



Public Policy Forum

Restructuring New York State's Health System

**Presented by
Stephen Berger**

October 24, 2007

Courtney Burke:

Good afternoon everyone. Welcome to the Rockefeller Institute's Public Policy Forum with Stephen Berger. Mr. Berger will be introduced in just a moment by the Institute's co-director, Richard Nathan. Let me first welcome everyone and thank you for attending today's forum. I think it will be very interesting and timely.

I'm Courtney Burke and I serve as director for the Institute's new Health Policy Research Center. Some of you are probably familiar with the Rockefeller Institute's previous work on health policy issues such as Medicaid enrollment, Medicaid managed care, and more recently, bioethics. In all of our research, whether it's health care, education, urban issues, or fiscal studies, our focus is always on the role of state and local governments. The Institute established the New York State Health Policy Research Center in order to build our own research capability in health care and increase our collaborations with the many great organizations in New York State that are already doing research on health care policy issues. You can visit our website, www.rockinst.org/HPRC. The Institute periodically holds public policy forums on a variety of issues and Institute staff, Michael Cooper and Michele Charbonneau, are critical for helping that series go on.

In September, we had an interesting forum that we cosponsored with United Hospital Fund, whose staff did an excellent job securing speakers to talk about the choices and challenges in New York's health insurance market. We had views from health plan business

leaders and labor leaders; a very interesting discussion. The goal of the policy forums is to inform the public about important policy issues, so we welcome your suggestions for future forums and topics, and we'd like to see you at future events.

To introduce today's policy forum speaker, I'd like to turn it over to the Institute's co-director, Richard Nathan.

Richard Nathan:

Thank you, Courtney. I'm excited and pleased that Courtney is paying a lot of attention to the role of the states in health policy and administration at a time when it's very appropriate for us to do so. She is getting us increasingly into the health policy field, working with our state and on state government involvement generally in health policy issues all across the country — in lots of different states where exciting things are happening. States are at the forefront.

Today, I'm really pleased that Steve Berger is here to speak to us. He's somebody I've gotten to know and I respect a lot. He's had wonderful experiences in the private and the public sector. He is a very smart and special person whom I admire.

Steve was one of the founders and is the head of Odyssey Partners, a capital investment company. He's worked in the private sector at various times in his career, in financial management. He also has a distinguished career in public service. I won't list all the things he's done because there are too many. He was head of The Port Authority of New York and New Jersey for five years. He is, most recently, the chair of the New York State Commission on Health Care Facilities in the 21st Century. I was the chair of the Regional Advisory Commission for the upstate region. Courtney Burke was the secretary to that group. So, I had a chance, up close and personal, to see how that process worked and particularly to spend time with Steve, whom I've known over the years. He was also executive director of the New York City Emergency Control Board during New York City's fiscal crisis. He was the welfare commissioner under Governor Hugh Carey. He worked initially for Nelson Rockefeller, then for Carey and Cuomo. He is somebody who knows a lot about state government, and is trusted and respected for his advice and insight on things that state governments do in the public sector.

The topic today is a broad-gauged look at the restructuring of New York State's health system. I'm going to call on Steve and then there will be some time for people to ask questions. Steve, welcome and thanks so much for coming.

Stephen Berger:

Actually, when Dick invited me to come up here, I figured I absolutely had to because one of the rules in public life is when somebody sticks their neck out for you, you have to at least do a favor for them and come visit when they ask. I want to thank Dick and Courtney for doing that. Obviously, of course, nobody lets me go out in public anymore unless I'm protected from people who will keep me from making a fool of myself.

There's a certain point in life when you've got to say what you're going to say, because you've been quoted and misquoted and requoted so many times, it doesn't matter.

I want to do three things. Partly because this is an unusual audience and an important place in the state, I want to take advantage and talk a little bit about the process and some of the lessons that we've learned in this recent experience. I want to talk a little bit about substance. And then I want to talk about what we know we didn't do and what we think we did and what still has to be done.

The Decision Process

The process was important. In digging through my files, I actually found the damned letter which started all this. I was asked, "What are the issues the governor should talk about?" And I said, "Health care and Medicaid reform." I wrote the letter in May of 2003, which talked about establishing a commission. I never heard anything for months, until one day a guy who I'd never met, George Pataki, called me on the phone and said, "I want to talk to you."

