THE CATHOLIC CHURCH

AND

HEALTH CARE PUBLIC POLLICY

IN

NEW YORK STATE

1924 – 2004

By Jack Balinsky

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PREFACE

This is the third volume in a series of documents about the work of the New York State Catholic Conference over the last ninety years.

This work describes both the internal development of the New York State Catholic Health Care Council and also the role of the Catholic Church in development of Health Care Public Policy in New York State.

This volume follows on the A History of the New York State Council of Catholic Charities Directors published in June 2004 and A History of the Advisory Committees to the New York State Catholic Conference Public Policy Committee published in January 2005.

Once again, I thank individuals who helped in preparation of this work including Walt Wojtowicz, the Catholic Conference volunteer who has made possible the Archiving and History Project; Catholic Conference staff members Richard Barnes, Ron Guglielmo and Earl Eichelberger; former Catholic Conference staff person Richard McDevitt; Mark Lane, Father Pat Frawley and Monsignor Alan Placa from Fidelis; and those familiar with the role of Catholic Conference during the Carey administration – Monsignor Charles Fahey, James Introne, Dr. James McCormack and Dr. Robert Whalen.

I also once again thank JoAnn Anderson for her tireless assistance in producing this volume.

Jack Balinsky
Pittsford, NY
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Introduction

In 1916, Bishop Gibbons of Albany, and an Albany attorney, Charles J. Tobin, Sr., together led the formation of what has become the New York State Catholic Conference.

Throughout the first half of the twentieth century Catholic Church leaders involved in this endeavor were the Bishops of the state, a group known as the Catholic Welfare Committee or the Catholic Committee, comprised primarily of Catholic Charities Director and Diocesan attorneys, and the part-time staff support of Mr. Tobin who was Secretary to the Catholic Committee.

Though the approach to government and public policy debate was more informal than it was to become later, nonetheless, the Bishops, the Catholic Committee and Mr. Tobin had significant input into a broad range of public policy areas affecting the Church and the poor and vulnerable for whom the Church advocated, including especially health care policy.

In the latter half of the twentieth century, under the leadership of Charles J. Tobin, Jr., who succeeded his father as Secretary to the Catholic Committee in 1954, this statewide Catholic Church structure evolved in response to the ever greater role that government played in areas of concern to the Church. Already in the 1950's, there were created ad hoc subgroups to address issues in particular areas. Examples would be the Catholic School Superintendents and Catholic Charities Directors.

In the wake of the Second Vatican Council, which provided for the creation of National Conferences of Bishops and by extension similar state organizations, the New York State Catholic Conference of Bishops was formally organized in 1968. Already at this time the Council of Catholic School Superintendents and Council of Catholic Charities Directors existed as formal constituent groups of the Public Policy Committee of the Catholic Conference. They would soon be joined by formalized constituent groups representing Diocesan Human Life Coordinators and the presence of the Catholic Church in health care ministry.

Throughout the 1970's, 1980's and 1990's, the work of the Catholic Conference was further enriched by the evolution of various Advisory Committees to the Public Policy Committee, including the Criminal Justice Advisory Committee (established 1975), the Advisory Committee on Persons with Disabilities (1980), the Advisory Committee on Government Fiscal Affairs (1983), the Advisory Committee on Women's Issues (1987), and the Advisory Committee on African-American and Hispanic Ministry (1992).

This volume focuses on the involvement of the Catholic Church in its various forms from the early 1920's until 2004 in the area of health care public policy.

It is organized into the following Chapters:

Chapter One

The Early Years

1924-1958

Introduction

The work of the Catholic Conference during this time period can be described in three categories: activities related to individual pieces of legislation, provision of more general advice and information to Catholic providers, and internal organizational activities.

Individual Legislation

Reflective of the relatively informal structure of the Catholic Bishops' Conference and Catholic Welfare Committee, and the comparatively simple and straightforward nature of health care public policy, most of the statewide Catholic activity during this era consisted of providing information to Catholic hospital leadership about proposed legislation and, where appropriate, advocating for or against such legislation. Most of this activity occurred through communication between Charles Tobin, Sr. and leadership in the Health Division of Catholic Charities of the Archdiocese of New York, and with such leadership in the Brooklyn Diocese or in connection with the Hospital Association of New York.

Examples of this activity included:

On February 15, 1929, Mr. C.E. Ford, Chairman of the Legislative Committee of the Hospital Association of New York solicited the support of "My dear Mr. Tobin" for Assembly Bill No. 476 entitled, "An act to amend the lien law, in relation to the lien of a hospital for treatment in case of accident", as a way to insure that hospital bills were not left unpaid after a patient received a settlement in compensation for injuries.

On March 26, 1931, Mr. Tobin wrote to Father Edward Davern, Supervisor, Syracuse Diocesan Charities and Welfare, recommending that, on advice of the State Charities Aid Association, no position be taken on Senator Wick's Bill Print No. 1111 amending the State Charities Law.

On March 29, 1933, Father Joseph F. Brophy, Director of the Division of Health, Catholic Charities of Brooklyn, wrote to Mr. Tobin asking him to oppose Senate bills 437 and 438, the Crawford-Evans bills seeking to establish stricter parameters for operations of clinics in hospitals.

On April 9, 1934, Father Brophy wrote to Mr. Tobin asking him to do all in his power to assist in the passage of Senate #2002, Mr. O'Brien's bill for the establishment of non-profit hospital service plans.

