HEAL NY Phase 11

Capital Restructuring Initiatives #3

APPLICANT CONFERENCE

Friday, May 15, 2009
1:00 p.m.
Governor Nelson A. Rockefeller
Empire State Plaza
Concourse Meeting Room 5
Albany, New York

APPEARANCES:

James W. Clyne, Jr., Deputy Commissioner OHSM
Neil P. Benjamin, Director, DHFP
Lora Lefebvre, Deputy Director, OHIP
Larry Volk, Director, Portfolio Mgmt, DASNY
Tracy Raleigh, Asst Director, Portfolio Mgmt, DASNY
Charles Abel, Director, Financial and Support Svs, DHFP
Christopher Delker, Director, Bureau of Grants and Procurement, DHFP
Janice Dee, HEAL Implementation Team, DHFP
Martin Bienstock, Special Counsel, Div of Legal Affairs

REPORTED BY: Paula M. Miller, CSR

P R O C E E D I N G S

MR. DELKER: Good afternoon. Thank you for coming. It's a beautiful spring Friday afternoon, and I think we would all rather be somewhere else, but we'll try and make this go as quickly as we can so you can get home or out on the golf course or wherever you want to be this afternoon.

Everybody should have picked up a copy of the agenda outside as you came in, and that's -- let me tell you how that will work. We will go through all the agenda items first. The main purpose of this gathering is for your questions and our answers; so, if you will hold your questions until we're done. That's the way we'll proceed, and when that time comes, we'll have a mic there in the middle and you can come up and ask your questions.

I would just like to first introduce the panel. I'm Chris Delker, Division of Health Facility Planning.

MR. BENJAMIN: Neil Benjamin with OHSM, the Division of Health Facility Planning.

MR. CLYNE: You would think this is Neil's first time. I'm Jim Clyne, OHSM.

MS. LEFEBVRE: Lora Lefebvre, OHSM, Division of Health Care Financing.

MS. DEE: Janice Dee, Implementation Team with the HEAL Unit.

MR. ABEL: Charles Abel, Health Facility Planning.

MR. VOLK: Larry Volk, Dormitory Authority.

MS. RALEIGH: Tracy Raleigh, Dormitory Authority.

MR. BIENSTOCK: Marty Bienstock, Division of Legal Affairs.

MR. DELKER: And I would like to acknowledge Joe LeDuc who is there by the computer projector; is our contract and finance manager from the HEAL Unit. You may have met Elizabeth when you signed in. Probably the most important person in this whole process is not here, Bob Schmidt, who is the Director of the HEAL NY implementation team. Those of you have HEAL grants know him well. He's recovering from his own encounter with your acute care systems; so, we expect him to be back sometime around the end of the month or early June, but he's here in spirit, nonetheless, and he will be a key person

in all these activities.

I think that, first, we have to go through a couple of ground rules here. This is a competitive procurement under the State Finance Law. This is different from your average categorical grant or grant and aid. There's some very strict rules under the State Finance Law about what we -- how we can and cannot impart information.

Basically, any information about the grant or the grant process, or our application process, has to be imparted in a public forum like this one or like the web question and answer process that we have set up on the DOH website; so, ask your questions today. If any occur to you during the coming week, send them in on the web. After that happens, after next May 22nd, we'll not be able to give you any additional information. So, think carefully today and succeeding days about what you might want to ask.

Also, you cannot come up to any of us afterwards for a sidebar follow-up or question. We can't talk to anyone one on one. Whatever we say has to be heard by all interested parties,

so we'll have to be rude if you come up to us and not talk about that. You can talk about other things, but not the grant process.

And also, it's in the nature of these proceedings that any statements that will be made are to be deemed preliminary until we publish the transcript on the web, which we'll probably do in a week or so, after this gathering. Generally speaking, we just issue the transcript as it is, but occasionally, believe it or not, we do make mistakes and have to issue a clarification or correction. So, we reserve that right to consider what we say here as preliminary until the transcript is issued.

Okay, that's the ground rule stuff. I would like to, now, turn to the Panel and have a few of the members talk about the whole context of this grant and how it fits in with some of the things that have been going on at the State level for several years with the Berger Commission and then with additional to further realign the health care system for more efficiency and more effective services. And the first person will be Jim Clyne, Director of the Office of Health Systems Management.

MR. CLYNE: Thank you. The Department remains committed to pushing forward on the restructuring goals that were laid out in the Berger Commission. The Berger Commission recognized that the report was only the beginning of restructuring the health care system and the Department, through the HEAL process, the CON process, through reimbursement reform and through attempts to reinvigorate health planning are going to continue to push forward the Berger reforms.

This RGA offers assistance to hospitals that want to voluntarily downsize, that want to consolidate services and governance; they want to merge and they want to operate more efficiently. We think that collaborative activities can be the most effective means of reducing excess beds and inpatient services and reorient the health care system towards more appropriate care. Bringing together financially strong facilities with financially weaker partners; partners that are still needed in the community can bring many long-term benefits to the health care system and the communities that are being served.

Inpatient care is always going to be needed; it's vital to the communities, but too often, the hospital capital investments have not done enough to strengthen ambulatory or outpatient services. Hospitals have looked at inpatient in a silo. As we rolled out the new prevention quality indicator data system that's on the web, we've been encouraged by the enthusiasm shown by hospital administrators throughout the state in using this information to make services more responsive to the identified community need.

The entire CON process now uses the PQI data has been a change. HEAL 11 grants will help support the capital component of these efforts. I would just like to note as much as this is a beautiful day for HEAL 11, HEAL 12's conference is going to be held on the convenient time of the Friday before Memorial Day weekend, for those who are interested. So, this RGA is really focused on hospitals. The next one will be focused on right-sizing the long-term care system and then there will be additional HEAL opportunities next year, after October 1st.

As a goal of previous HEAL RGA's, we

will, of course, receive more requests we could possibly fund. The over/under right now is about three billion right now; therefore, we urge you to put together projects that offer substantive changes in the way that you do business; more collaboration, new ways of organizing and delivering care, more innovation in connecting people through needed services in the most efficient setting possible. It's an opportunity to be resourceful, be innovative. This is an opportunity to make some of the changes that some facilities maybe have wanted to make but haven't had the ability to do so financially, so we urge you to take the time and effort to put together thoughtful proposals that really change delivery in your local community. Focus on what's the need of the communities being served. Thank you.