Let's begin by talking about the stages of the process because they're very important. The first part of the process was the establishment of a task force by the governor to look at the issues relating to Medicaid and health care. The governor's task force was basically a private group. We spent a year and a half and probably talked to 40 or 50 different organizations, interest groups and "interested parties" around the state, both upstate and downstate. We went through a process of trying to chart out the issues that had to be dealt with.

Obviously, the genesis was the state's spending on Medicaid and the impact that had both on the state and local governments. From that starting point we laid out what I have described continually as an architectural rendering of some of the issues that have to be dealt with. Subsequently and partly driven by an impetus from a lot of the county executives who were facing some of these major issues, the Commission on Healthcare Facilities for the 21st Century was established by the legislature.

The legislature also did two things which, frankly at the beginning, I thought would be a nightmare but turned out to be extraordinarily advantageous additions to the original concept that was put on the table. They established not only a statewide commission, with broad powers and responsibilities, but they added two additional layers. They broke the state up into six regions each with regional commission members with voting power in this area. That guaranteed that we would have people from all over the state involved in the decision-making process. They also added regional advisory committees (RACS) for each region. The importance of the RACS was that since they were not legally "decision makers," they were not bound by Freedom of Information (FOI) states, which meant these folks could have private meetings to get off-the-record discussions, get real local color, talk to anybody they felt was important and then come back and brief the commission. The entire process actually worked extraordinarily well. I thought up front that it was going to create chaos, but it was just the opposite. It worked very well and helped us get a real understanding of local conditions.

In terms of the process we went through, I saw my job and the staff's job as, first of all, keeping all the members of the commission totally informed on the conversations, the data, the structuring, and the decision-making process. By doing that, we developed an extraordinary sense of responsibility, concern, and care on the part of the very diverse members of the commission. We were trying to do something that had not been done and has still not been done anywhere else in this country, which was to begin the process of looking at, rationalizing, and reorganizing a health care system that was fundamentally broken, not working, and spending too much money on and not delivering the quality of service that patients deserve. Again, I want to publicly thank all the people who worked on it; I thought it was really an extraordinary activity.

Medicaid and Health Service Challenges

There's nobody in this room for whom I have to go through the background of the spending and the patterns of Medicaid and health service delivery in New York. There are some people in this room who know the details a lot better than I. When we began this process, I realized the gap between now and when I was social services commissioner "145" years ago. I'm the only commissioner in history who ran the Medicaid budget in the state of New York where the budget was less when I was done than when I started, and we expanded services considerably during that period of time. Of course, in those days it was "almost" real money, \$2.6 billion, and today it's over \$47 billion. The concept that what you spend and what you deliver are two different things was not something I ever believed in. I haven't believed it in public life. I do not believe it in private life. It can be done. What you have to have is a mindset that says, "We are going control costs. We are going to cap spending and we are going to improve the quality of services while we're doing it." These are not conflicting goals. In order to achieve that you need a couple things. You have to have a vocabulary that not only says, "Yes," but you also have to know when to say, "No." You have to map out program goals. That's why the original task force policy questions are so important: You have to have an architecture that says, "This is the plan toward which we want to build over time." And I'll talk more about time later. Second, you have to have the political will, which means both the executive and the legislature together. Remember that? The two together working to achieve long-term goals. That's the sort of wave that comes in and goes out, but it has to be there at periods of time if you're going to actually make change.

We're spending between \$45 and \$50 billion a year on Medicaid in this state, and while that's the state's primary obligation, there are also the Medicare dollars, insurance dollars, and private pay. There are an enormous number of dollars spent on health care in this state. My goal was not necessarily to cut spending, but to try to put a cap on it and to begin a series of programs to reallocate dollars based on directed health care goals. We spend more than anyone else. We have inferior outcomes, which we're going to talk about, and nowhere do the benefits equal the kind of dollars we're spending.

When I looked at the 30 years between the time I ran the program and came back to look at it, the mental image I had when I was trying to explain it to my kids, Medicaid had become like a mountain and there was water flowing down it. Alongside the mountain, farms had been created over time. Now it's been 40 years and the water is deeply ingrained, coming down the mountain, and everybody who owns a farm along the mountain believes

they own the water and that the crops they're growing are necessary. Not only that, they need 10 percent more water the next year than they used the year before. (By the way, if you can't explain what you're doing to your teenaged kids, then you don't understand it yourself.) So what we have in this state, and we're not the only state, is a system that's provider-driven, institution-driven, labor-driven, and, by and large, a politically directed funds-flow system. It is not consumer-driven. It is not policy-driven or one that encourages good personal health management.

