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May 13, 2010

Senator John L. Sampson
Democratic Conference Leader
409 Legislative Office Building
Albany, NY 12247
Phone: (518) 455-2788
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Re: Senate Bill S7589: Relates to the approval of hospital construction by the state hospital review and planning council

Dear Senator Sampson:

The Commission on the Public's Health System (CPHS) and New York Lawyers for the Public Interest (NYLPI) request that you take into consideration our comments, outlined below, with regard to Senate Bill S7589 and Assembly Bill A10640 concerning modification to the approval process for hospital construction by the state hospital review and planning council.

As you know, CPHS and NYLPI both work toward ensuring increased transparency, accountability and opportunities for meaningful community input in the healthcare decision-making process, particularly for medically underserved communities of color and immigrant communities in New York City. In 2008, for instance, both organizations provided testimony to the State Hospital Review and Planning Council (SHRPC) on proposed reforms to the certificate of need (CON) process. In that testimony, we offered recommendations on issues including: orienting the CON process around ensuring that racial and ethnic disparities in access to healthcare were a primary consideration in planning, expansion and decreases in services; a more effective assessment of "public need" requirement in the CON process; and, setting methods for ensuring that needs assessments meaningfully drive allocation decisions. Unfortunately, not one of our concerns or recommendations is incorporated into the proposed regulations, or legislative changes being reviewed.

We remain concerned with several provisions of current bill that would take the CON process significantly further from the kind of long-term, strategic, and participatory planning process that is fundamental for effective healthcare planning. Our concerns are that the bill would: 1) completely circumvent any oversight for review of proposals for certain projects and expenditures; 2) retain an overly flexible definition of “public need” that does not prioritize the needs of medically-underserved communities; and 3) establish an *ad hoc* process for new construction that would prevent the strategic allocation of healthcare resources.

In order to maximize the potential benefits of the increased efficiency to the CON process, but also ensure that the healthcare decision-making process has community input and does not exacerbate existing disparities in access to healthcare, we recommend that S7589 be amended to include the recommendations below. Specifically, we recommend: 1) maintaining an oversight and approval process for infrastructure projects, medical equipment expenditures, and health information technology projects; 2) prioritizing medically-underserved communities when considering “public need”; and, 3) establishing a “batching” process, instead of an *ad hoc* process.

Recommendation #1 – Retain An Oversight Process for “Minor Equipment” Purchases; “Non-Clinical Infrastructure” Proposals, “Health Information Technology” Projects; and Clinical Projects Costing Less Than \$25 Million:

The proposed legislation should maintain an oversight and approval process, as well as an opportunity for community input, for “minor equipment” purchase proposals of up to \$10 million, for non-clinical infrastructure and health information technology projects, and for clinical projects costing less than \$25 million.

EXPLANATION:

Senate Bill S7589 provides that no approval would be required for certain hospital expenditures or projects. Such items would include the repair or maintenance of “minor equipment” costing less than ten million dollars; “non-clinical infrastructure” projects regardless of cost; and “health information technology” projects regardless of cost. In addition, construction of clinical projects costing less than \$25 million would similarly only require consent from the Commissioner, as opposed to the approval of both the Commissioner and SHRPC.

While these provisions would no doubt mitigate administrative inefficiencies in the CON process, they would do so to the detriment of community stakeholders who are left without any opportunity for involvement in the decision-making process. If enacted, a hospital could simply purchase a \$10 million piece of equipment or install a new parking lot as it saw fit, without any administrative oversight or community input on the issue. In addition, health information technology projects can also be problematic because of costs and lack of interaction with some systems. These provisions would also undoubtedly increase the cost of care without improving healthcare services.

A recent incident at St. Barnabas Hospital in the Bronx provides an apt illustration as to why community input and oversight in such seemingly “minor” or “routine” projects is so important. The Hospital was recently awarded over \$19 million in federal stimulus funds, which were

allocated by the City, to build a parking garage. Community stakeholders opposed the parking lot construction because they claimed it would eliminate needed jobs in the community, and called for an additional round of hearings to revisit the costs and benefits of the garage. If the CON process were amended to remove such non-clinical infrastructure projects from any oversight, it would leave community stakeholders with even fewer avenues for providing their perspective on decisions that could have a negative impact on them. Indeed, under the bill, neither the Commissioner nor SHRPC would have authority to review such a proposal.

In conclusion, community stakeholders should be afforded an opportunity to provide their perspective, and an oversight and approval process should be maintained, for “minor equipment” purchase proposals of up to \$10 million, for non-clinical infrastructure and health information technology projects, and for clinical projects costing less than \$25 million.

Recommendation #2 – Prioritize the Needs of Medically-Underserved Communities When Considering Public Need:

The proposed legislation should more clearly define “public need” by emphasizing the importance of allocating healthcare resources in such a way as to address health disparities and access to healthcare services in medically underserved communities.

EXPLANATION:

Senate Bill S7589 retains the two necessary requirements for the Commissioner to act on a hospital construction application that are currently law: a) obtaining required approvals and consents; and b) demonstrating “public need.” The definition of “public need,” however, remains inadequate because it is defined by the regulations in an overly broad way.