MR. DELKER: Next, Neil Benjamin will kind of go a little bit further with that. Those of you that know Neil know how difficult it is for him to be here the day before a major triple crown race, but his sense of public service has won out over his profit from racing horses, and he's here with us.

MR. BENJAMIN: It's not post time yet. Thank you. I just want to pick up and expand on what Chris, and certainly what Jim, said. You know, the purpose and overview, I think, have been made clear by Chris and by Jim, and the main goal is that we're looking for projects that, you know, really better align health care resources with community needs.

Now, I've said this kind of thing before as a pretty simple example. We're -- the whole process, as Jim said, of health care planning and, you know, I call it resource management, is really changing. It's changed dramatically from really what we have catered to for the past 30 years, or at least from the planning process, CON, has really been focused on institutional needs. You know, the institution serves the community and what are the needs of that institution to continue to serve the community.

And a lot of times, it was just on a straight line. You know, we've had this much growth and therefore on our inpatient side and we're expected to continue; therefore, we will always need more beds, etcetera. What we're trying to do now, as Jim mentioned through the

PQI and other new data bases, is identify just what really are the needs of the patients that are served in that -- that live in the community; not just necessarily just patients who are hospitalized, although that's a big focus of the PQI but also focused through the whole continuum. And so we're changing things from a top-down look to a ground-up look; meaning, identifying the health care characteristics of the people who live there and what's the most appropriate, efficient and cost effective system to meet their needs.

You know, everybody knows about Berger. Everybody knows about the concepts that it espoused in terms of moving capacity, and, you know, we're moving beyond that but those concepts still guide what we're trying to do both with this RGA and through the whole planning process. And that is continue to move services to the most appropriate and cost effective setting.

So, I think that we made it pretty clear in this RGA that those will be the -- those will be the types of projects most favorably looked on. Just a quick example is, you know, with the

PQI's, if you look at a given community and see that their hospitalization rate for the people who live there is, pick a number, 50 percent above the statewide average and that is contributing not only to repeated admissions but to higher than, you know, normal occupancy levels; services that could be devoted by the hospital to other things. We're really looking for ways that can prevent those hospitalizations from occurring in the first place.

I know that's a lot easier said than done, but that's why you see a lot of the focus here on community based resources needed to make that shift. And we also recognize it can't happen overnight, but this is a real good opportunity to set in place the fundamentals in the infrastructure so that the system can begin to radically change towards and to meet those goals and objectives. And then the second -- and so when we talk about alignment, there's really two alignments here. The alignment I just mentioned about resources versus need, but also very important is the alignment of the planning process, and what we're trying to do here with the reform -- the reimbursement reform

and change agenda that was put forward during the budget process.

We think that's very important that we -- we align the planning process with those types of reforms because they do go hand in hand. And in that regard, Lora Lefebvre is here to say a few words from the Office of Health Insurance side. Thank you.

MS. LEFEBVRE: Thanks a lot, Neil. Glad you're here and not at the track. How is everybody today?

So, as Neil points out, a lot of the objectives of this RGA really do drive at assisting, I think you all, in realigning the way the service delivery is provided in New York State. As Medicaid, and as one of the larger insurers of folks that you see in the State, we have a huge stake, we believe, in assisting you all and your clients shape the delivery system on behalf of our clients; Medicaid clients.

And one of the kind of mantras I think that we used as we were working through Medicaid reform over the last two years is making sure that our clients are served in -- at -- with the right service, in the right setting at the

appropriate price. And over the last couple years, we've really been working on making sure we get that pricing structure right; we get the pricing structure evolved to a place where everybody understands it, because it's an inherently unknowable and complex system that we've got right now; and also making sure that we provide incentives for aligning services where they should be provided.

In keeping with all of that, last year' budget, the one prior to the one that was just enacted, we did a lot of major reform to outpatient reimbursement through the ABG system. This year, we were successful along with the legislature, and I must say the industry has been really helpful also in reforming fundamentally inpatient Medicaid fee-for-service reimbursement. We think we have a pricing methodology now that makes a lot more sense than it did.

It's a lot more understandable and it pays for appropriate costs on the inpatient side. The other thing -- not to mention it reduces inpatient reimbursement by $225 million. That's not insignificant. It's a major -- we

understand that it's difficult for the industry to absorb, but on the flipside of it, we invested significant dollars on the outpatient side not only through hospital-based clinics, we, on a full-annual basis, there will be $180 million more in that outpatient setting. There will be another $180 million more on a full annual basis attributable to physician fee schedules which is significant, and then there's another $50 million that was invested on a full annual basis in freestanding clinics.

So, as the major insurer, we're trying to speak through where our dollars are being driven on where we think good quality care should be delivered. We understand that that's difficult. This state has really developed a kind of inpatient centric, you know, delivery system and it can't necessarily change overnight. All of the work that we've been doing through Berger and certainly all the rest of the HEAL's has been an attempt, I think, to try to help you all kind of reconfigure your service delivery system.

So, we see this next HEAL as an opportunity for you all to take advantage of

capital dollars to assist you on kind of shifting this rather large, you know, ocean liner towards another method of delivering care.

I would just also mention that operationally, inside the reform package, you know, there are other transition dollars available for those hospitals that were having difficulty, so we put up $75 million in year two to kind of assist folks in operationally who were having difficulty also making that change. So, we're really excited, and I hope you guys are all looking at this as an opportunity to kind of shift. And I would just note, also, that the Federal government clearly is on the same, you know, quality of service bandwagon that we certainly were able to achieve this year, and I expect there will be more changes coming down with Medicare changes, too. So, Chris, I think that's all I have. Thank you very much.

MR. DELKER: Thank you. Well said. Can everybody hear me? We would like to just quickly go through a couple of the elements of the RGA before we get to the questions. The first one probably that is most important is who

is an eligible applicant. And those are defined on page 3 of the RGA. And the first eligible category is general hospitals as defined in 2801 Part 10. Now, that's what most of us think of as hospitals; you know, your community hospital, your major medical center, whatever. The term "general" is not really restricted to general. It does include hospitals that are dedicated to a specific purpose. So, for example, rehabilitation hospitals are eligible under this RGA. Now, the next two, your active parent or co-operator of a hospital established under the Public Health Law or an Article 28 Network established under the Public Health Law, be careful.