On April 16, 1936, Father Bryan McEntegart from the Archdiocese wrote to Mr. Tobin urging opposition to Senate Bill Int 1957 Print 2481 about the process of referral of patients to clinics by the Commissioner of Public Welfare, rather than by the Commissioner of Hospitals.

During the 1937 Legislative session, there was correspondence about the Wojtkowiak bill, Int 159, Print 608 which would subject religious orders to rules about time of duty, which resulted in a letter to Charles Tobin from John J. Dunnigan, Temporary President of the Senate saying:

> "After careful study of this bill, I agree that this type of bill would be a hardship and will act accordingly."

In a letter to Mr. Tobin on March 24, 1937, Father McEntegart provided advice on several health related bills, in response to a request for input.

On April 3, 1937, Mr. Tobin wrote to Assemblyman Irwin Steingut, stating:

> "We feel that your bill, Assembly last Pr. 2165 providing for a change in the Public Welfare Law to permit the establishment of bureaus of hospital clinics is unwise and impractical."

Senator Francis L. McElroy responded to a letter from Mr. Tobin in opposition to his Senate bill, Introduction No 310, repealing Section 1910 of the Penal Law, stating:

> "You may be assured that I will never do anything to injure the hospitals of the State of New York."

On February 16, 1940, Mr. Tobin wrote to Senate and Assembly sponsors in opposition to legislation relating to waiver of immunity by charitable and public corporations.

Throughout 1940, Ms. Lucille Hart of the Division of Social Action of the Archdiocese of New York provided consistent input to Mr. Tobin on a variety of bills.

Attorney Jay Twohey from Brooklyn wrote to Charles Tobin on February 27, 1940, recommending continuing opposition to the Hampton Piper Bill seeking to qualify non-liability of hospitals and charitable institutions.

On April 9, 1940, Mr. Tobin wrote to Nathan Sobel, Counsel to the Governor, expressing opposition to A Int 150 Pr 1759, amending the Lien Law with relation to inspection of hospital records.

In December 1940, there was correspondence between Mr. E. W. Jones, Director of the Albany Hospital and Mr. Tobin about proposed amendments to the Public Welfare Law, in which Mr. Jones indicated he would not present them until they "had been discussed and agreed upon by the Catholic Welfare Committee".

On February 13, 1941, Mr. Tobin wrote to Assemblyman Harry Reoux, stating that he had a phone call from the Counsel to the Governor stating his agreement with Catholic opposition to A Int 96 Pr 96, and suggesting that it be withdrawn from the Governor. This bill would have repealed provision of state payment for care of tuberculosis payments in private institutions.

On March 19, 1942, Mr. Tobin wrote to Father Brophy asking him and his associates to lobby against the Davison hospital lien bill (Assembly Int 1212) which would allow the court to fix the amount of a lien at less than cost rates.

On April 2, 1943, Mr. Tobin wrote to Charles Breitel, Counsel to Governor Dewey, to express opposition to A Intro 958 Pr 2266, lifting certain restrictions on public hospitals treating workmen's compensation cases.

Provision of Advice and Information

As the field of health care provision became more complex, and there was more government involvement, at both the federal and state level, the role of Mr. Tobin and the Catholic Conference broadened to include provision of advice and information on various issues.

These were several examples of such activity in the 1940's and 1950's:

1. Principles for Federal Health Care Policy

   In 1942, Mr. Tobin was involved with a gathering of Assembly of Presidents and Secretaries of State and Provincial Hospital Associations which recommended to the American Hospital Association the following set of guiding principles for any discussion of proposed legislation affecting hospital practices and the community relations of hospitals:

   a.) The voluntary hospitals of the United States, which account for more than 60 percent of all hospital admissions, are a national asset of incalculable value.
   b.) The efficiency of these institutions is traceable in large part to their freedom of action under local control.
   c.) The independence of voluntary hospitals and of hospitals under city, county and other local community control, should not be jeopardized by other federal legislation.
   d.) Programs seeking to widen the use of voluntary hospitals, and their more perfect adaptation to the needs of workers of the country through voluntary contributory plans, merit government consideration and support.
   e.) A full opportunity should be given to the voluntary hospitals of the country through the American Hospital Association to study proposed legislation affecting the hospitals before such legislation is offered to the Congress.

2. Malpractice Insurance

   By memorandum on January 25, 1945, Mr. Tobin informed Diocesan Directors of Health Care that a number of Catholic Hospitals had been called upon to meet lawsuits involving the subject of malpractice. It was found in two instances, one very expensive, that the hospital had not been covered. Mr. Tobin therefore strongly advised that Diocesan Directors check with their hospitals to determine if there was adequate coverage.

3. X-Ray Technicians

   On May 31, 1945, Father Martin Wenzel, Associate Director, Division of Health, Catholic Charities, Diocese of Brooklyn, wrote to Mr. Tobin inquiring about the legal requirements for a radiology technician to administer deep x-ray technology. After

consulting with the State Health Department and the State Medical Society, Mr. Tobin advised a policy that such activity occur only under the direct supervision of a physician.

4. Reimbursement for Sisters' Salaries

In 1946-1947, Mr. Tobin was involved as a member of the Catholic Health Association in on-going dialogue with the Social Security Administration about an appropriate valuation of employment time of Sisters in calculating reimbursement rates. This matter came to a successful conclusion.