Department of Health regulations with regard to hospital construction define “public need” broadly.¹ Missing from this evaluation is any affirmative requirement for the Commissioner or SHRPC to consider, let alone prioritize, the needs of those living in medically underserved areas and groups that traditionally suffer from a lack of access to healthcare services. While a reviewing entity could conceivably include such considerations in its determination of “public need,” it need not. Thus, we strongly support amending the definition of “public need” for hospital *construction* to directly contemplate, and to prioritize, factors that a reviewing entity must contemplate when *establishing* a hospital,² including:

- the “extent to which all residents in the area, and in particular low- income persons, racial or ethnic minorities, women, handicapped persons, and other underserved groups and the elderly, will have access to those services”;³
- how the proposed construction would “meet the health needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services (for example, low-income persons, racial and ethnic minorities, women, and handicapped persons).”

¹ See 10 N.Y. COMP. CODES R. & REGS. § 709.1(b) (2010).

² See 10 N.Y. COMP. CODES R. & REGS. § 709.1(a) (2010).

³ 10 N.Y. COMP. CODES R. & REGS. § 709.1(a)(5) (2010).

- the “performance of the applicant in meeting its obligation under the applicable civil rights statutes prohibiting discrimination on the basis of race, color, national origin, handicap, sex and age”; and
- “the extent to which Medicare, Medicaid and medically indigent patients are served by the applicant.”⁴

By making such factors a priority in defining “public need,” the Commissioner and SHRPC will be able to ensure that the needs of traditionally medically underserved groups and communities are more directly addressed through proposed hospital construction. In addition, there should be a reporting mechanism developed that ensures that facilities are meeting the requirements of state laws and regulations, such as the requirement for providing interpreters and translated materials, and the requirements under the Patient Financial Assistance Law (Manny’s Law) to post charity care policies and offer a sliding fee scale to uninsured patients.

Recommendation #3 – Establish a “Batching” Process to Strategically Allocate Healthcare Resources

The proposed legislation should establish a “batching” mechanism to group similar new construction proposals in order to ensure that the Commissioner and SHRPC are in the best position to allocate healthcare resources equitably.

EXPLANATION:

Senate Bill S7589 would fundamentally alter the timeline for CON approval, creating an *ad hoc* process for construction approvals with a tight (30 to 120 day) timeline for decision-making. While such a provision would ensure that determinations occur in a more timely manner than under the current law, it essentially creates a system that is even less equipped to evaluate proposals that might share common characteristics or could be evaluated on a competitive basis. Since SHRPC would have to make determinations with a quick turnaround, the “public need” requirement would be reduced to nothing more than what providers construe as public need, which is not always consistent with the community’s view of its need.

Moreover, since applications would be considered strictly on a rolling basis, the State Department of Health (SDOH) would be put in a disadvantageous position because it would be unable to see or compare applications against each other. As a result, SDOH would be unable to channel healthcare funds to the highest-priority areas or to projects where funds could be maximized for increased healthcare outcomes.

We propose amending the legislation to create a batching process whereby SDOH would have the ability to weigh similar proposals against each other in order to approve those with the greatest potential to address the most pressing needs. Such a process would also speed up the CON process, but would do so without sacrificing the ability for SDOH to maximize the impact of their approvals. Indeed, examples from other states are instructive. Over two-thirds of the states that still have CON regulations “batch” proposals such that the state health agency can evaluate and compare proposals. For example, proposals can be grouped by: the type of project proposed; the geographic area for the proposal; the cost of the project; or, the population that would be served. This essentially creates a request for proposal-style procedure to help determine

⁴ 10 N.Y. COMP. CODES R. & REGS. § 709.1(a)(7) (2010).

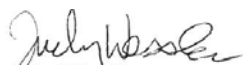
which projects to approve. As a result, these states are in a better position to effectively determine what healthcare needs are in the community, and then accepts applications only around addressing that need.

It is worth noting that New York's CON regulations already contain a provision for batching of construction applications.⁵ Although the provision appears to have never been used, the Commissioner is currently empowered to "establish a schedule for the review of project scope and concept construction applications by the health systems agencies, the department and the council . . . for the consideration of applications proposing similar types of construction and services . . ." ⁶ It would be more practical to use current regulations to create a more efficient—and more equitable—CON process, than to enact a new set of laws that would do just the opposite.

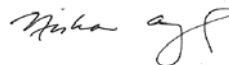
On behalf of our organizations, thank you for your consideration. We urge you to carefully consider our comments on this important legislation. As New York prepares for the new era of national health reform, the state should be in a position of working to ensure that all residents of the State will have access to healthcare services. Weakening regulatory authority should not be a priority for action.

If you wish to discuss this legislation, please feel free to contact Judy Wessler, CPHS, at 212.246.0803, ladyhealth@cphsync.org, or Nisha Agarwal, New York Lawyers for the Public Interest, at 212.244.4664, nagarwal@nylpi.org.

Sincerely,



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⁵ See 10 N.Y. COMP. CODES R. & REGS. § 710.11 (2010).

⁶ *Id.*