Recommendations to the Governor

In the original report to the governor we made several points. I'm just going to pick a few. We should restructure and right-size the hospital system. After a year of talking to 40 to 50 groups, no one, no hospital association, no group, no union we talked to, no individual hospital, disagreed with that concept. Of course, everybody told us that we should look someplace else. There was nobody who was bellying up to the bar to buy the first drink, but they told us who should. It was basically universal. By the way, just parenthetically, the hospital system is *part of* the health care system, not *the* health care system, although institutional providers tend to define and market it as such. The job of rightsizing had to be done while keeping the issue of public good in mind. What was important was to look at service delivery in each region and try to figure out as best we could levels of appropriate care that were available, what was not available, and to try to keep in mind the sidebar issues that are crucial for public policy, involving poor communities and communities with limited options, and to try to structure conclusions that met the public need. It was never our mandate or our responsibility, despite conversations with an awful lot of people, to be involved in either protecting or not protecting an institution, hospital, nursing home, or clinic. Our issue was what do you need for services in that community, whether there was or was not an infrastructure there. What does the community actually need?

Third, we said you've got to use the rate-setting mechanism to drive patterns of care. It's a simple formula. We will get the health care system we're investing in. How we decide to invest and where we invest will drive care because the people who are running the system are not fools. People criticize those who are health care administrators. I was there in a session with the governor and one person said, "Well, maybe what you could do is have a new commission that teaches our financial people how to do their work." I said, "That is nonsense. They're terrific. They know exactly how to do their work. Their job is to maximize revenue, right?" Their job is not to design health care. Their job is to maximize their own



institution. Part of the problem with how we fund and how the decisions are made is that one of the things we are not doing is improving hospital quality across the board. We have got to focus and build a delivery system in the hospital sector as well as outside that creates centers of excellence, that reduces the arms race between institutions, and that allows appropriate hospitals to be built, to run and survive in communities. We have to

have a funds flow that encourages it, which basically means you've got to change the reimbursement pattern to fit the true public and social needs.

It's time we start using information technology to create the medical information that will do a whole bunch of things. First, it will improve care and reduce costs at the same time. It will allow consumers to make better choices. The free flow of available medical information would be an important part of changing the culture of health care delivery in this country. And, just parenthetically, since most institutions or many institutions already have been some part of this process, you probably can't interrupt or break it up and you probably can't wait. We'll talk more about that in a minute.

The Commission — A First Step

The commission, as established, was meant to be the first step in what would be a decade-long process to restructure the hospital system. It began with the issue of over-capacity. It focused on rightsizing because the practice patterns in New York are expensive. They are wasteful. They actually jeopardize the quality of care. They limit our ability to provide a safety net and preventive services. They produce inferior treatment options. What's funny is we were criticized by a whole bunch of people for doing so much. But we really didn't do that much. It was meant to be a first step. And why is this a first step? It's a first step because we're feeding dollars in to keep institutions alive just because they are there and not necessarily because they deliver good care. Stop for a minute and look at where New York State has spent money, which has come a long way from when I was commissioner. The average hospital stay in this state is 6.2 days. The national average is 4.8. It is different in different regions of the state, and I understand that. If, in fact, you moved to the national average, we

probably still have, depending on who does the numbers for you, between 30 and 45 percent excess inpatient capacity in this state. Now, the excess beds are excess dollars. What they produce are some interesting things. First, they take money away from places we should want to put it. Second, longer stays aren't good things. Longer stays do not produce better results. The outcomes in New York, with an extra length of stay, are 5 percent worse than they are in many of the districts around the country, which is kind of surprising. Those dollars should be shifted — some to community hospitals — to help redefine and redesign preventive and primary care; to create electronic medical records; and to truly change how health care is delivered. Dollars should not be trapped in bricks and mortar and ownership. The issue is not a hospital. The issue is service in a particular area. So we really need a reversal strategy that meets policy goals, goals of universal coverage, goals of appropriateness, and the ability to create new institutional structures where they're needed so that each community can have the patterns of care necessary for that region.