5. Sharing Best Practices

Through the work of Mr. Tobin in communicating with Diocesan Directors of Hospitals, there were distributed in the summer of 1947 copies of professional staff booklets and application forms developed by Mary Immaculate Hospital in Jamaica, NY, and shared as a best practice model.

6. Survey of Admission Requirements

Charles Tobin, Jr. and the Catholic Conference became involved in 1957 in an issue relating to Admission Requirements of Catholic Hospitals with regard to practicing physicians. A group related to Planned Parenthood had raised questions about a federal grant from the Joint Hospital Survey and Planning Commission because St. Charles on Long Island had denied admitting privileges to a physician associated with Planned Parenthood. The Catholic Conference did a survey of Catholic Hospitals in the state and found that most of the Catholic Hospitals in the state adhered to the Code of the American Catholic Hospital Association governing the conduct of staff of the hospital. From this survey, it was concluded that this challenge was indeed a serious problem from a legal perspective. However, in 1958, Mr. Tobin reported on a court decision that a Hill-Burton grant did not impose greater requirements on physician admissions standards for non-profit hospitals.

7. Union Activities-Medical Technologies

In August 1957, having been made aware by Dorothy Coyle, an attorney for Catholic Charities of the Archdiocese, of possible organizing activities by medical technologists in New York City, Mr. Tobin made this information available to the Catholic Committee.

8. Metcalf Proposed Legislation on Health Insurance

In early 1958, Mr. Tobin made available to Diocesan leadership information on legislation proposed by Senator Metcalf to broaden health insurance coverage from group insurance coverage to individual coverage.

9. Hospital Coverage in Blue Cross for Mental Illness

In light of current public policy debate, it is interesting to note that Mr. Tobin provided information about a Joint Legislative Committee on Health Insurance Plans Hearing to be held in Syracuse on June 16, 1958 on the question of inclusion of hospital coverage in Blue Cross for mental illness.

Internal Organization

It is clear that the increasing complexity of health care service delivery and government involvement created an awareness within leadership of the Catholic Church in New York State, that there needed to be a more formal and focused public policy presence of the Church on these issues.

This recognition was first articulated in a letter from Monsignor Joseph Toomey, Diocesan Director of Catholic Charities in Syracuse to his counterpart in Brooklyn, Monsignor James Fitzpatrick on February 5, 1957. He wrote:

> "For a long time, I have been anxious to see something done with regard to the many problems that plague our Diocesan hospital administrators, be they Diocesan managed or owned by a religious community".

He proposed that there be regular meetings of the seven Diocesan Directors of Hospital Ministry in the state, to address such issues as third party payments, nursing education, and the evolution of medical specialties.

He suggested that this group then seek to meet with the Ordinaries of the State to recommend establishment of a Catholic Hospital Council from which two representatives would be appointed to the New York State Catholic Welfare Committee.

This letter precipitated a meeting involving Bishop Scully of Albany, Monsignor Toomey, and Monsignor Gilfoyle, Director of Catholic Charities of the Archdiocese of New York. Out of this meeting, came agreement not about creation of a Catholic Hospital Council, but rather that there be a meeting of Priest Hospital Administrators.

While this particular proposal went no further, the forces demanding that the Church get better organized continued to escalate.

Chapter Two

The Rockefeller Era

1959-1974

A. Introduction

As in so many other areas, the landscape in health care policy in New York State was dramatically transformed during the Rockefeller administration.

Described in this Chapter first is the internal organizational evolution of the Catholic Conference in regard to Public Policy.

Then are chronicled the major milestones in evolution of health care policy in the state with description of Catholic Conference involvement in these policy making decisions.

B. Internal Organization

1. Bishops' Hospital Representatives: Early Meetings

On February 9, 1960, Father James Fitzpatrick from Brooklyn wrote to Charles Tobin Jr., in response to a request for input on various legislative proposals, indicating:

1.) an expression of appreciation that Charles would "cull out" legislative proposals of particular interest to Catholic hospital leadership;
2.) that he had enclosed a list of Diocesan hospital representatives;
3.) that the Diocesan hospital representatives clearly wanted closer communication with Charles and the State Catholic Conference;

4.) and, concluding:

> "It is our hope that a State Conference of Priest Hospital Representatives be established which would serve much as the School Superintendents in reporting to the New York State Catholic Welfare Conference. We would be pleased in any capacity to serve this end."

As follow-up, in March 1960, Father Fitzpatrick wrote to Charles Tobin, informing him that there would be the first meeting of the Bishops' hospital representatives held in Albany on April 7, 1960. He wrote: "we have hesitated to organize such a meeting in view of our discussion at the January (State Catholic committee) meeting. However, we presume that your latest letter leaves us free to develop a conference of the priests of the diocese of New York State concerned with hospital affairs and nursing education." Invited to this meeting were Father Jack Sise from Albany, Monsignor Edward Melton from Rockville Centre, Mr. Jay Twohey from Brooklyn, and Monsignor Patrick Frawley from the Archdiocese.

