required, the Certificate of Need process in

regulations, et cetera. So we need to start

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from that perspective.

Also to say that I was a member of the Health System's Agency in New York City and the Executive Committee, and there were some really bad things that went on, but there were also very important things that happened within the health planning process, particularly when there were what we called "Saveric Councils" (ph), where providers and consumers in local communities sat together and really worked out a lot.

It was a lingering process on both sides and, again, although there were problems, there was also a lot of benefit, and I don't think that we should say out of hand that it didn't work, as many people are doing, so that we don't have to look at processes like that again. I would hope that you will, and we would be happy to talk more about what

the benefits were, as opposed to all the negatives. As a matter of fact, we worked with the City Council in New York in 1998, I believe, to sponsor legislation to restart a Health Systems' Agency in New York City. Of course, Greater New York Hospital Association

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opposed it and we did not get it through, which was too bad. Now I think I hear them saying they believe in health planning. So, again, health planning and CON in the same sentence, that is very important.

What I want to talk about a lot is that in the 1980's I worked for legal services and, also, as I said, was involved in the Health Systems' Agency. We felt very strongly in working with community organizations that the State Health Department and the Health Systems' Agency were ignoring what we felt was very important -- and I am not a lawyer, by the way, let me be clear -- was a very

important Federal and State regulation and law, and that was the concept of access to care as clearly defined in Federal law and, again, repeated in State law. Access for low income, communities of color, immigrant communities, based on race and ethnicity, based on age, and for women and disabilities. That is, I believe, still the language in the State law. It's totally ignored, but it's still in the State law.

So we actually filed a civil right's

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complaint against the State and the New York City Health System's Agency, that resulted in negotiations. There were various parts and outcomes of those negotiations, but one very key part was -- actually it's attached to the testimony, if you follow with me the last two pages. It was called, and I negotiated this with Ray Sweeney who was then at the State Department of Health, the access schedule, the

facility access Schedule 18, which was not required for all applications, but certainly was required for large, capital construction projects. I believe it was projects that affected three or more services.

This is sort of out of date. If you look at the bottom, it has 11/86 or 1/86, I can't see, but that's when it went into use and, unfortunately, in the Pataki era it went out of use and nobody in the Health Department knows about it any more. I would hate that we have to file a complaint again or sue or whatever else to require, once again, that the State consider access to care. More populations -- you asked Ms. Brown this question, Dr. Berliner, and she answered, "No,

it doesn't take it into account" -- it doesn't.

This is the kind of thing that could begin to capture some of the access data.

This needs to be renegotiated. I would take Phil Burton questions off, for example, because it's not a factor any more, but there's Manning (ph) law questions or others, and I would happy to sit down with whomsoever and bring people together to talk about what should be going in, but the fact is that there has got to be some kind of schedule, some kind of information gathering like this. If there is really serious interest, and I'm hoping and thinking from the invitation that there really is interest in change and some redirection so that we don't have another Berger Commission, so that we can start thinking about resources where they need to go, and for the types of services that are really needed and would be utilized. We don't have to talk about under utilization because that shouldn't happen any more.

I just want to finish. There are some very specific answers to questions, I

won't read them out; we did, however, skip number one and say that we would start with, I believe it's 2A, that clearly -- or 3, question 3, because that, from our perspective, is the important series of questions.

I have also detailed some of the activities that we have been involved in that begin at a community level, do very competent, very wonderful planning, do not require providers but providers are allowed to be involved in them, and they enrich what we do, but that they are community driven with excellent efforts. So I want to, again, complete what I want to talk about by talking about some principles.

Some principles on the last page of our testimony that we would ask that you very much consider in your discussions about CON reform: Again, step number 1 is what is meant by "need," and how is that defined and how must it be redefined; from our concept, how

must it be redefined? We would ask you to look at the definition of the concept of "need."

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That racial and ethnic disparities and access to healthcare should be a primary consideration in planning, expansion and decreases in services. People have made comparisons to other states; we are so far behind in looking at disparities -- from the State, looking at disparities, there's lots of it -- at the community level, but lots of states have done very important work on this issue and New York State has not. So that is certainly something we need to catch up on.