States Are the Key

Dick said that the states are the key, whether it's Maine, Massachusetts, California, Oregon, or New York. These are the places that will experiment with models of care delivery. In Washington, Congress will just trip going up and down the stairs as they try to come up with a program. They'll shovel more money at us and God help us if we don't know how to use it. So the answer is we've got to do the experimenting in the states.

We will find different pieces in different packages from different budgets. I don't know if the Massachusetts experiment is going to work. California's talking about major changes. We're just at the beginning. But I think out of the states we will see changes that will enable us to move the system. I absolutely believe there's still hope. I believe that the goal will be to develop programs and packages whereby you can begin to create changed patterns of care and you can incentivize different patterns of care.

The issue's not the cost. I don't believe that. I haven't for a long time. I think the issue is will, political will to redesign the system and to make choices. The answer's not to cut a slice here or take off a little piece there. It's the fundamental change of what we want to have as an outcome and what we want to see in the system later, down the road, in five or ten years.

The commission had extraordinary powers, which I had recommended in 2003. I never thought we would get it but we did. But we have an extremely embedded infrastructure with massive political interests that can be brought to bear on these issues. On the other hand, the core players in this also understood that change was absolutely necessary. If you ask the people who are some of the leaders in the health care community, there are very few people who will disagree with what I'm saying here today. For a system that has resisted change, overall there has been enormous change. The number of closures of facilities that have taken place over the past 15 years were market driven. I think in the end our job was driven by patterns of care and what we believe were needs, not by specific financial conditions of individual institutions. If we were to continue to let the market make all these decisions, they would be financial failure decisions, not health policy decisions.

Some people thought we should go for the whole thing: total restructuring in every region, in every hospital. It just would not have happened. There would have been too much dislocation all at once which the system could not absorb.

“A Template and a Process”

The reason we thought what we did made sense was we were striving to set out a template and a process, not just regarding the particular institutions that were affected. By the way, every institution here in the state would be affected because part of the underlying theory was as you make consolidations, as you change facilities, as you remove certain patterns, you will strengthen other institutions that can benefit by that change, whether they are primary care institutions, tertiary care institutions, clinics, or physician-based operations. So the process we tried was to start the change, to show how we did it, and to lay out a pattern for people to think about and to create what would be the first step of continuing change, which has to take place over a long period of time.

The problems in health care range from patterns in disease that require disease management to information transfer, towards availability and appropriateness of care. What we hoped we could do was, by creating a first step, to encourage the industry. Put in place these changes, step back, take a breath, and then move to the next set of changes that have to take place. Make this a continuing process for reevaluation, partly voluntary, partly pushed by state and federal government, so that we can move to the kind of system we'd like to have. Every kid should have a doctor and that doctor should have the ability to have the information available to move that child to the proper institution when necessary.

We are at a point in time where technologically we have the capacity and the ability to redesign health care delivery. The technology is there. We can do things now we never dreamed about doing 20 years ago. We have to build a system that can take care of people, not take care of institutions. The budget in the state of New York is built around education and health care. These are the two most political areas that exist in any state's government and are always driven by directed political pressure. We've got to change that system going forward. So the goal of the commission was to start something. My hope is that the combination of changes will continue. You do something this year, you do something next year, you do something every year, and at the end of 10 years you are then at the beginning of the next 10 years of changes that you are going to need for health care. I'll be glad to answer questions.

Richard Nathan:

Thank you very much, Steve. Tell it like it is. Let me ask the first question and then open it up. You said that this is a first step. Every time I talk to Steve, he keeps reminding me the next thing is "reimbursement, reimbursement, reimbursement." There were some changes made in the budget this year. Paul Francis was here the other day and talked about similar things that they want to focus on for the budget for next year. Do you have any reflections on what happened in the budget last year? And what's the next step? Do you think there's an instrument or mechanism that could begin a process?

Stephen Berger:

This is how I approached some of this. During the three and a half years I was working on the commission, I made a very deliberate judgment that I would make no comments at all on the annual budget process. It was not, I thought, of long-term value and substantive for myself or the commission. We at the commission stayed out of that. The reason was, frankly, if you only work on this on an annual basis then what you've got is a game of puttin'-and-takin'. So, by and large, I have stayed away from it. I haven't tried to look at that. I've sort of closed off that part of the brain and refused to get drawn into that.