The "Conference of Bishops' Representatives", met again on December 8, 1960, at Father Sise's office in Albany. Present for the meeting were:

Monsignor Joseph Lucker - Ogdensburg
Monsignor Arthur Ratigan – Rochester
Monsignor Patrick Frawley – Archdiocese
Monsignor Joseph McPherson – Buffalo
Monsignor Edward Melton – Rockville Centre
Father James Fitzpatrick – Brooklyn
Father Daniel Lawler – Syracuse
Father Jack Sise – Albany
Mr. Charles Tobin – Catholic Conference
Mr. Jay Twohey – Brooklyn Attorney

The outcomes were:

1.) It was agreed that "Homes for Aging" should be coordinated with hospitals "so as to qualify for Blue Cross reimbursement, Hill Burton Funds, any federal aid that may be forthcoming";

2.) It was agreed <u>not</u> to take a stand against A.M.A. rulings with regard to the status of foreign graduate interns;
3.) With regard to the Trussell Report which proposed that more power be given to the State Health Department, it was agreed to ask for a delay in implementation;
4.) The group endorsed creating a state Office for Aging in the State Social Welfare Department.

Father Fitzpatrick continued his advocacy for formal recognition of this group by writing to Bishop Scully of Albany on January 12, 1961.

He reminded the Bishop that several years prior to this communication, Monsignor Toomey had tried to organize a New York State Conference of Catholic Hospitals because "the weakness of the Dioceses in the hospital area has made our efforts fruitless". He asked for establishment of regular meetings of the priests representing the Ordinaries of the State in Hospital Affairs. He said: "It is our hope to establish the Conference of Catholic Hospitals centered on the Diocesan level, rather than that of the religious community". He concluded by stating that since the Catholic hospitals were dependent on the New York State Hospital Association, they had a minimal impact on the formulation of policy.

The result of this discussion was the establishment of a more formalized group of Bishops' Hospital Representatives which would help the Catholic Conference deal with the challenges of the 1960's.

2. <u>December 12, 1961 Report to the Bishops</u>

The next significant evolution of the work of the "Conference of Bishops; Representatives" was a report given by Father Fitzpatrick to Albany Bishop William Scully on December 12, 1961.

The highlights of this report included:

A. Statistics – Catholic Hospitals in New York State

Type	Institutions	Beds
General Hospitals	51	10,736
Special		
Cardiac	1	160
Maternity	1	63
Pediatric	3	158
Chronic	1	415
Psychiatric	1	208
Tuberculosis	3	841
Total	61	12,581
Related Health Facilities		
Cancer	2	200
Chronic	13	896
Homes for Aged	20	2,745
Pediatric	1	4
Psychiatric (Pediatric)	2	77
Visiting Nurse	13	--
Total Related	52	3,922
Overall Total	113	16,503

B. Projections of Capital Investment

1.) 12,581 hospital beds at	$30,000	$377,430,000
2.) 3,922 related beds at	$15,000	$ 68,635,000
Total		$446,065,000

C. Totals – All Hospitals in New York State

Number of Institutions	373
Number of Beds	97,444

D. Status of Catholic Hospitals

1.) "Only the Archdiocese of New York, the Dioceses of Buffalo, Rockville Centre and Brooklyn have organized divisions of Catholic Charities, headed by a fulltime Bishop's representative, supervising hospitals."
   a.) "several years ago, the late Monsignor Toomey tried to organize a New York State Conference of Catholic Hospitals. The weakness of the Dioceses in the hospital area made his efforts fruitless."
   b.) "At your Excellency's request, we have organized over the past two years regular meetings of the priests representing the Ordinaries of New York State in hospital affairs. Monsignor Lucker has been chairman of the

group, and it is our mutual hope to establish a Conference of Catholic hospitals centered on the Diocesan level, rather than the religious community".

2.) "Hospitals most often have antedated the organization of Catholic Charities in the individual Diocese. The fact that the institutions are owned by the religious communities, usually Pontifical congregations, has been proposed as an obstacle to cooperation within the Diocesan framework".
3.) "The Catholic hospitals have depended upon the New York State Hospital Association and its local affiliates to protect their interests. As a result, our institutions have a minimal influence in the formation of policy. There has not been an effective liaison or communication with the New York State Hospital Association".
4.) "The charitable character of all hospitals, including the Catholic institutions have changed with:
   a.) the growth of health insurance programs (i.e. third party payments), and
   b.) reimbursement from government that approximates cost".
5.) "In recent years, both the Legislative and Executive branches of government have taken increased interest in the affairs and operation of hospitals, viz, Columbia and Cornell University studies, Metcalf hearings, reorganization of the Department of Health. It is in this area that coordinated action by our Catholic hospitals seems to be **imperative".**

E. Problems in the Immediate Future

1.) Department of Social Welfare for General Hospitals
2.) Regional Planning
3.) Legislation relative to employees in non-profit institutions
4.) Labor attempts to organize employees
5.) Role of Catholic hospitals in medical, para-medical and nursing education

3. Bishops' Hospital Representatives: Mid 1960's

In a development which would later influence the work of this committee, Cardinal Spellman appointed Monsignor Patrick Frawley and Mr. Thomas McLaughlin as co-Directors of the Department of Health and Hospitals of the Archdiocese.