Every year with every HEAL iteration we get applications from something calling themselves a system or association or a network that think they're running a hospital or a nursing home or whatever; they're not because the name is not on the operating certificate. So, whatever organization you plan to be the applicant organization, make sure the name of it appears on the operating certificate. If it doesn't, we cannot even read the application,

and we've had to disqualify several in the past for that very simple reason and a very fundamental mistake on the part of the consultant or the applying organization or whoever it was. So, make sure that the name of the applicant entity is on the operating certificate.

The major fundable activities: Substantive collaboration, reduction of excess inpatient capacity; we're talking about staff capacity here. You know, you may have some beds you haven't used in 20 years and you don't even heat that part of the building and you say, "Oh, we can knock 20 beds off and look like we're right-sizing." We're talking about a reduction of staffed inpatient capacity; whether it's beds or some inpatient service or some major medical activities, so, keep that in mind. Substantive collaboration, that's -- that's on pages 4 and 5 mostly on the RGA, but these are some examples: Mergers or shared governance, some change in the way you do business, as Jim Clyne was saying. If not overall, then maybe a major service or bed category you're going to do a collaboration with another entity or it can

even be with an ambulatory provider, but something substantive that either needs establishment approval under the Public Health Law or some sort of a legally binding agreement.

A referral arrangement or some business marketing arrangement, things like that, those we would not consider substantive for purposes of this RGA. And as Jim said in his remarks, be resourceful. I mean, we don't know all the models yet and this is an opportunity for you to come up with some new ones and you may well meet the criteria of the RGA. We would encourage that kind of innovation and new thinking.

Major eligible costs are the same as those that have been in most of the previous HEAL RGA's for capital restructuring. So, you're used to that: construction, renovation, legal fees associated with mergers or downsizing or other collaborative arrangements; equipment expenses and so on. I would also like to ask Larry Volk to say a little bit about bonds matters and the costs associated with those; and whether you know it or not, a large portion of the majority of the HEAL funds are under the Dormitory Authority's bonding authority, so

Larry, you may just want to say a few things.

MR. VOLK: Sure, Chris. The funds for HEAL 11 come from two major funds; one is actual hard dollar appropriations to the Department of Health, the other is through issuance of bonds by the Dormitory Authority. The Dormitory Authority's ability to issue bonds are severely constrained by State law, and to issue tax exempt bonds are even more constrained. And those constraints largely have to do with what you would normally consider to be capital. They are buying some physical piece of hardware. They are buying a building. They are constructing a building. A major renovation of a building. Those types of things, and there's some language in the RGA from the State Finance Law that goes into a little more depth, but if you would normally capitalize a cost for accounting purposes or for tax purposes, in all likelihood we can issue bonds for it.

The one area that's a little interesting is that once you have an actual capital project, then there are some additional costs that can go along with that; some planning, some design, legal costs in connection with it. Those softer

costs that are associated with a real hard dollar capital project. The capital funds available under the hard dollar state appropriation have considerably more flexibility than the Dormitory Authority bonds. The reason why it's important for you to at least take a first crack and what you think is going to be capitalizable and bondable is so that we can track that we actually have enough funds of the right type of funds to fund all of the projects.

Thank you, Chris.

MR. DELKER: There's an important provision that governs all HEAL funds. Under the HEAL Enabling Legislation any costs incurred are deemed public work, and they have to comply with Articles 8, 9 and 10 of the Labor Law. That means that the contracts for construction and other related activities have to pay prevailing wages. And this has been a stumbling block, frankly, for a few of the awards we have made in the past where the -- once the recipients realize they had to pay prevailing wages they found that they had not budgeted enough for the construction component.

So, in putting together your

application, be very sure that you calculate what the prevailing wage impact will be on any construction or other capital activities you're proposing.

You can get the schedule of prevailing wages for your area from the New York State Department of Labor website, and just Google it or go onto DOL's website and punch in "prevailing wage," and you can get all the information you need on that. These grants are also subject to Article 15-A of the Executive Law regarding Minority and Women-Owned Business Enterprises, and I think most of you are probably familiar with that; if not, your legal staff can advise you on that. So, just keep those two things in mind.

Another legal aspect we have to keep in mind when we're encouraging things such as collaboration, mergers and so on are State and Federal anti-trust concerns. And to address those, we have Martin Bienstock, Special Counsel from the Division of Legal Affairs who has a long history with the Berger Commission and related activities and he will advise you on some of the pros and cons and opportunities,

frankly, that these types of activities represent.

MR. BIENSTOCK: Thanks. Thanks, Chris.

When I made this presentation for the HEAL 7 grant, a friend of mine came over to me afterwards and said, "I heard everything you said and now I'm just not going to do what I was thinking of because of the anti-trust laws," and my jaw dropped open and my hands went up to my head. That was the exact opposite of the message I was trying to convey. So, let me kind of give you the message at the outset, and hopefully that message will stick with you throughout the rest of the presentation.

The basic message here is that the HEAL grant is a unique opportunity for you to do things, engage in mergers, reach agreements, create active parents, to do the kinds of things that you might not otherwise be able to do because of the anti-trust laws. So, this is a unique opportunity that you should be looking to see if you can come up with structures that advance the cause of HEAL or that are good for the health delivery system but that the

anti-trust laws might have prevented you from doing otherwise.

So, just briefly to explain that, there's something called The State Action Doctrine that says that action by the State, essentially, is exempt from the anti-trust laws. Sometimes when the State takes the action itself it's entirely exempt. The HEAL grant is a little bit different because the actions by private entities, you guys will be doing something, but it's under our direction and supervision. So, in order to be exempt from the anti-trust laws, you need to meet a two-part test. First, do we have a clear -- does the State have a clearly articulated policy in support of the activity. Did we say that we want to do this; did the legislature say we want to do this. And second, are we actively supervising what you do.

So, if the State comes out and said it wants to accomplish a certain goal and then it keeps its eyes on the private sector to make sure it is accomplishing that goal, the anti-trust laws won't apply because we're supervising it. It's like the State of New York

is acting; not as if you private hospitals are acting. So, you need to meet those two tests in order to get immunity. The first test will be satisfied for every successful grant application. If you come in here and demonstrate that you're entitled to State funds because you're doing something that we're trying to accomplish through a HEAL grant which was authorized by the legislature, then you're acting pursuant to a clearly articulated State purpose. We said this is what we want to do, you came in, you passed the steps for grant application, we approved it, so boom; you've satisfied the first part of the test.