Community based health planning should include community health needs' assessments and collaborative efforts between community and providers; make expansion and prevention and primary care services the priority, and that's where funding should go

as well. Require that almost all CON's be based on the collaborative effort that we talked about. Use community data and tools, such as a revised and updated Schedule 18, to assess applications. There also needs to be a redistribution of wealth and resources, and, the favorite, stop the empire building. If you look at -- someone asked a question, I

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think it was you, Dr. Berliner: Should networks be able to move resources around? If you look at Saint Vincent's Catholic Medical Center, and how they have devastated medically under served communities in this City, and they actually had to go through a process and got approval to do it, which was a crime from my perspective -- that may be a strong word -- but the fact that they were allowed to strip medically under served communities, like Central Brooklyn and South Jamaica and now they may get approval to build

a nice, new building on 12th Street and Seventh Avenue, which is where I live, but I think it's an outrage if they get approval after stripping other communities.

That's the kind of concepts and needs and different ways of looking at it. Also, we feel very strongly, again, following up on that point, that there needs to be a strengthening of the CON process for the reduction closing of services, particularly in medically under served communities. Right now an application is filed and it's like a joke. You know, they close before they file the

application, and nobody is really looking at, Is this something that should happen? That's very scary and we would wish, again, that that would change.

Finished, I would just ask that lots of people would be really willing to sit down with members of this Council, members of the

State Health Department and others, to talk about more specifics on what we feel should and could be done. It's great that the State, that the Governor and the Health Department put money in the legislature, in the budget, to do some models of community health planning, and maybe out of that we will have a better sense of direction. Maybe we should go with that, but we are not doing well now. Obviously, there are serious changes needed and, hopefully, you are serious about working with the likes of us to try to make those changes. Thank you.

MR. KENNEDY: Thank you, Ms. Wessler. Thank you for providing some specifics. I know Dr. Berliner and Mr. Kraut both have comments.

MR. KRAUT: I think this may be an

issue, just to echo something that Ms. Wessler said. The issue about the Schedules 18, 19,

facility access, and picking up what Cynthia Maccallum said about a standing database. If we modified, let's say, the community service plan, let's look beyond just Certificate of Need, we have to file a lot of this information as part of the community service plan. So, to the degree that some information is useful and informs the conversation at a Certificate of Need review, "Who do you serve?" "What's the Medicaid access?" "What is the service there?" Those are standing pieces of information that we file anyway every year or every two or three years we update it. There is probably a lot of benefit of making sure that that information is always available in a conversation; it may not need to be filed with a CON, but should be accessible through the community service plan.

I am just suggesting, when we kind of synthesize the comments, not just look on CON reform, but let's look at other places that we're filing data and see if we can bring it to bear on some of the issues Ms. Wessler

spoke about.

MS. WESSLER: If I may respond to that: One of the other outcomes of the civil right's complaint that we filed was we tried to get into the patient's Bill of Rights the language that healthcare facilities would serve everybody, regardless of the ability to pay. Unfortunately, the Health Department caved on that and set up what was called a task force on the ability to pay. That was chaired by Bruce Vladeck, and came up with the proposal to have community services' plans by hospitals, instead of allowing access to care.

People have tried to get copies of community service plans from hospitals in New York City, and the hospital association called them and asked them why they wanted it. These are public documents. I'm sorry, I don't think it works. I know people think community services' plans are wonderful; we, in the

community, don't. They're hard to get hold of, and it's more of a public relation's vehicle than something that actually helps the community or provides information.

I'm sorry to challenge you that way,

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but maybe your hospital does it right, maybe you are open with it, but that is not the rule and saying that that be a substitute to collecting this kind of data, I think, would be very troubling.

DR. BERLINER: Ms. Wessler, I am calling you "Ms. Wessler" because you called me "Dr. Berliner."

MS. WESSLER: Howard, you can call me Judy.

DR. BERLINER: Thank you, Judy.

Two questions: The first is, how do you feel -- I mean, we regulate hospitals. That has its good side and its bad side. You pointed out some of the negative parts of it,

but also some of the good parts of it, in terms of requiring hospitals to provide services. How do you feel about the regulation of non-hospital providers, physicians, dentists, through the same kind of a CON mechanism that would, also, perhaps, have the same kinds of -- actually what you were just talking to. Is there a way of requiring people to provide services, independent of ability to pay?