Based upon a memorandum to the Bishops' Hospital Representatives written by Charles Tobin on August 17, 1965 about the passage of the law to transfer jurisdiction over hospitals to the State Health Department, the Bishops' Hospital Representatives at that time were:

Monsignor Patrick Frawley - Archdiocese
Monsignor Daniel Lawler - Syracuse
Monsignor Arthur Ratigan – Rochester
Monsignor James Fitzpatrick - Brooklyn
Monsignor Joseph Lucker - Ogdensburg
Father Jack Sise - Albany
Father William Zenns - Buffalo
Father Richard Hendel – Rockville Centre

Following on passage of the law, these Hospital Representatives met with Dr. Robert Whalen, Assistant Commissioner of the Department of Health on November 30, 1965 to discuss the new administrative responsibilities of the Health Department. Thus began what was to be a longstanding, warm and mutually beneficial relationship between Dr. Whalen and leadership of the Catholic Conference.

4. Reactivated Membership - 1967

Through the leadership of Father Richard Hendel from the Diocese of Rockville Centre, the Bishops' Committee of Hospital Representatives was reactivated and revitalized in 1967. On October 6th, Charles Tobin wrote to Father Hendel thanking him for agreeing to serve as Chairperson of the Committee. On October 25th, Father Hendel wrote to all the Ordinaries asking them to name a representative to the committee. On December 19th, Father Hendel replaced Monsignor Fitzpatrick as the hospital representative on the New York State Catholic Welfare Committee.

This newly reconstituted group met on February 29, 1968.

Membership on this reconstituted committee group included:

Monsignor Dan Lawler - Syracuse
Monsignor William Charbonneau – Rochester
Father William Zenns – Buffalo
Father John Hunt – Brooklyn
Monsignor James Fitzpatrick – Brooklyn
Father Jack Sise - Albany
Father Richard Hendel – Rockville Centre
Monsignor Patrick Frawley – Archdiocese

Jim Sanderson was present as a representative of the Catholic Conference.

At this meeting, the group recommended:

1.) support for expansion of the Article 28 A program for construction of nursing homes;
2.) support for universal health care;
3.) opposition to proposed Medicaid cutbacks;
4.) support for increases in Regents Training Grants;
5.) support for the concept of the presence of a physician or intern at a hospital at all times to treat emergency patients.

At its next meeting, held on April 17, 1968, the committee made these decisions:

1.) agreed to take immediate steps to contact legislators in support of the proposal to expand Article 28 A funding to make homes for the aged eligible for construction money and place them under the jurisdiction of the Health Department;
2.) recommended support for the Hospital Association proposal to amend the purposes of the State Dormitory Authority to include the construction of health facilities, if the program were amended to change its "title restrictions" to match the Federal dormitory plan;

3.) recommended advocacy for restoration of proposed Medicaid cutbacks;
4.) had general discussion about the concept of universal health insurance;
5.) discussed the desirability of broadening representation on the committee, providing greater continuity and communication, and establishing and clarifying the contribution of the Apostolate to the sick.

It was agreed that with concurrence of those members not present, the committee would propose addition of a Hospital Administrator, a Trustee and a Professional Staff representative from each Diocese to the committee as "consultants" to the Bishops Representatives.

At its meeting on October 1, 1968, the committee reviewed and made recommendations on Catholic Conference "Program Goals for 1968-1969".

At an informal meeting held during the Catholic Hospital Association mid-winter meeting in San Diego in January 1969, it was agreed that the group would set a regular meeting date each month, and when there was insufficient business, to cancel the meeting.

The first such regular meeting was scheduled for March 4, 1969. On the agenda for this meeting were the following items:

1.) the formation of some type of advisory group to the committee;
2.) the hospital loan program pending in the state legislature;
3.) a number of items resulting from the Governor's austerity budget;
4.) the Universal Health Insurance program.

At this meeting, it was agreed that each Bishop's Representative would decide whom to invite from his Diocese to form the nucleus of an advisory committee to this group and to invite these additional persons to the next meeting to be held on April 1, 1969.

At this meeting, the following matters were addressed:

1.) the committee decided on a variety of advocacy measures to respond to significant budget cutbacks enacted two days earlier;
2.) with regard to the Governor's proposals for Universal Health care, it was the consensus that since this legislation had been now introduced for the past three years with no action resulting, that it was likely that to have a chance of success, this concept had to be addressed at the federal level;
3.) the group discussed ways in which the Catholic Conference could support the proposed Constitutional Amendment permitting loans to hospitals which would likely be on the ballot in November 1969;
4.) the committee endorsed pending legislation to provide "conscience protection clauses" for hospitals, doctors and other employees in regard to performing abortions;
5.) the committee received the provisional draft about the work of the Joint Commission on Accreditation, and reached the conclusion that it seemed redundant of the certification process required by the State Department of Health;
6.) there was lengthy positive discussion about creation of an advisory committee which had been authorized by the State Catholic Committee with agreement that

the Bishops' Representatives would develop a specific proposal at their next meeting.

The next meeting of the Bishops' Representatives was held on June 3, 1969 at the Sheraton at LaGuardia. On the agenda for the meeting were:

1.) plans for developing voter support for the Hospital Loan Constitutional Amendment;
2.) plans for creating an Advisory Committee to the Bishops' Representatives;
3.) legislative goals for 1970, including Universal Health Insurance, Medicaid Payment Formula, membership on the Public Health Council and Tax Exemption;
4.) compensation for religious;
5.) staff person approved in budget on a shared basis with Charities Directors;
6.) recent developments on Medicaid cutbacks.

