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HEAL NY Phase 11  
Capital Restructuring Initiatives #3  
APPLICANT CONFERENCE

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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.

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

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

5 MR. ABEL: Charles Abel, Health  
6 Facility Planning.

7 MR. VOLK: Larry Volk, Dormitory  
8 Authority.

9 MS. RALEIGH: Tracy Raleigh,  
10 Dormitory Authority.

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

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

1 in all these activities.

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

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

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

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

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

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

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

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

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

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

25          As a goal of previous HEAL RGA's, we

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

11 Thank you, Chris.

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

25 So, in putting together your

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

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

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

1       frankly, that these types of activities  
2       represent.

3                   MR. BIENSTOCK:  Thanks.  Thanks,  
4       Chris.

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

1 on the financial component. We get the scores  
2 through uniform scoring criteria; that's the  
3 requirement of the State Finance Law with  
4 competitive procurements. The minimum score is  
5 65; so, if you don't get a combined score of --  
6 financial and technical combined of 65 or more,  
7 that will be deemed, you know, not passing.  
8 Kind of like when you were in school, depending  
9 on where you went to school.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

9 MS. DEE: Kind of speaks for itself  
10 there.

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

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

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

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

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

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

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

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

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

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

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

9 Gerry. Health planner from way back.

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

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

1 unrelated activities.

2 MR. HIRSCH: Yeah, of course.

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

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

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

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

19 MR. HIRSCH: Gerald Hirsch.

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

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

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

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

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

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

24 MS. REGAN: I know what you mean.

25 MR. DELKER: You may have some



1 paper beds around there is what you're saying.

2 MS. REGAN: Yes.

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

8 MS. REGAN: Thank you.

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

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

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

1 MS. TOMPKINS: Okay, great. Thank  
2 you.

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

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

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

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

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

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

25             MR. DELKER: Yeah, we will flag any

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

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

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

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

1 are being taken down. If you're taking down  
2 inpatient beds, then it seems more reasonable  
3 that they would fall under 11. In you're taking  
4 down nursing home beds, then it would fall under  
5 12 because in both of those cases, that's the --  
6 not the sole component, but one of the key  
7 components, though, is the reduction in the  
8 institutional capacity maybe.

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

16 MS. CARR: We were thinking both.

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

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

4 MS. CARR: Right. Thank you.

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

11 MS. PLUMMER: It's Corinne Plummer  
12 from Bassett Health Care. This is a section  
13 1.5-A Eligible Activities, specifically the  
14 passive parent issue. And this is an example  
15 scenario. There's one Article 28 hospital under  
16 passive parent, and a second Article 28 hospital  
17 that may be willing to become a subsidiary of  
18 the same passive parent. So, if these two  
19 Article 28 hospitals get together and do, let's  
20 say, a shared services collaboration, is that  
21 activity fundable? Is it clearly fundable? Is  
22 it one of these -- I think your term was be  
23 resourceful in the models.

24 MR. DELKER: Sounds resourceful.

25 MR. CLYNE: Neil and I agree. The

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

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

5 MR. CLYNE: Yes.

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

8 MR. CLYNE: Between the two  
9 hospitals?

10 MS. PLUMMER: Right.

11 MR. CLYNE: Correct.

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

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

19 MR. DELKER: Right.

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

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

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

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

23 MS. ROLDAN: Thank you.

24 MR. THOMPSON: Fred Thompson.

25 There's a lot of emphasis on sharing and



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

9 MR. CLYNE: That is allowable.

10 MR. THOMPSON: It is permissible?

11 MR. CLYNE: Yes.

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

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

22 MR. THOMPSON: Okay, thank you.

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

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

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

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

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

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

20                   MR. FITZPATRICK: Thank you.

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

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

5 MR. FITZPATRICK: Great things.

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

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

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

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

22 MS. DIETZ: I know.

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

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

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

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

15 MS. DIETZ: Thank you.

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

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

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

4 MR. MURPHY: That was the question.

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

7 MR. MURPHY: Okay, thanks.

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

14 MR. DELKER: All or nothing.

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

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

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

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

12               MR. DELKER: Absolutely, yes.

13               MS. COOKE: Thank you.

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

23               MR. DELKER: Good point.

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

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

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

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



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

24 MS. ANDERSON: Thank you.

25 MR. DELKER: Anyone else with a

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

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

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

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

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

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

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

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

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

5               MR. DELKER: Yes. Go ahead.

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

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

25              MS. ROLDAN: Coupled with that is

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

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

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

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

3 MS. ROLDAN: Thank you.

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

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

10 \* \* \*

1 STATE OF NEW YORK     )  
2                                     ) ss.  
3 COUNTY OF                     )  
4

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

15         I further certify that I am not an attorney or  
16 counsel for any of the parties, nor a relative or  
17 employee of any attorney or counsel connected with the  
18 action, nor financially interested in the action.  
19

20 Dated: At Albany, New York, this 20th day of May, 2009  
21

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23 PAULA M. MILLER, CSR  
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