The second part is a little bit more complicated and requires active supervision, and that's kind of case specific. If you're doing something once, you know, that doesn't -- in that case we might need to supervise very closely what you're doing this one time. If you're doing something over time, we might need to kind of continuously supervise you to make sure that you're continuing to meet our goals. So, you'll need to evaluate just what it is that you're doing and how it is that you, you know,

that you're looking to us to supervise what you're doing.

And you should take into account when you're kind of figuring all this out, try to take into account the limitations that the Department has and how it can supervise it. For instance, we're not going to supervise rate negotiations with managed care companies, so if you're thinking we'll do such and such and our exclusion will be the Department is going to be what the rate should be, that's not a tactical solution to how we can act as a supervisor to what you're doing.

In addition to a merger, consolidation, whatever you're thinking about, you might also be worried about preparing and submitting your grant application, and that's also protected. You can do that if it's kind of a reasonable attempt to get in front of the Department with your applications. You can do that even if it would otherwise violate the anti-trust laws. One kind of final caution I would give is I can give this kind of general advice to you, and I think it's a very valuable, both in terms of you knowing that the Department supports activities

that might otherwise implicate anti-trust concerns, and also to kind of let you know what kinds of things you can do.

But my advice can only go so far, so if you think that what you're doing might implicate anti-trust concerns, you should get your own attorney and have him -- you know, you can get a transcript of everything that I've said here, and if you've got some generalized questions, make we can answer them on the internet. But you do need someone to give you kind of particularized advice to get you through the specifics of the application. So, you know, I started by saying it's a unique opportunity, so let me end it with that; that this is -- you know, anti-trust is a little scary, but the RGA process offers an opportunity to do some things that you might not otherwise be able to do; so, you should look at it with those eyes and see if there is something that you could come to us with that would advance -- and again, we're looking to advance public health and the health care delivery system. And if that's what you're trying to accomplish and it works, some of the anti-trust barriers might not apply. Thanks.

MR. DELKER: Okay. Thank you. We'd just like to talk in general about the basis of the awards. Generally, is the application responsive to the goals of the RGA: The collaboration, the right-sizing, the reconfiguration of services towards community needs. The things you've heard Neil and Jim and Lora talk about, and are the proposed activities reasonable, cost effective and financially feasible. Keep those things in mind. We had someone in one of our earlier iterations say, "Well, we think our proposal is a pretty long shot." I mean, as Jim said, we get three to four times as many of these things that we can fund with about every iteration.

So, if you think it's a long shot, it is, and you're going to be paying a consultant a lot of money and as well as you're going to waste a lot of our time. So, focus on the RGA and write to those goals and the other information we stated here today.

When we score, the scoring is done numerically. 75 percent of the score will be on their technical side or program side, is probably a better word; and 25 percent will be

on the financial component. We get the scores through uniform scoring criteria; that's the requirement of the State Finance Law with competitive procurements. The minimum score is 65; so, if you don't get a combined score of -- financial and technical combined of 65 or more, that will be deemed, you know, not passing. Kind of like when you were in school, depending on where you went to school.

I think I'm going to stop here and turn things over to Janice Dee, who is Bob Schmidt's associate, and who's very capably stepped up to the plate in his absence, and she is going to walk you through some of the particulars of the application form and how to submit an application.

MS. DEE: Thank you, Chris. The next slide is a little disturbing; so anybody who has a squeamish stomach might want to look away. That's our conference room. Those are the applications that we received for Phases 6 and 7. And it's just -- there's a box of cookies there, and we kind of don't let staff out; we send in food once in a while. Well, the ladies get to leave to go to the bathroom; men

we kind of hand them a urinal sometimes. Of course, I'm kidding.

The point I wanted to make there is that we get an overwhelming number of applications, and I want to make you aware of the level of competition, so now that I've got your attention, I'll go over some aspects of the application process and hopefully help you submit a stronger application. As with most of our HEAL applications, we'll require a separate technical application and a separate financial application. And the first point on this slide is that please insure that there is no financial information in the technical application. And that's not even -- don't discuss the amount of the grant that you're requesting.

Next slide is -- discusses the executive summary, which is the first section of the technical application. We request that this really be a brief summary. We would like to see it no greater than two pages in length. There are other sections in the technical application where you can provide the detail that you will want to include, but we don't want to see it in the executive summary. We have multiple

functions for that piece of the application, and for that reason we need to ask you to keep it to less than two pages in length.

Next slide. The template for the technical application is on pages 32 and 33 of the RGA. And the first bullet here is the other components of the technical application, and I'm going to hit on a few of the more important points I want to make today. The first thing we want to be clear on is that we really want to see strongly defined activities and objectives; and that's both process objectives and outcome objectives. The process objectives will be the activities and nuts and bolts of your project and outcome objectives would be measurable changes or impacts you want to make to the health care delivery systems.

The time line is we want to see split into milestone and hopefully in quarterly increments to what extent possible. For the continuation, I think this is a new section we're adding with this phase, and here we want to see how you're going to continue the goals of your project after the active contract period. The monitoring section of the application

continues to be one of the weakest sections of the technical application. What we would like to see there is a strong discussion of how you're going to monitor the project activities and the project outcomes.

The project activities are typically a piece of your contract during the active contract period, and the outcomes will mostly be things that you will monitor in the three years after the contract period is ended. For three years, you will be required to submit an annual report, and that's -- that's where we want to see that you've successfully reached the goals of your project that were -- did you improve care, did you increase access, did you increase efficiency or decrease costs. And so, it's important to include in this piece how you're going to monitor that evaluation.

Community need is another vital part that we would like to see a really strong discussion. We don't want to see generalized statements of community need. We would like to see documented proof that you understand your health care community, that you understand the competition, that you understand what the need

is and clearly convey to us how your project will meet that need.

The next few slides are addressing the financial application, and I'm hoping Charlie will speak now because you'll have a stronger application if you follow his directions rather than if you follow mine.