Following up on the discussions about an advisory group, the Bishops' Representatives determined to organize a meeting of the Advisory Committee on Health Affairs to be held at LaGuardia Airport on October 7, 1969. Invited to this session in addition to the Bishops' Representatives were the Administrator of each hospital and one other person from each institution, preferably a member of the Governing Board or Medical Board.

On the agenda for this meeting were:

1.) Constitutional Amendment
2.) Cost Control Formula
3.) Cost Control Effect
4.) Nurse Recruitment Program
5.) Joint Commission on Accreditation of Hospitals: New Standards
6.) Universal Health Insurance
7.) Compensation Carriers
8.) Regional Advisory Board (AHA) Participation

The Committee of Bishops' Representatives for Health and Hospitals held its next meeting on December 2, 1969. On the agenda for this session were:

1.) Debriefing the October 7th Advisory Committee meeting, in which it was pointed out that basically this was an educational session for all participants and that perhaps a small group could be convened to actually serve as Advisors to the Bishops' Hospital Representatives. It was pointed out that a further problem in this regard was the differing administrative structure in the Dioceses;
2.) Medicaid issues;
3.) Implementation of the Constitutional Amendment on Hospital Loans which won approval in the November election;
4.) the HANYS Nurse Recruitment program;
5.) Universal Health Insurance;

6.) Comprehensive Health Planning;
7.) Recodification of the Mental Health Law

The committee then moved into a more inactive phase.

5. Diocesan Coordinators of Health Affairs - 1971

In appointing Monsignor Christopher Kane of the Archdiocese to the Catholic Committee by letter on April 2, 1971, Charles Tobin indicated his concern that the hospital representatives had not been functioning actively in recent months, and pledged staff support to the group through James Sanderson and John Szulgit.

The committee reconvened under the new title Diocesan Coordinators of Health Affairs on December 5, 1971. Items addressed at this meeting included:

1.) the committee urged endorsement of the Ethical and Religious Guidelines for Catholic Health Facilities;
2.) the committee recommended that each hospital make available data on abortion results;
3.) the committee recommended support of legislation on minor's consent for health care with the exclusion of "abortional procedures";
4.) the committee suggested that matters relating to hospital staff privileges should be handled locally;
5.) the committee discussed issues relative to the New York State Health and Hospitals Planning Council;
6.) the committee asked the Bishops to endorse a National Catholic Health Assembly.

Following this meeting, the committee did not meet again for a year due to the illness of Monsignor Kane. At the July 27, 1972 meeting of the Catholic Committee, it was agreed that the Diocesan Coordinators of Health Affairs needed to be reconvened.

The committee finally met again on November 10, 1972 at which these matters were addressed:

1.) the committee unanimously passed a resolution in honor of the late Monsignor Christopher Kane;
2.) the group agreed to support Bishop Head's committee at the national level in their work to update the Ethical and Religious Directives;
3.) the consensus of the group was that Catholic hospitals were not having problems related to abortion issues;
4.) the committee had lengthy discussion about cutbacks in maternity beds;
5.) the committee discussed Departments of Pastoral Care, agreeing that such services, if provided ecumenically, could be reimbursed by Blue Cross;
6.) the committee discussed issues relating to genetic counseling and euthanasia;
7.) Monsignor McPherson brought to the attention of the committee an issue relating to a Catholic hospital in Buffalo;
8.) the committee had lengthy discussion about the issue of staff privileges for a physician whose outside activities diverged from Catholic teaching;

9.) Mr. Sanderson reported on a Montana Court decision upholding a forced sterilization in a Catholic hospital which could have significant implications for Catholic health care programs;
10.) it was agreed that the committee would set aside time at the January 1973 meeting to discuss its role and purpose.

This meeting marked the addition to the committee of several new persons: Father Douglass from Albany, Monsignor Cassidy from New York, Monsignor Lawler from Ogdensburg and Father Mattei from Rockville Centre.

The committee reconvened on January 17, 1973 under the leadership of Acting Chairman Father Saverio Mattei of Rockville Centre and addressed these issues:

1.) Monsignor McPherson updated the committee on the continuing process relating to the application of Our Lady of Victory to rebuild 108 beds, indicating that the State Hospital Review and Planning Council had not made a decision, but that there was hope the situation could be resolved voluntarily at the local level;
2.) there was agreement to henceforth use the nationally used term Diocesan Coordinators of Health Affairs;
3.) there was agreement that the Diocesan Coordinators of Health Affairs would work closely with Diocesan Human Life Coordinators on abortion issues.

At their meeting in Albany on July 25, 1973, the Coordinators addressed these matters:

1.) report on 1973 New York State Legislation:
    a.) Hospital Based Prepaid Group Practice
    b.) Fiscal Disclosure
    c.) Child Abuse Act
    d.) Blood Utilization and Sterilization
    e.) Ghetto Medicine
2.) 1974 Health Affairs Legislation:
    a.) Emergency Medical Services
3.) review of American Hospital Association Statement on Patient's Bill of Rights;
4.) review of recommendations of USCC Committee on Law and Public Policy;
5.) abortion issues;
6.) discussion of Functions and Responsibilities of Diocesan Health Affairs Coordinators including:
    a.) relationship with Ordinary
    b.) relationship with Diocesan facilities and programs
        - should Diocesan Coordinators be Ex-Officio members of Boards of Trustees or Advisory Boards
        - ongoing relationships with Administrators and Chief Operating Officers of facilities or programs
        - formulation of long-range plan for individual health care facilities
        - involvement of hospital and health executives in development of coordinator's functions and responsibilities
        - Bishops' representative to health related and planning agencies