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MS. WESSLER: Are you asking me if there is a legal way of doing that? No. Should this be done? Absolutely. Totally, yes. Actually, you know, it is done, there are very small healthcare providers that are part of other institutions that are required to file CON applications, modified but still file them, so why shouldn't some of the other types of providers that you are talking about also be required?

DR. BERLINER: Within that vane, do you think the general -- you know, we've heard Ms. Waltman talk about protectionism and other uses of CON as a franchise and things like that, within that context, the way that it has been brought up here today; do you think we should continue CON in its current form? I guess I am asking you sort of a summary judgment. Is it, overall, better that we have it or would it be better without it or in some radically different form?

MS. WESSLER: It depends on whether we want Wall Street or we want some services. You know, if we want fiscal collapse or economic crisis because nobody was minding the

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store and perhaps making money and encouraging them to do whatever they were doing which I don't want to know about. All I know is my 401K is suffering, that kind of thing.

Yes, we absolutely need a process,

and what we are encouraging is reforming the process, making it better so that it works not for the benefit of institutions, but it works for the benefit of communities who are supposedly the ultimate recipients. So, the short answer is "yes."

MR. KENNEDY: Thank you, Ms. Wessler.

At this point we are going to hear from Ms. Elizabeth Swain, who is the Chief Executive Officer of the Community Healthcare Association of New York.

MS. SWAIN: Good afternoon. My name is Elizabeth Swain. I'm the Chief Executive Officer of the Community Healthcare Association of New York State, CHCANY. CHCANY is New York's primary care association and a State wide association of community health centers, also known as Federally qualified health centers or FQHC's. New York's health centers serve as a family doctor and

healthcare home for over 1.1 million New York State residents, at more than 425 sites, rural and urban.

Community, migrant, and homeless health centers offer comprehensive primary care, including family medicine, pediatrics, obstetrics, gynecology, dental, laboratory, mental health and substance abuse services. Health centers are located in designated under-served communities and provide an array of services targeted at those who are the hardest to reach. Most health center patients have family incomes below the Federal poverty level. 74 percent are racial or ethnic minorities; 43 percent are covered by Medicaid; and 28 percent are uninsured.

Health centers are, by design and by law, community based and patient focused, and that is because every federally qualified community health center has a board that is composed of patients of the health center. A majority of every community health center board must see patients at the health center,

ensuring that each health center is both patient focused and truly community based.

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We appreciate the Department of Health and the State Hospital Review and Planning Council's sincere efforts to access and improve the CON process and to take a fresh look at revitalizing health planning. We've got a healthcare system that is disjointed, inefficient, and inequitable. CON reform and improvements in health planning are important pieces of the puzzle in reforming healthcare in New York State in order to improve access and quality while reducing cost and disparities.

We appreciate the opportunity to be involved in the State's efforts to improve healthcare for all New Yorkers. In anticipation of this hearing we surveyed community health centers across New York State to gain a more complete understanding of their

on-the-ground responses and recommendations. My testimony will summarize and reflect upon our thinking about the CON and health planning in general. The survey responses have been compiled and synthesized and are included in an addendum to my testimony.

Regarding the CON process: For

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safety net primary care providers, like community health centers, it rarely feels as though there is a level playing field. We are often smaller than other institutions and we are, by design, a mandate located in areas where we do not have significant opportunity for revenue generation. The CON process itself was clearly developed with larger, inpatient facilities in mind, rather than primary care clinics. Small entities with few resources frequency do not have staff members who are fluent in the CON process, and they have limited funds available to hire private

consultants to shepherd a project. The process can be lengthy, time consuming, and draining on limited resources. Healthcare providers must operate like any other business, and like any other business, the regulatory environment can either support or drag down business.

In our survey, many health centers cited that the process is incredibly slow, requires too many steps from submission to approval. There are too many forms, and often the forms are needlessly held up on someone's

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desk. When CON applications take six months to complete, providers are waiting and losing ground. It then becomes difficult for them to respond or change their community in a timely fashion.

In a new CON process, some types or sizes of projects should be subject to a streamlined application and undergo a simpler,

speedier review. These might include, for example, expansion of existing services such as primary, renovation projects under a certain amount, equipment generally available in a physician's office and the addition of a new office space for preventive care services -- for example, dental, mental health, especially office-based consults. In addition, an automatic approval time requirement should be added so that certain CON requests should be deemed "approved" automatically within a short time frame -- for example, 60 days -- if action is not taken.