MR. ABEL: In the RGA, the financial application -- the financial portion of the application, is defined beginning on page 37. It goes through several of the major points that we're looking to see within a quality application. I'll -- I'll switch things around, or at least give you different -- slightly different perspectives so you'll have a better understanding perhaps of the -- of what we expect to find in a quality application; take the two things together and see what comes up.

The reasonableness of your budget given your project scope. Financial folks have the advantage of being able to see the whole project and also the -- your financial projections, your budgets, what you expect to achieve over time; the capability of you to do what you say, what you're proposing and that may be -- that may not

just be your facility or your network. You may be recruiting others to help you in this project. So, we're going to be looking for you to demonstrate that -- that you're able to do what you propose to do, and if that includes others helping, for instance, financing partners or what have you, that you've included evidence of the willingness to participate. An example, if you're proposing a loan, a letter of interest from a bank to support that borrowing makes sense.

The cost effectiveness of your project, and that could be viewed from a number of different perspectives. We look at it from a number as well; to the extent that there are other funding sources in addition to HEAL to achieve what the desired result is, I think, is a positive. The savings to the system; define "system" in a number of different ways. We look for a return on our investment. The HEAL dollars being public dollars, and we are here to serve the public good. We want to make sure that there is a quality return on that investment. Now, be as specific as you can be in addressing each one of these points. Folks

who have been involved with certificate of need applications, I think appreciate the level of detail the financial reviewers apply to your proposals. Things are tested and -- and we look for underlying assumptions and justification for all the elements that you put in your application.

Now, in a certificate of need application, we have the advantage of having financial reviewers correspond with you after the application; so, if something is needed, we think that something is missing to connect the dots, we can ask for that. Here, we will not have that opportunity to. It's incumbent upon you to insure that all those elements are there in the application.

Speaking certificate of need, whatever we approve here, if it's -- if it requires a certificate of need approval, it will still have to get -- go through the system and -- and we will still need a certificate of need approval before you can begin your project. The folks who were involved in the financial review of HEAL applications go well beyond the staff, the limited staff we have for CON application

reviews and so that we have folks who may not be familiar with all those intricacies. So, just be aware that you probably want to infuse CON elements into your application so that it provides for a more seamless or streamlined review through HEAL and ultimately if your project requires a certificate of approval through that process as well.

MS. DEE: Kind of speaks for itself there.

MR. DELKER: Let me add one thing. Occasionally, we get questions about CON applications. And I think -- "Okay, we already have our CON application in. Can we use the HEAL money for part of that?" The answer is if you've got your CON application in, you've already put together the documentation for project financial feasibility, so you would be substituting HEAL funds for whatever funding arrangements you've already made, so that rule is not just with CON but with other activities as well.

MS. DEE: As discussed earlier, this is a competitive procurement. And what that means is at this point in the program that

once you submit your application you're finished; the application as submitted will then go into the evaluation process. There is no ability to make changes or corrections after it's been received at the Department of Health. So, please do a careful job, submit an application that you're pleased with and make sure that it gets submitted by the deadline.

Mentioning the deadline, if you're going to drive the application in and deliver it in person in Troy that day, please give yourself a good cushion of time to, in the event of bad weather or traffic or detours or anything of that nature, because speeding tickets issued on the New York State Thruway are not a reimbursable expense.

Next slide, please. The application, as discussed before, will have two separate pieces; the technical application and the financial application. We have changed the numbers of the copies this time a little bit. It is -- we'll ask for two originals, four hard copies and three flash drives with the applications in a pdf format. In a short while we'll be going to question and answer period, but we'll also

accept questions through May 22nd, and the e-mail address is in the RGA, but that's HEALNYPHASE11@Health.State.NY.Us. The deadline is given there. It's going to be three p.m. on July 1st, 2009. We know how to spend our summers in HEAL NY Grant.

Next slide, please. The -- a change in this phase is that we're going to require separate boxes for the technical applications and the financial applications. They're both going to be separate check lists and separate cover pages on those. And I think that's all that needs to be said there.

Chris, you might want to go over the ground rules from here.

MR. DELKER: Okay. We're ready to answer your questions, and the way we're going to do this that microphone there in the middle of the room. If people could come up and ask -- now, everyone can ask initially one question, and if necessary a related follow-up. We'll give everybody a chance to do that, and if time permits you can then come back and ask a second question. But have one question as you come up this first time. Just go right to that

microphone there. These mics, they have to be practically in your teeth before you can make yourself heard, so make sure you step up closely, and that one tilts and adjusts if you need to lower or raise it a little bit.

So, who is the first volunteer? Come on, we can't be that good. There must be some questions.

Gerry. Health planner from way back.

MR. HIRSCH: My age is showing. Mr. Bienstock, my question is the State Action Immunity. If you have a conversation with another hospital in preparing the application, is that covered under the State Action Immunity?

MR. BIENSTOCK: There is a separate document called Noerr-Pennington, that says that actions undertaken in preparation for convincing State officials to kind of respond to your application are also protected. So, you can engage in those kinds of conversations in reasonable preparation for submitting your application. You know, the question kind of prompts me to suggest to be careful, be honest with yourself about what you're doing and not use this as an excuse to engage in otherwise

unrelated activities.

MR. HIRSCH: Yeah, of course.

MR. BIENSTOCK: And I'm just directing that to everybody and not specifically to you.

MR. HIRSCH: The other follow-up question related is if you are awarded a merger or some sort of corporate relationship, were you suggesting that that would obviate the need for a Hart-Scott filing?

MR. BIENSTOCK: No, I think you still need to file the Hart-Scott, but you want to talk to the Feds about the Stated Action Immunity so in its review of the Hart-Scott they would be aware that you're protected from anti-trust problems.

THE REPORTER: I need your name, sir. I need everybody's name. Your name?

MR. HIRSCH: Gerald Hirsch.

MR. DELKER: Just state your name before you come up and ask your question. Thank you.

MS. REGAN: Good afternoon. My name is Blossom Regan from Nassau Community Hospital. I just want to clarify, first of all,

my understanding that currently vacant inpatient space would not qualify for this; is that correct?

MR. DELKER: Well, I think if you were converting inpatient space to a community identified need in an ambulatory outpatient side, yes, that's certainly eligible activity but it might not score as high, let's say, as if you were actually taking staffed beds out of service in that space. So, you know, certainly we're not disqualifying the application, it just -- depending on the competition within your region, it may not be as strong as some others.