At its October 17, 1973 meeting, the committee addressed these issues:

1.) euthanasia
2.) chaplains
3.) services to pregnant women

At its meeting on January 15, 1974, the Committee of Health Affairs Coordinators addressed these matters:

1.) there was lengthy discussion recognizing the validity of need for consolidations or reducing maternity services and identifying various alternative approaches;
2.) it was agreed that committee members needed to learn more about the HANYS proposal to create a State Health Services Commission to assume most responsibilities currently held by the State Health Department before taking a position on it;
3.) it was agreed that Coordinators should cooperate in the planning of the Catholic Conference Spring Conference on Crisis Pregnancy;
4.) it was agreed to try to hold a State Health Assembly under the joint sponsorship of this committee and the Division of Health and Hospital Affairs, Catholic Charities, Archdiocese of New York;
5.) Monsignor James Cassidy was elected Chairman of the committee.

This group next met on June 19, 1974 to discuss plans for a State Health Conference to be held in October. The purpose of such a convening would be to discuss the future involvement of the Church in the delivery of health care in the state.

This statewide convening was held at the Foundling Hospital on October 9, 1974 and was a fitting conclusion to this era in the evolution of Catholic Conference attention to health care concerns.

C. Influence on Public Policy

1. Introduction

The description of the evolution of the internal Catholic Conference organizational structure details the wide variety of public policy issues which the Catholic Conference addressed during this period.

Here are described in somewhat more detail Catholic influence on four major public policy issues relating to health care during the Rockefeller era:

1. Metcalf-McCloskey Legislation
2. Marion Folsom committee on Hospital Costs
3. Article 28 Loans, Article 28A Loans, Constitutional Amendment
4. Abortion

In addition, there is brief mention of several other issues the Catholic Conference addressed during this time period.

It is interesting to note in this introduction that there is little evidence of Catholic influence in the establishment of the Medicaid and Medicare programs in New York State. It is reported that the Medicaid program was basically established when Alton Marshall and Bill Ronan from the administration met with legislative leaders and presented a proposal that was readily accepted. Only later was it recognized that the financial implications of this proposal were grossly understated, and that New York's finances would be burdened for the next forty years up until the present time by the costliest state Medicaid program in the country. With regard to Medicare, the Catholic Conference is on record only as applauding the initial decision that the state Medicare agency would be the State Board of Social Welfare. Obviously, this responsibility was transferred early on to the State Department of Health.

2. Metcalf-McCloskey Legislation

The stage was set for consideration of what would become Metcalf-McCloskey Legislation with the passage of Chapter 331 of the Laws of 1960, which transferred all the functions of the Joint Hospital Survey and Planning Commission to the State Department of Health and reconstituted the Advisory Council to the Commissioner as the State Hospital Review and Planning Council.

Following publication of regulations implementing this legislation, on October 25, 1960, Charles Tobin wrote to Department of Health Commissioner Herman Hillaboe questioning articles in the regulations on oversight of "general operation", "use", and "renovation or expansion." Thus was joined the battle over the role of the Health Department.

Following on this legislation came the Trussel proposal that the Hospital Review and Planning Council would serve as an advisory body to the State Board of Social Welfare with respect to construction, approval of renovation or expansion of services for health facilities.

On December 1, 1960, Senator Metcalf invited Charles Tobin to a meeting to discuss these proposals. At their meeting on December 8, 1960, the Bishops' Hospital Representatives affirmed their opposition to granting further powers to the Department of Health and agreed to continue to support the role of regional bodies and the State Board of Social Welfare in planning and decision-making. Monsignor Fitzpatrick followed up with a conversation that the proposed bill in no way extended the powers of the Department of Health. As this legislative proposal further evolved during 1961, however, Father Patrick Frawley wrote to Charles Tobin on December 11, 1961, expressing concern that it would allow Commissioner Hillaboe to control capital funds and operational income through the limitation of powers of regional planning groups.

By mid-1962, it was clear that approval powers for construction or expansion of facilities would be turned over to some state agency. On July 25, 1962, Charles Tobin wrote to Father Frawley that "perhaps it is in the cards, but we have to give it very serious study because we recognize that the desire of a religious group in the community to have a hospital to serve its people would not be a consideration in the determination of community need by a governmental agency."

The next important moment in the evolution of the Metcalf legislation was a meeting of the Joint Committee on Health Insurance Planning, Chaired by Senator Metcalf held on June 7, 1963. Representing the Catholic Conference were Charles Tobin and Father Chris Kane from the Archdiocese of New York.

At this meeting, Charles spoke forcefully advocating that ultimate responsibility for planning remain with a citizen group, i.e. the State Board of Social Welfare, and that religious factors be taken into account. He wrote two weeks later to the Bishops' Hospital Representatives saying that there was very little support for these two positions. In fact, Father Kane had expressed to Father Frawley and through him to Monsignor Head concern that there was so little support for these positions that perhaps Mr. Tobin had done a disservice to the Church with these interventions and that perhaps the Church should negotiate quietly on the religious issue. Monsignor Head in response supported Charles. On the other hand, Monsignor Lawler sent Charles the minutes of the June 14, 1963 Syracuse Regional Health Planning Council with Senator Metcalf indicating his belief that the definition of "public need" discussed at the meeting was broad enough to include religious and teaching needs. He further reported after the September 11, 1963 meeting that both Senator Metcalf and the group would accept without question that some change should be inserted protecting the rights of religious groups in establishing hospitals. Yet, at another Conference called by Senator Metcalf on September 27, 1963, both Charles and Father Frawley felt that there was not much support either for the religious need question or for retaining the powers of the Board of Social Welfare.