Providers that are willing to take all patients, regardless of insurance status or ability to pay, should be rewarded; particularly if they exist in or are moving

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into under-served areas. This is one way that the State can facilitate improved access. We propose rewarding applications from safety-net

providers that take all patients, by expediting the approval process, establishing higher thresholds for projects to qualify for administrative review, providing assistance in preparation and data research, prioritizing expansion approval and giving reductions in any associated fees. In addition, the State should enforce uninsured sliding-fee rules and ensure that they are posted in visible places within institutions.

The process should also reward applicants that meet properties established by the Department of Health, such as improving access to primary care, extending hours of primary care and diminishing unnecessary emergency room costs and usage. Projects that are focused on addressing extraordinary means, unique world needs, increased utilization of community based care, health disparities and other similar factors should also receive special CON consideration.

These are factors in developing a

comprehensive needs' plan and multiple health planning should include this type of data review. The plan presented should meet some of the required criteria.

Regarding health planning data and the CON, the CON process should take into consideration and support local, regional, and State wide health planning goals. Organized, coordinated, properly funded community health planning should inform State policy regarding the CON process and local planning, though we are not suggesting that local health planning entities conduct reviews with specific CON applications.

Effective health planning should provide the foundation for establishing the need and aid in simplifying and shaping the CON process. There are also opportunities for the State to coordinate the work of the agencies that are engaged in data collection. There are at least three important issues with

regard to data from local health planning, the first, is addressing data gaps. There are large gaps in health data that's available in New York. There is consensus that we need

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better data on non-physician clinicians, including practice settings. To date there is a relative abundance of data on inpatient care and little data on the ambulatory care provided in clinics or physicians' offices.

Comprehensive community-level data is needed that includes information on health disparities; payers; high-need patients, including those best served in a language other than English; costs and utilization. Secondly, insuring that health data is publicly available at the smallest geographic unit -- I.E. a census tracked zip code. Go to the large populations and land areas in most counties, county-level data frequently masks significant differences within and between

communities.

Thirdly, insuring that local agencies can assess and understand the data. In order to ensure community involvement, data should be accessible to community users, especially those lacking technical skills.

Regarding SHRPC representation, the SHRPC could be more thorough by diversifying its membership in a variety of ways, including

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bringing on more community ambulatory care and non-institutional members. CHCANY's members, New York's community health centers, care for a patient population that is extremely diverse. 35 percent are Hispanic or Latino; 34 percent are black African American; 26 percent are white; and 5 percent are Asian or Islanders. More than one in four health center patients are best served in a language other than English, and by design, community health center boards and staff are reflective

of the communities they serve.

CHCANY is eager to work with the SHRPC and policy leaders to ensure representation that is diverse in terms of healthcare sector expertise and experience, race, ethnicity, gender, and geography.

Thank you for the opportunity to comment. CHCANY and its members look forward to continuing to work with you in terms of all New Yorkers, particularly ensuring that those living in under-served communities have access to high-quality, community based healthcare services.

MR. KENNEDY: Thank you, Ms. Swain.

Questions?

MR. KRAUT: I am intrigued with the recommendation of treating the federally qualified health centers slightly differently because of the unique role they have with the Certificate of Need. Do you have any sense

of, other than establishment, how many CON's collectively -- I know this is kind of catching you off guard, but how many CON's collectively your membership might have filed in the last three or four years, and is it for facility issues like expansion or programs? Is it a licensing issue for services or is it to move to a facility or to build out a room?

I am just trying to get a sense because I can see an argument being made that these things might, if not go to full review, may be treated administratively or are they being treated administratively or with limited reviews now, that can make it a little easier for these organizations?

MS. SWAIN: I don't have that information.

MR. KRAUT: I don't need it now, but it would interesting --

MS. SWAIN: We can get it for you,

for sure.

MR. KRAUT: On the other hand, I don't want to kind of carve out "this group" and "that group" either, but there may be an argument made that because of the access issues and the focus on access, that you can get special consideration.

MS. SWAIN: Just to clarify, the point I was making also was based on the fact that health centers are established in medically under-served areas that have already been designated as studied and established.