MS. REGAN: And as a follow up to that, would that conversion require the hospital to accept a reduction in its certified capacity?

MR. DELKER: Well, if the space were already vacant, presumably your capacity was low anyway; right? It was -- reflected that; that it was vacant space; right? I mean, if there were no beds there the beds would probably no longer be on your operating certificate; correct?

MS. REGAN: I know what you mean.

MR. DELKER: You may have some

paper beds around there is what you're saying.

MS. REGAN: Yes.

MR. DELKER: Well, if they're just paper beds, it would not, you know, weigh very favorably in the score but as a matter of bookkeeping, it would certainly be appropriate to just take those off for the sake of accuracy.

MS. REGAN: Thank you.

MR. DELKER: You don't have to wait for the next speaker. If you want to line up, that's okay, too.

MS. TOMPKINS: Kathy Tompkins, Kaleida. In regard to eligible soft costs, I was just wondering in the case of a closing or consolidation will any resulting labor costs be eligible; for instance, incentivizing staff based on the fact that, you know, they may have to change sites or change shifts or different things of that nature?

MR. DELKER: We generally do allow, you know, cost of closure or downsizing that have an impact on employment; pension matters and that sort of thing. We've done that in Phase 4 and earlier phases, so in general, the answer is "yes."

MS. TOMPKINS: Okay, great. Thank you.

MR. VOLK: Just a follow up, very quickly on that. In the RGA itself on page 7, there is a list of examples of types of costs that one would not normally consider to be capital costs that are possibly to be paid in connection with the closing.

MR. DOWLING: Edward Dowling. My question has to do with the Berger Commission recommendations. Surprisingly, some of the facilities have not complied with the some of the Berger Commission recommendations and will that weigh with respect to facilities that might have had recommendations made about them but make other proposals under this?

MR. DELKER: I'll defer to the legal staff in a second; but first, any of the facilities here that are affected by Berger Commission recommendations, none of the Berger-related activities would be eligible for funding under this RGA; even if you were funded only partially for them before. Because funding, $550 million, was made available under Phase 4 for those purposes. So, you may still

apply, but nothing could be related to any of your Berger-mandated activities. As for noncompliance, I'll ask Martin if you can address that or maybe Matt.

MR. BIENSTOCK: It's hard to respond in the abstract. I think we've taken significant actions to self-implement whatever hasn't been implemented by the facilities themselves. And in some cases implementation will occur -- the self-implementation will occur at a later date, so the hospital's operating certificates that are going to be expired at a certain point and later time giving them time to come into compliance on their own. So, you know, I think we're headed towards full implementation and take over things, all the steps that we need, in order to get there.

MS. ROACH: Karen Roach for HANYS. A question about the people who get awards under these. Will they be given any special consideration in the CON process to kind of streamline the process, because I know they have a two year window to get everything done; kind of a quick time line.

MR. DELKER: Yeah, we will flag any

HEAL-related CON application that comes in. If you do get an award under this solicitation and a CON application is involved, when you send in the CON application, put in the cover letter in bold and underlined or some way "HEAL related," okay? When those come in, we track them separately and we're trying -- we're building up our database to link HEAL and CON so that the reviews are coordinated and to try to expedite the CON approval so that they occur within the HEAL grant time frame. So, yeah, we will fasttrack them as fast as anything can go in CON.

MS. CARR: Hi, Kim Carr from EJ Noble Hospital. My question is, we're a sole community provider hospital, and also with a sole nursing home in our town. So, under this grant would a merger between the two with reduction in inpatient beds go between the hospital and the nursing home?

MR. DELKER: Seems to be something you might coordinate between 11 and 12.

MR. CLYNE: 12 is focused on the taking down of nursing home beds, so I think it really depends upon, you know, where the beds

are being taken down. If you're taking down inpatient beds, then it seems more reasonable that they would fall under 11. In you're taking down nursing home beds, then it would fall under 12 because in both of those cases, that's the -- not the sole component, but one of the key components, though, is the reduction in the institutional capacity maybe.

MS. LEFEBVRE: And maybe I would add, also, it depends on -- it's taking down the beds, but then it's like what's the focus of the new delivery system? Is it, you know, more outpatient clinic service for your community or it is an alternative to long-term care that aren't institution based?

MS. CARR: We were thinking both.

MR. CLYNE: But it might simply be submitting two applications; the one that you're taking down the inpatient beds and looking at your PQI data and creating a, you know, patient-focused program on diabetes and then that's through this one, and if it's taking down long-term care and developing community based alternatives in long-term care, then it would be under 12.

I mean, an application that was taking down inpatient beds and bringing up nursing home beds is not really what we're looking for.

MS. CARR: Right. Thank you.

MR. VOLK: If I could just add one quick caution on that; just to make sure that you don't design your projects so that they're interdependent. Make sure that they're two separate projects that either of which can be carried out separately.

MS. PLUMMER: It's Corinne Plummer from Bassett Health Care. This is a section 1.5-A Eligible Activities, specifically the passive parent issue. And this is an example scenario. There's one Article 28 hospital under passive parent, and a second Article 28 hospital that may be willing to become a subsidiary of the same passive parent. So, if these two Article 28 hospitals get together and do, let's say, a shared services collaboration, is that activity fundable? Is it clearly fundable? Is it one of these -- I think your term was be resourceful in the models.

MR. DELKER: Sounds resourceful.

MR. CLYNE: Neil and I agree. The

passive parent wouldn't be funded for that, but the two individual hospitals would be.

MS. PLUMMER: Yes, they would be the applicant.

MR. CLYNE: Yes.

MS. PLUMMER: And it comes out as a shared services collaboration.

MR. CLYNE: Between the two hospitals?

MS. PLUMMER: Right.

MR. CLYNE: Correct.

MR. DELKER: Yeah, and I think the shared services has to have some strong legally binding agreement between the two, even though it may not be a governance agreement, but something binding.

MS. PLUMMER: Yes, it's not the referral pattern.

MR. DELKER: Right.

MR. WATSON: Jim Watson from Ira Davenport Hospital. We're talking an affiliation and active parent arrangement with Arnot Ogden. We're wondering if the money could be used to retire debt if it's an impediment to the process?