The emphasis ought to be on reimbursement. By the way, I still have not been very close to anybody because as you all know, I'm toxic. I'm a walking toxic site, so nobody in government wants to get anywhere near me. Some of my partners actually like that. Reimbursement is far more difficult than what we were doing because, frankly, while there are

individuals, including some in this room, who disagree with our decision-making process, by and large the disagreements were individual, not conceptual.

Reimbursement goes to the heart of how we practice health care delivery. You can talk about it at the level that the people inside the industry like to talk about it. It's a very careful observation about how we do the "weightings." How are we going to change the weightings? They can have arguments about this until my teenager is on Social Security, but the fact of the matter is you have to deal with some of the broader policy issues.

I talked about some of the broad issues; about services around which a hospital can survive; the services around which they can't survive. There's no reason why you can have a perfectly good community hospital and then need a thoracic surgery unit to generate revenue so they can serve their population. The guys who run those hospitals will tell you they don't need it to serve their population. They need it because the reimbursement they get for the community services is not enough for them to keep the hospital operating. What kind of a system is it that from a quality point of view drives system administrators to move into services that they don't have experience or quality for in order to get to a certain reimbursement level? This is not sane.

That does not mean that we don't want to support research, because it is yesterday's cutting-edge stuff that is today's health care commodity. You have to figure out how to design an appropriate reimbursement system that is fundamentally fair. It's not going to be perfect, but it has to be directionally great. I think the big task is going to be on redesigning reimbursement and then linking that redesign toward some of the stuff we started to do on what the shape of the institutions ought to be. I think that's the most important thing because until we start doing that you can't change practice patterns.

There are two levels of practice patterns we have to deal with. One of the practice patterns is administrative (i.e., we need these services because we've got to keep the place alive). The second set of practice patterns, which is just as hard and maybe psychologically even harder, is to have the medical industry begin to look at how it delivers care. In this state, there is no reason that we ought to have lower levels of outcome. Our people aren't sicker; they aren't that much different than people everywhere else in the country, and our outcomes are worse. Therefore, we ought to be looking at what the practice patterns are and that has to do with the management of care for people. By the way, it's probably a multi-year redesign. You're getting a dollar for this for this year and you're getting 42 cents

for this next year, but you're getting 30 cents for that, but you'll be getting 52 cents. It's not a one-year process. It's a phased-in change so institutions can move in a direction. You then move to change step functions along the way and drive patterns and changes. If I had one thing to pick, that's what I'd like to see them doing now.

Neil Benjamin:

I'm with the NYS Department of Health. You mentioned the "arms race." I think one of the things that we all confront in the Health Department in dealing with crisis situations, even post-Berger, is the argument about the nonlevel playing field. The fact that we regulate the institutions and we don't regulate the privates. I have a couple of pieces to my question. Number one, what are your thoughts on that as we move forward either in terms of bringing everyone in or possibly making our existing regulatory structure looser and more competitive? The second thing goes to the reimbursement. Regardless of where the whole system may go in terms of wholesale change, there's going to be a need for transition dollars to the institutions because we're trying to incentivize them to reduce avoidable hospitalizations. But, as you know, with the fixed costs, that carries a steep price. That carries into the last part of my question, which is about the high debt leverage in the institutions in this state, supported mostly by state authority dollars, and the need to protect that unless we want a credit market meltdown. So I'll just throw it out at you.

Stephen Berger:

Let me start with the first part, the regulated and unregulated piece. We talked about this. The arms race is part of it, but there are other issues as well. I asked you and the department several times during the process, "Can you say to me that you know that in any unregulated area there's a quality of care issue?" And the answer was, "We don't know. We don't have any evidence. We don't have any evidence that says this emergency room is getting eleven transfers from this little clinic every day. It's not necessarily a health care issue so far. I haven't seen any evidence. It's a question of how you approach a partly regulated and partly unregulated system. It's a financial issue and a structural issue.