MR. DELKER: Jeff, in general, except for new facilities, most of the D&T center projects are under 10 million. So they are getting administratively -- a lot of them are under 3 million or something like that.

MR. KRAUT: So it's really on the processing side?

MR. DELKER: Right.

DR. BERLINER: I am wondering if you find, as the hospitals do, that some of your patient base is migrating away towards

25 physicians' offices or ambulatory diagnostic

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1 and surgery centers? Has that been something
2 that your membership has talked about?
3 MS. SWAIN: No. No, we are not
4 losing -- we just recently studied very
5 carefully the impact that seeing a large
6 number of commercially insured patients is
7 having on the health centers, an interesting
8 study that we did last year. We are having
9 precisely the opposite. We're having a
10 migration into health centers of patients who
11 are either uninsured -- increasing numbers of
12 uninsured or under-insured patients. So a lot
13 of commercially insured patients who are
14 poorly reimbursed.
15 The health centers, about 51 percent
16 of the revenues in the health centers in the
17 State of New York are Medicaid revenues.
18 There is an increasing sort of alarming number
19 of commercially insured patients who are

really under, as all providers struggle with that, but because health centers are subsidizing essentially a large uninsured patient population with revenues that don't often cover everything, that with all of our costs, it's a big issue for health centers.

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MR. KENNEDY: Ms. Swain, from where you sit with CHCANY, how would you advise this body, in viewing the reality and the growth of pre-clinics -- I'm thinking particularly in upstate, places like Schenectady and Ithaca and Syracuse, Rochester, in terms of the continuum of care, particularly for the population you just described?

MS. SWAIN: Healthcare providers volunteer in so-called free clinics; while well intentioned and they're certainly doing it out of the goodness of their heart, it's a problem. Free clinics are a problem. They're hard to manage, they're hard to regulate. The

quality of care is really spotty. The research on free clinics is just not a good way to provide healthcare because it is not regulated and it's not managed in any way. It doesn't provide any sort of continuity of care. Providers come and go.

I ran a community health center for many years, and we had a volunteer -- mainly dentists, because dental care was much harder than medical care -- and it was great to have somebody who was willing to come in and

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volunteer but we never agreed to accepting volunteers unless they were willing to commit to a regular schedule so that they could manage a patient panel and provide some continuity.

Free care, there really isn't any free care. Free care is not necessarily free, because the cost of managing a patient who has a potentially complex illness when you're

dealing with a churning provider set as well as a churning patient set.

MR. KENNEDY: Thank you.

Any other questions?

(No response.)

Thank you.

Our last presenter for today is Mr. Gavin Kearney, staff attorney for the New York Lawyers for the Public Interest. They were a member of the Coalition for Community Health Planning.

MR. KEARNEY: Good afternoon and thanks for the opportunity to provide testimony on ways to improve the Certificate of Need process. As already stated, my name is Gavin Kearney. I am the Director of the

Access to Healthcare Program at New York Lawyers for the Public Interest. We are a non-profit, civil rights firm -- I guess the testimony is just getting circulated now -- we

are a non-profit civil rights law firm, formed in 1976 to address the unmet legal needs of New Yorkers and, in particular, our Access to Healthcare Project was created in 1978, and is focused on ensuring access to high quality healthcare for New York City's low-income communities of color.

Over the last several years we have worked with a number of community coalitions in New York City, fighting to preserve and enhance critical healthcare resources in their already under-served communities. As stated, we're also a member of the Coalition for Community Health Planning or CCHP, which is a diverse coalition of community-based organizations, providers, advocacy groups and others whose overall mission is to institutionalize community-based health planning processes throughout the State, in order to ensure the provision of and access to quality healthcare services for medically

under-served populations. Although my testimony isn't exclusively endorsed by the larger coalition, much of what I have to say today comes out of our work with the coalition.

By way of framing, I just want to underscore a couple of lessons that have come out of our work with community coalitions to address healthcare needs. We have been working with communities over the last several years in Central Brooklyn, Southwest Brooklyn, Southeast Queens, and the Northeast Bronx, and I think these are lessons that are obvious and not controversial, but also worth iterating: One is that healthcare decisions that are driven solely or primarily by financial considerations often fail the health needs of low-income communities. I would also add that in a broader sense such decisions are often not driven by a full consideration of fiscal impacts, particularly when you look at the fact that residents of these communities are

then forced into more expensive emergency care.