MR. ABEL: Not to get into the specifics of any application, but the answer was for money to be used to retire debt is yes.

MS. ROLDAN: Kim Roldan, New York Presbyterian Hospital. Under shared services, if two hospitals were to look to provide a combined service, what would they need to show as part of the application? What intent between the two hospitals in terms of documentation?

MR. DELKER: I think there would have to be some intent for a legally binding agreement, so perhaps a memorandum of understanding or something as a preliminary. And I think more to the point, not just sharing services, but what efficiency does that result in? Presumably you're going to eliminate some duplication or redundancy between the two systems, and what's the effect of that? Are there savings elsewhere or reconfigurations of things that may be more appropriate for community identified services. So, those kinds of things.

MS. ROLDAN: Thank you.

MR. THOMPSON: Fred Thompson. There's a lot of emphasis on sharing and

substantive collaboration. If you're a single health system and you want to do work within the health system, removing beds from one part of the system and increasing, for example, inpatient beds and using those beds to improve outpatient services but it's within the same system, is that a problem within this particular HEAL application?

MR. CLYNE: That is allowable.

MR. THOMPSON: It is permissible?

MR. CLYNE: Yes.

MR. THOMPSON: You've stressed very strongly this collaborative arrangement, and I just wanted to get clarification.

MR. CLYNE: Again, I mean, we are stressing collaborations; but within the system, you can do it within a single-standing entity, it's possible because the state is diverse and each place, it's going to be a different look at the way the health system is set up in that region.

MR. THOMPSON: Okay, thank you.

MS. SPORN: Hi, Nina Sporn from New York City Health and Hospital Corporation. If we wanted to consolidate services within our

network hospitals, we're already affiliated, would we just have to show that the shared -- the savings was on an economy of scale or any is there any legal --

MR. CLYNE: No. Again, it sort of fits into the same -- I mean, it's essentially the same system, so to the extent that you are making more sense of your system, that's certainly eligible.

MR. FITZPATRICK: My name is Paul Fitzpatrick and I'm representing the community Memorial Hospital in Hamilton. And my question is about the single hospital projects; where it talks about hospitals that are not conducive to collaborative arrangements, and I'm specifically concerned about what it means for -- if there's a project that is to bolster outpatient and primary care services, does that project have to have, as part and parcel of it, a second part of the proposal which is to reduce some excess capacity that's there or could it be a stand alone without reduction of the excess capacity?

MR. DELKER: I think it's looking, to -- we have to know -- for instance, we have to look at the area. You know, in rural areas,

like other underserved areas with few providers, it would make -- it might make a lot of sense. You know, collaboration may be a moot consideration, so I think the context would be one thing, and I think we could entertain that. Depending upon the competition within the region it might not score as high as some other projects in the region that do have collaboration in order to serve that types of consolidation. And I think, also, in consideration is what is the hospital's record of serving the underserved. If your community need component is rather strong, you're very responsive to it, that would certainly strengthen -- you know, that might outweigh it or at least moderate the effects of not actually collaborating or merging with another facility. So, we kind of have to take all those things into consideration.

MR. FITZPATRICK: Thank you.

MR. CLYNE: Again, this can get complicated because I can envision a scenario where a hospital can't take down any of their beds yet could make a case that because of the geographic area where they're providing primary

care there will be less people going from those zip codes going to other hospitals for inpatient care. So, would we look at that? Yeah, that's certainly eligible.

MR. FITZPATRICK: Great things.

MS. DIETZ: Karen Dietz, Bon Secours Charity Health Systems. Could we get some clarification on Article 28 Networks. I have some confusion on what that is versus active parent, passive parent; what that means.

MR. DELKER: It's in the RGA. It's Section 401.1.

MS. DIETZ: I have looked at that. And I guess what we're looking at we're in discussion with a hospital about a relationship and we don't necessarily at this point want to become an active parent, and we know that they don't want a passive parent, so we're trying to figure out how we can work together.

MR. DELKER: There isn't much in between.

MS. DIETZ: I know.

MR. DELKER: There has to be some active -- you know, some organization whereby the hospital delegates the authority of one or

more of the activities under 405.6 to either the other hospital or to a separate corporation that they -- it's those eight or nine functions that are listed under 405.6 that are the critical things.

MS. DIETZ: As a follow-up, because Sponsor Health is a system with three hospitals, could they form a corporation with this other hospital to assist them or do they have to form a corporation with this other hospital?

MR. DELKER: It would have to be some shared commonality; one of those listed functions, at least one of those, among those -- within what would be the four hospitals.

MS. DIETZ: Thank you.

MR. MURPHY: Charlie Murphy from Cicero Consulting Associates representing various clients. Chris, if -- and I'm sorry, I missed the beginning of Paul's question, so if it's the same I'm sorry, but you have provision for a single hospital, generally rural; and what I've heard is if it's merger activity or if it's collaborative activity, it sounds like it's hospital with hospital or...

MR. DELKER: No, it doesn't have to

be. I think you can have a collaborative activity between a hospital and an Article 28-D and T or some other --

MR. MURPHY: That was the question.

MR. DELKER: -- entity like that. I think we would encourage that.

MR. MURPHY: Okay, thanks.

MS. COOKE: Janet Cooke. I'd just appreciate a clarification. There's a statement that this project will not fund portions or segments of proposed projects, and that could be interpreted more than one way, so I appreciate knowing what's in your minds.

MR. DELKER: All or nothing.

MS. COOKE: So, you in terms of our projects, is what we submit, it's the total grant proposal or nothing?

MR. DELKER: Right, your project will be evaluated on its merits in their entirety; okay? So, we will not say, "Well, this has -- this component, we won't look at this but this other part is really very good, so we'll fund these two-thirds." We won't. If that other part is bad and drags down your score, that's the way it is. Now, we do state

some visit costs may be disallowed. There may be some costs in something that we approve that we don't like and we will disallow those costs, but if you accept the grant, you will still have to do the entire scope or work you propose without the cost we disallowed. But generally, it's all or nothing. There are few that we fund with disallowed costs, but generally we look at the whole corpus and make a decision.

MS. COOKE: The total project as defined in our application.

MR. DELKER: Absolutely, yes.

MS. COOKE: Thank you.