The arms race, though, is basically focusing on the community. The first piece was the arms race at the high end in pre-existing institutions. What your comments suggest are important. It's the cherry-picking part that moves some of the higher margin items. Remember, it's not a dollar business, it's a margin business and that's the issue for people. It's not

how many dollars you get, it's the margin. My answer, at this point is I'm open, and we've had this discussion. By looking at reimbursing and deciding how we're reimbursing, we may or may not begin to affect the out-movement and out-migration and the cherry-picking. So before I'm ready to try to re-manage the whole thing, I would like to use reimbursing as a tool for incentivizing, de-incentivizing, for what goes into the regular institutions and perhaps change the impetus and move stuff.

There is no question that making changes is extraordinarily expensive. The answer's yes, it will be expensive. Just on the operating side as you move I think you've got to have a step down funding process to move things along. I think you've got a real plan and you're doing things. I think that's a good investment. I think I'd like to get that as an investment not only both coming from us but from the feds, and, by the way, the insurers. The answer is that we're going to get it from all three. I think that ought to be a piece of how you structure this. Absolutely. These are not cost-free changes. There are some people in this room who were here when I was doing it thirty-something years ago and God knows what are you doing here. What am I doing here? But the answer is the budget is a one year time shot and you're talking about major multi-year changes. You've got to be real. If you want to finance it, it's got to be hardass. You've got to know where you're going, you've got to have a plan and a commitment, and then you've got to help people get there. Is that worth investing some state dollars, some fed dollars, or some insurer dollars? Absolutely, over the long run.

Third, and this one I thought about a lot because we were very nervous about this all during both the task force and the commission, though more in the task force. This was really a major issue at the task force level. We thought a lot about the issue of capital access. We're going to need capital access in the state, by the way. They are going to need it so they can be remodeled. When your good institutions have 2 percent margins, when you're living at the fault line all the time, your access to the capital markets is marginal or nonexistent. By the way, that's one reason for taking out the excessive capacity, for creating institutions that are stronger, for giving them higher operating margins. It is not a sin for a hospital to have decent operating margins. If it has, they can reinvest in information technology. They can borrow in the capital markets. They can invest in services they need. It is not sinful. We have hospitals that have 10 or 11 percent operating margins around the country and ours are between minus 5 and plus 3. A piece of getting a hospital and institutions access to the long-term capital markets is to have healthy operating margins. I think ultimately we were wrong on how we approached that sort of decision.

I've thought about this on and off for the last three and a half years. I may change my mind tomorrow, though, okay? But right now I'm wrong. Anybody's who's bought stock in residential mortgage funds knows this: We live in a free-market economy. The answer is we may have to have some hospitals go belly up. You can't sink all your capital into protecting hospitals that don't have to be there. If some of them go under, they go under. The capital markets have the memory of a gnat, okay? Not only is Orange County back in the market, but Merrill Lynch, which got sued by them, is underwriting them! Give me a break, guys! So the answer is I wouldn't be cavalier about it. I wouldn't do it loosely, but I would not break the bank to protect an institution that had to default on its funds. Because the goal has to be to not have a capital structure that is totally dependent on HFA or state financing. It's a capital structure for the institutions of this state where they can access the credit markets because their operating margins are good. If we get held out of the credit markets for a couple of years but come back in with strong and healthy institutions, for the long run, that's much healthier for the state.

Richard Nathan:

I want to make a quick comment. It is good to bring people in who care and want to be heard, but you need a decision-making apparatus for what you're talking about that I think could have worked with that kind of a group.

Cari LaCroix Pan:

I'm Cari LaCroix Pan from the Coalition for the Protection of Reproductive Health. Can you talk about what research was done to predict the cost-savings by closing or merging the hospitals and how many years it will take before that savings is realized? You started to talk about that.

Stephen Berger:

I think it's something that's different in different cases. There were different patterns throughout the state. You would have to sit down and go through the details for each particular one. The answer is different in different cases.

Cari LaCroix Pan:

Are we saying we're going to see this in 5 years, 20 years, 50 years, 100 years?

Stephen Berger:

No, less. There are two sides to the question you asked about savings. It was not just a question of savings. Because when you think about it that way, you say, "Here come the damn cost cutters again." The notion was, yes, there are some state savings, but largely in a transfer of revenue from institutions that we wanted to either close or consolidate with the remaining institutions in the area. The core goal was not to make state budget savings. The core goal is to strengthen regional institutional networks so that the remaining institutions have the cash flow and the patient volume to be able to sustain themselves. So you wouldn't see this continued individual collapse of what are institutions in different regions. The savings was a part of this. The larger chunk was not the savings. The larger chunk was revenue transfers to other institutions.