By way of example, financially driven

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clinic closures in Central Brooklyn over the recent past have left 6,000 residents without access to local services and resulted in the loss of primary care screening and other services. As I mentioned already, residents of this community are disproportionately likely to lack a primary care physician, and also disproportionately and likely to make expensive emergency room visits when ill. That pattern is exacerbated by these closures.

Another lesson that our work has underscored is that to be effective, planning for healthcare must be transparent and it must involve the stakeholders in the community that are most knowledgeable about its healthcare needs and resources, and those stakeholders that are most affected by healthcare

decisions. This lesson is illustrated by the ways in which the Berger Commission's planning and implementation have affected communities in New York City. Although a stated goal of the Commission was to save hospitals critical to serving access, achieving that goal was undermined by recommendations that led to the closure of several New York City hospitals in

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under-served, medically under-served communities. While some degree of public outreach was performed as part of this process, the opacity of the decision-making process makes it difficult to determine the degree to which locally articulated needs affected Commission recommendations, recommendations which ultimately were implemented.

With that in mind, we offer a handful of recommendations to improve the CON process. The recommendations that we offer focus on

using effective, participatory health planning as a means to better alignment of healthcare resources with community need. First, I will recommend a process or elements of a process that could be used to more accurately assess public needs, and then I will discuss recommendations for ensuring that that assessment meaningfully drives allocation decisions.

Public participation is essential to effect a need's assessment in health planning. Such an assessment should look comprehensively at a community's health profile and the needs

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for services that it suggests rather than more narrowly at whether there exists sufficient demand to ensure utilization of a given service. Public participation is key, because among other things, local stakeholders possess a wealth of knowledge about healthcare needs and the utility of existing healthcare

resources that are not captured by existing quantitative data. Supplementing quantitative data with qualitative knowledge gained through public participation ensures that relevant gaps in knowledge are addressed rather than implicitly ignored.

To be meaningful, public participation must occur early and it must occur often. In order to ensure that stakeholders are involved, notification of pending CON applications should be provided in multiple languages, driven by the language demographics of the affected area. Notification should also occur through channels such as local media, local elected officials and local providers, and in addition, efforts should be made to develop outreach lists that tap into a given

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community's social infrastructure.

In the communities with which we

work, key conduits of information include social service agencies, local faith-based organizations, local community boards, and various other community-based organizations. Developing distribution lists that utilize these resources, particularly in medically under-served areas, will be essential to effective planning.

As stated, opportunities for meaningful input should occur regularly, and we think that a useful model for considering how to accomplish this is the environmental review process required by the New York State Environmental Quality Review Act, otherwise known as SEQRA. SEQRA is designed to ensure that potential impacts of a proposed decision -- potential environmental impacts of a proposed decision are fully assessed and that thorough consideration is given to ways in which potential negative affects can either be avoided or mitigated.

While we are in favor of a more comprehensive plan in medicine, solely

responsive to particular CON applications, we believe that the SEQRA process offers useful lessons either for broader planning or for application-specific assessments. Although flawed in some ways, and I won't go into those, SEQRA includes an explicit process for assessing impacts and developing remedial measures, and it's a process that requires public participation at several key junctures throughout the decision-making process. It also requires that public input be addressed by the applicable agency.

Projects undergo an initial limited evaluation to determine whether significant, adverse impacts are likely to occur. If the answer is "no," further analysis is not required. If the answer is "yes," fuller consideration of impacts is required in the form of an environmental impact assessment. Stakeholders are given the opportunity to

challenge the initial determination that a significant impact will or will not result.

During environmental impact assessment, public participation is required in the scoping phase, and during the scoping

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phase, the breadth of impacts is to be evaluated and decided upon and methods for evaluating those impacts are also decided upon. Stakeholders and public participation is already required during the assessment itself. Stakeholders are given opportunities to comment on conclusions drawn with respect to projected impacts, and the viability of measures for avoiding or mitigating them, including additional measures for doing so.