MR. ABEL: Let me just -- a little clarification. The project as defined in your application must be separate and stand alone and it should be able to achieve what you are trying to achieve independent of other external activities. If it's dependent upon anything, those other elements should be in your application as well and demonstrate the ability to fund those other elements.

MR. DELKER: Good point.

MR. ANDERSON: Kristen Anderson from Niagara Falls Memorial. I was just

wondering if you could expand a little bit on the prospect of a sole community hospital that may not be able to get rid of inpatient beds but would like to expand their outpatient serving a high-need community. What would you consider a high-need community? I'm trying to decide if, you know, if it's even worth it for us to try to put something in and we don't want to waste your time, basically.

MR. DELKER: It sounds like a very worthwhile endeavor, but with that said, you're talking about expansion of outpatient services and your inpatient things remaining the same?

MS. ANDERSON: Yeah, we're right now going through a community-needs assessment, an assessment of the services of our hospital, what we provide to the community to align it, but if at the end of the day it should come to the fact that, you know what, it doesn't look like we really should get rid of any inpatient beds but we do have these outpatient needs in our community; you know, high dialysis, high kidney failure kind of things with a high Medicare population. Is that something that that grant would consider?

MR. CLYNE: It would be, but I think what you have to -- I think what you need to -- what everybody needs to think about, though, is what else is going on in our region, because that's going to be your initial competition. So, we look at things regionally first, and then depending on how the criteria goes, you know, go beyond that. So, you also have to think about what is going on in the region that you're proposal is going to be competing against. This is also, again, at the beginning. This is not the last iteration of HEAL. There will be other proposals going out there. And maybe just a little explanation, one of the reasons we didn't look at doing primary care is we're just getting the six contracts out on primary care development; there's a lot going on in the Federal government on primary care development. So, it seemed like a lot to force on the community right now. But that does not mean we're not going to do another round on primary care development that just looks at primary care.

MS. ANDERSON: Thank you.

MR. DELKER: Anyone else with a

first question? Anyone who hasn't asked a question yet who wants to?

Okay, anyone who has asked a question but would like to ask another one? I can tell it's Friday afternoon.

MR. CLYNE: Chris, I just wanted to mention three things again. I know we touched on it before, but it is -- I know you might think we're cold-hearted bureaucrats, but there is nothing more distressing than having to invalidate a proposal because some simple mistakes that were made that don't even get you to judging. So, all three of these things have happened in various rounds of HEAL; that is, make sure you have the right legal entity. I know we've said this a lot of times. I can almost guarantee someone is going to send in passive parent and we're going to have to disqualify. We can't call you up and say, "Hey, guess what, you made a mistake."

So please, make sure it's the correct legal entity. Don't ask for more than the maximum amount. This is not one of those things where you can see, "Geez, it says 25; I'll ask for 30 just in case." We won't even look at

your application. So, it has to be within the amount set out. And also, don't -- don't try and get ahead of this by sending in the CON and have it approved and saying it's financially feasible without having something in there saying it's only financially feasible if you get a HEAL grant. If it's financial feasible, then we're not going to fund it under HEAL. You're not going to have the opportunity to say, "Oh, it's not really financially feasible. I meant to cross that out."

So, those are three things that we see happen and we have had to disqualify applications. You don't even get started, and I know you put a lot of time and effort into putting applications together, but it would be a shame if we have to disqualify without even giving you the opportunity to compete.

MR. ABEL: If I can just kind of chime in, and I don't know, maybe this will spark a little interest in discussion between the Department of Health folks, but if your proposal is for something that you could probably do on your own without additional funding, it's likely that that will score less

than something that's truly challenging that would necessitate HEAL dollars into the project.

MR. BENJAMIN: Thank you, Charlie, for protecting the state treasury.

MR. DELKER: Yes. Go ahead.

MS. ROLDAN: Kim Roldan, New York Presbyterian. In terms of timing for this, they're due July 1st. Do you have a vision by when you will have reviewed them, given award letters, things of that sort?

MR. DELKER: I don't call it a vision as much as a nightmare, if it's anything like last summer. No, seriously, we -- because of the nature of HEAL, as you're aware there's federal matching funds for this, Federal-State Health Reform Partnership or F-SHRP; because of the peculiarities of our funding agreement with the Feds, we have to have the award letters out by September 30th. And so we would hope to have them out in advance of that date, but that's the absolute drop-dead date that the letters go out. So, we'll be spending July and August reviewing and rating and scoring and arguing and that stuff.

MS. ROLDAN: Coupled with that is

are there rules around the spending that's associated with your award letters; that you have to have spent your total allotment by a certain time frame?

MR. DELKER: I was afraid somebody would ask us that. You may be aware of some of the problems we had with the extensions on the Phase 2 applications this past year, this past January. The Federal -- with the Federal government officials saying that they do not want any extensions on the initial 24-month contract periods. They have seem to have come around to our point of view on that and allowed the extensions for Phase 2. Nevertheless, it's not something that we can take for granted. And we would encourage everyone to design a project that you can get done in 24 months, and don't build in a presumed extension. It's in your best interest to get these things done as quickly as you can.

As I said, on our side we're trying to fasttrack the CON side of it and, you know, it's -- it's -- no one loves the prospect of another difficult negotiations at the federal level over these things, and we can't assume that they will

always be flexible. So, plan accordingly and design accordingly.

MS. ROLDAN: Thank you.

MR. DELKER: Anyone else? Okay, thank you for coming. As I said, next Friday, the 22nd, we will take questions through the e-mail site through that date and enjoy the rest of the day.

(Proceeding concluded at 2:20 p.m.)

* * *

STATE OF NEW YORK)
) ss.
COUNTY OF)

I, PAULA M. MILLER, a notary public in and for The County of Washoe, State of Nevada, do hereby certify: That on Friday, the 15th day of May, 2009, at the hour of 1:00 p a.m., at the New York State, Empire State Plaza, Concourse Meeting Room 6, Albany, New York; that the proceeding was held; that the foregoing transcript, consisting of pages 1 through 61, is a true and correct transcript of the stenographic notes of the proceeding taken by me in the above-captioned matter to the best of my knowledge, skill and ability.

I further certify that I am not an attorney or counsel for any of the parties, nor a relative or employee of any attorney or counsel connected with the action, nor financially interested in the action.

Dated: At Albany, New York, this 20th day of May, 2009

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PAULA M. MILLER, CSR