Cari LaCroix Pan:

A little more specifically, what I'm seeing is people are having a really hard time grasping the idea of the savings when they're seeing how the hospitals have to ask for so much money to close or to merge right now.

Stephen Berger:

We knew that. Look, there are major costs in reorganization. We think we booked proper amounts and in big numbers for some of these institutions. If you look at what it's going to look like over a period of time, you are going to achieve a series of things. I said before, my goal in all this was not to cut the state's spending. It was to put a cap on and to begin to move the dollars so we'd have a better system in the end. The cost of that is expensive because what we have done is sunk so much into existing infrastructure and how does that equate? It gets some from "by bed" service that the state guarantees. It gets some by special bills that get passed down the street. So we continually are building into this existing infrastructure whether or not it's healthful and good for the infrastructure.

Sharon Miller:

My name is Sharon Miller and I'm from the Office of the Medicaid Inspector General. I'm hearing what sounds to me maybe like a little bit of a dichotomy. One of the things that strikes me listening to you is that the wrong hospitals may fall. I'm just wondering about your thoughts are on that.

Stephen Berger:

You have to have a reimbursement structure that sets out principles and goals. One of them has got to be appropriateness of care in the community. You have to have a reimbursement structure that allows a community hospital to survive without pretending to be Columbia Presbyterian.

John Ruge:

I'm with the Hudson Headwaters Health Network. The process that you've inaugurated is impressive. The success, though, depends on significant investment in community services. Some parts of the prospects look dim. Medicare was looking at county positionings year by year, except the Band-Aid reply. Perhaps beyond the dark curtain there's a new reimbursement strategy being formulated in Albany, but nobody's seen it yet. The question is what are the prospects? What can we do to engender it?

Stephen Berger:

Well, the first answer is I don't know what's going to happen. The second is we don't know, although I do believe in a nonpartisan, nonpolitical way since I've now worked for two Republican and two Democratic governors. I think that a Democratic administration in Washington will produce some dollars. We are a democracy, our political system, and the political system responds, as we all know. I think that as the decisions are made, both executive and legislative, the voices that are inside, they're hidden behind the dark curtain and tend to be the classic institution we all see because they have the most they can bring to the table. We all know that. If there is no other sort of voice, then those are going to be the only voices that people are going to hear. And the people who are listening are busy, they're under pressure, they're making choices all the time. They're making trades. There have got to be public policy choices. You've got to create an argument that gets them thinking about

the policy issues and health care network issues and not just about the guy who's always talking. I think that's part of it and I think that you've got to be just and frank.

James McCallus:

I'm with the New York State Assembly Health Committee. The one thing that you haven't touched at all on when you talk, especially about reimbursement, is the nursing home industry. Here is an industry that in the 1970s literally took care and was reimbursed for some who could get up out of bed, feed themselves, or some who were bedridden and had to be fed in bed. Then it went to a system where there were different utility groups and reimbursement based on levels of care. Then, in the beginning, reimbursement was based on cost without regard to how many nurses, staff, and everything else. Then it went to a system when the state couldn't afford that, on a base year of 1983, to the point where two years ago when the state legislature in the last year the Pataki administration adjusted those cost rates up to the 2001 levels or 2003 levels. We were actually told at downstate nursing homes that they wanted to stay on the 1983 cost levels because they were making out better at reimbursement than they were in 2003. The nursing home industry reimbursement probably needs as much, if not more, tinkering with total over-structure because there are upstate nursing homes that are still on the old base year that didn't hire tons of people. They couldn't lay them off, at a distinct disadvantage to downstate nursing homes that seemed to be profiting and doing well in this year's market.

Stephen Berger:

There are fundamental problems with the existing nursing homes. There're reimbursement problems, capital problems, and capital reimbursement problems. Then remember half of them are for profit and half are not-for-profit.