Both the scope of assessment and the assessment itself is published in draft form. Once comments are received they are required to be explicitly addressed before either the scope or the assessment can be finalized. We

believe that this framework can be used to improve the CON process in a number of ways. In order to avoid unnecessary delay or expense resulting from a CON review, an initial scan of potential impacts of an application is to be used to determine the intensity with which the application was reviewed.

In addition, similarly engaging the fact that stakeholders, through an application review process, would help ensure that the

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needs of the affected area and, thus, the potential impacts of a proposed action are adequately considered. Require that legitimate concerns and questions be addressed, but also add to the accuracy and the credibility of the process.

We also strongly recommend that a needs' assessment exclusively consider race and ethnicity. As has been demonstrated in Massachusetts and elsewhere, race and

ethnicity data can and should be used to ensure that decision making in the health arena doesn't exacerbate existing disparities with access to healthcare. Such data are critical to identifying gaps in healthcare and developing effective measures for addressing them.

In terms of ensuring that a needs' assessment forms decision making, we have several recommendations as well. One criticism of the CON process is that it is reactive in nature. It depends on specific applicants coming forward before local health needs can be addressed. One way to make this process more proactive in nature without

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fundamentally restructuring it would be to engage in a healthcare needs' assessment outside the context of specific applications. The results of such assessments could be used to broadly communicate priority needs for a

given area and to invite and/or incentivize applications that meet those needs.

Consistent with current regulations, key areas of need that should be prioritized include low-income populations, populations of color, people with disabilities, and other medically under-served areas and demographics. Possible ways to incentivize applications that are responsive to these needs would include waiver or expedition of review, where appropriate; assistance in preparing applications that address critical needs; higher thresholds for triggering full review where an application addresses critical needs; and fee reductions for applications that address critical needs.

Ensuring that key areas of need are met through the CON process could also be aided by a review process that gives public need greater weight vis-a-vis financial

considerations in low income and medically under-served areas. Shifting weight in such circumstances would account for the reality that those care providers that are most financially troubled are also those that provide the most needed care, care that is uncompensated or poorly compensated.

Thanks for the opportunity to offer these comments.

MR. KENNEDY: Thank you, Mr. Kearney.

Questions for Mr. Kearney?

I would like to thank you for the number of ideas in there that reemphasize things that have already been said, as far as racial and ethnic -- the need for racial and ethnic data in order to more fully address the disparities' issue, but also an issue that hasn't been brought up before, and the Department has mentioned that, is the use of an RFP kind of vehicle. That kind of a creativity, imaginative thinking is appreciated.

Thank you, Mr. Kearney.

MR. KEARNEY: Sure.

MR. KENNEDY: In terms of our next

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steps in this process, what we would like to do in a not-too-distant future meeting is to ask our colleagues on the Public Health Council to come back and reconvene with us, the Planning Committee, and Karen Lipson and her staff will organize the testimony highlighting the salient features and issues, and then we will have an opportunity to discuss this and make some decisions moving forward, and prioritize the variety of issues, big and small, as we heard today and as we heard back in July, and create a strategy moving forward.

I would like to, on behalf of the Department staff, remind those who presented today to please, if you haven't done this already, put your presentation in electronic form, and send it to the Department staff so

that we can put that up on the website. Some of the testimony from back in July is already on the website, and our hope is to put all of it up to, again, increase our transparency as part of this overall process which we have been talking about today.

I would like to take this opportunity

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to thank my colleagues around the table on the Council, and again for our colleagues from the Public Health Council today, and also to Chairman Kraut for his leadership in keeping this process moving forward.

At this point I would like to ask for a motion to adjourn.

DR. BERLINER: So moved.

MS. JIMINEZ: Second.

MR. KENNEDY: Thank you.

MR. KRAUT: Thank you everybody for staying. I know it is a long, long day, but once or twice every eight or nine years, it's

reasonable.

(Time noted: 3:50 p.m.)

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

I, MARGARET EUSTACE, a Shorthand Reporter and Notary Public, within and for the State of New York, do hereby certify that I reported the proceedings in the within-entitled matter, on September 18, 2008, at 90 Church Street, New York, New York, and

that to the best of my ability, the above proceedings are an accurate transcription of what transpired at that time and place.

IN WITNESS WHEREOF, I have hereunto set my hand this _____ day of _____, 2008.

_____

MARGARET EUSTACE,

Shorthand Reporter