I think it's the wrong place to start. You can't ignore it, but it's the wrong place to start. The place to start is to chop the package. I think you've got to start including in this the whole issue of long-term care, both institutional, at home, and all the rest. I think we've got to start looking at that entire package as a continuum. The answer is, there are some more natural continuums than others, for example, from the doctor's office to the hospital. I know it can go all the way to the long-term care, but there's a first-stage natural continuum to manage between primary and preventive care and acute care. In the same way, not that we could ultimately put them all there, you've got to look at the personal care budget. You've

got to look at the whole health care budget, the institutional budget, the nursing home budget, and begin to do what is fundamentally a re-architecture, a redesign. The answer is you've got to redesign that whole continuum and begin to look at the dollars you have in there, look at the potential technology. That's the way I would start looking at it. I think we've got to put it in a framework that makes sense.

Ann Saile:

Hi, I'm with Bellevue Woman's Hospital. Mr. Berger, when you were talking about the emergency departments, you said doing something absolutely is wrong; like an absolute moratorium on expansions for emergency departments. Could you talk about what was going on with the commission when you were writing the report? Did you believe that report was flawless? Did you believe that it would be implemented wholesale, as it was? Or did the commission think that it was a guide for reform in the health care system?

Stephen Berger:

I'll answer the second part first. We thought it would be implemented totally. The law was drafted very clearly. It was up or down. If the legislature voted to turn it down, it would be turned down. If the legislature didn't, it would be implemented. And, yes, we assumed it would be implemented totally. In fact, we knew that there were some pieces that also needed legislation to follow up on that in relating to state university hospitals. We couldn't guarantee that that would happen. But yes, we believed it would be implemented totally.

Secondly, was it flawless? No, it isn't perfect. None of the members of the commission are perfect. Collectively, therefore, we can't be perfect. Did we think we made judgments that were correct, whether it was in your case and the other cases? Absolutely. You don't think so, a lot of people don't think so, but the answer is, yes, we believe that we made the best public policy decisions we could make. We believe that we were making decisions based upon broad regional need. Do I think that Bellevue or Westchester Square or some other places were bad places? Of course not. What I tried to explain is what we tried to do was to design solutions that would strengthen the regional health care networks in each place. That meant change. That meant some people would get more patients, some people would lose patients, some people would close departments. We didn't do a lot of that. That's another thing for the next stage. It's probably much more a downstate issue than

anyplace else. You've got four hospitals on the corner and every one has the same specialties. The answer is we thought we made the best decisions we could.

Unknown Speaker:

I'd like to ask a mental retardation question. On mental retardation in Medicaid they're spending about \$7 billion a year. We had a Berger Commission for that, which I think was a good commission. I think it was courageous. I think both governors were courageous and the legislature, surprisingly, was as well.

Stephen Berger:

Absolutely. It was the legislature's idea in the end that stood up.

Unknown Speaker:

Just to finish my question, mental retardation has spent the same amount of money. They were going to close all the developmental centers. Now they're not going to close all the developmental centers. They bought a house in rural Dutchess County for \$400,000-500,000. They put \$200,000 into renovations. They put \$50,000-100,000 into the septic system. They put four or five people in there and 10-15 staff with a \$400,000-500,000 a year operating budget. Ten percent of that can go right to the executive director, 10 percent of it goes to program administration. I think there's a flaw somewhere in that system. I think if you go over to 44 Holland Avenue in Albany, there's a nursing home right next to that building. I'm not suggesting that should be the next developmental center. It doesn't have enough parking and it doesn't have suitable grounds. But I think there should be a rethinking of the \$7 billion that is spent on mental retardation in the state.

Stephen Berger:

All right, but somebody else is going to do it. I think you've got to look at all the programs. I think that there are a whole bunch of other pieces the state ought to look at.

I've got to come back to Dick's point about getting people to do things like this. Maybe it's another commission. It's a noteworthy thing. One of the things that we found both in the task force and in the commission process, and I'm really amazed by this, is how many

private citizens are willing to commit vast amounts of time and energy, to this process. But how many people when asked, were willing to stand up and say, “I’ll help.” I would keep reminding them that they’re going to get a chance to do something that nobody else can do and it has real value in the end. I think there’s a vast reservoir of people in this state who are willing to do it. If you put it together — whether it’s mental retardation or other issues — they would participate if they felt that there was an outcome that would not be a report on a shelf. Then if we have what was clear to me, that a program is going to emerge, I think people would step up and say, “Yeah, I care about this.”

Richard Nathan:

That’s a hopeful note. Steve, thank you so much for singing my song.