Meanwhile, the Catholic Conference was developing language about religious inclusion in this legislation. In late 1963, the Catholic Committee adopted this proposed language:

"The term public need shall be deemed to include the needs of the members of the religious community for care and treatment in accordance with their religious or ethical concerns."

In what was a pivotal meeting held on January 16, 1964 involving the Catholic Conference, Senator Metcalf, the Department of Health, the Board of Social Welfare, and the Hospital Association of New York State, this language was accepted. It was later modified at the request of Senator Metcalf to read:

"Care and treatment under conditions consistent with their religious or ethical concerns".

So was enacted Chapter 730 of the laws of 1964, which left basic authority with the State Board of Social Welfare, increased the role of the Regional Councils, and expanded membership on the Hospital Review and Planning Council from 25 persons to 31 persons.

In conclusion, a note about Catholic participation on the Hospital Review and Planning Council. When it was constituted in 1960, the only Catholic member was Father Frawley. With the expansion, one of the new members added was Sister Mary Janet. As a result of numerous efforts by Bishop Head and Charles Tobin, Monsignor James Fitzpatrick was added as a member in 1970.

3. Marion Folsom Commission on Cost Control

The evolution of decision-making about health planning and cost control entered a new phase when on May 26, 1964, Governor Rockefeller appointed Marion Folsom from Rochester (former Federal Commissioner of Health, Education and Welfare) to Chair a State Commission on Cost Control. Charles Tobin wrote to the Bishops' Hospital Representatives on July 12, 1964 saying that Mr. Folsom had requested input from the Catholic Conference and asking for recommendations. Representatives of the Conference met with Mr. Folsom on December 1, 1964.

Meanwhile, in the spring of 1965, the State Department of Social Welfare, concerned about its status, organized a series of regional meetings to discuss:

1.) implementation of the Metcalf-McCloskey legislation
2.) reimbursement by public agencies
3.) nursing home legislation

Once again, things came to a head in June 1965, with introduction of legislation developed by the Folsom Commission. On June 3, 1965, Lieutenant Governor Malcolm Wilson sent an urgent telegram to Charles Tobin asking him to come to the Capitol building to discuss this legislation with Governor's Counsel Sol Corbin before it was introduced. This legislation would finally transfer all authority over hospitals to the State Department of Health.

The Catholic Conference initially opposed this legislation because it believed that such a transfer of jurisdiction would require a constitutional amendment and because it continued to believe that power for issuing Certificate of Need should rest with a body that included citizen participation.

Through further discussion with various advocacy groups, including HANYS and the Catholic Conference, the bill was amended in three important ways:

1.) rule making power would rest with the Hospital Review and Planning Council, not the Commissioner of Health;
2.) parameters were placed on the Commissioner's rate approval policies;
3.) current exemptions for institutions of religious groups would continue.

With these amendments, Chapter 795 of the laws of 1965 was enacted, and effective February 1, 1966, the Department of Health assumed even greater powers over the health care system in the state. Once again, however the Catholic Conference had advocated effectively for citizen input and religious needs

4. Article 28 Loans, Article 28A Loans, Constitutional Amendment

As indicated previously, the Catholic Conference worked to support Article 28 loans for hospital construction enacted in 1967, Article 28A loans for nursing home construction enacted in 1968, and the Constitutional Amendment for Hospital loans approved by the voters in November 1969. The Catholic community was quick to take advantage of these programs particularly Article 28A loans. The Mary Manning Walsh facility in New York

received the first construction approval, and St. Camillus in Syracuse was the first nursing home opened under this legislation.

5. Abortion

While it was the Catholic Charities Directors who took primary responsibility for leading Catholic Church efforts in opposition to abortion, no discussion of health issues would be complete without mention of this issue.

There had been growing support within the Legislature for the so-called Blumenthal Bill, (introduced by a liberal Manhattan Assemblyman, Albert Blumenthal) which would legalize abortion in New York State (several years ahead of the landmark 1973 Roe vs. Wade decision). As early as the January 26, 1967 meeting, there was discussion about developing a grassroots Catholic campaign in opposition to this legislation. It was agreed that the strategy would include a state Bishops' pastoral letter, a parish-based letter writing campaign, and systematically testifying at legislative hearings on this bill to be held around the state.

This campaign was given further emphasis in spring 1967 when the Administrative Board of the United States Catholic Conference formalized creation of a national campaign against abortion.

But with each passing year, the bill gained more support. Church advocacy was among the reasons why the Blumenthal bill was not enacted in 1967, but this legislation was ultimately passed in 1970, making New York State one of the first states in the nation to legalize abortion.

The story of passage of the bill is interesting. As happened many times over the years, there was internal debate within the Catholic Committee as to whether to support the Blumenthal bill as more restrictive legislation, and the "lesser of evils". The Church came to the conclusion that it could not do so because one of the conditions under which abortion would be legal would be if the health of the mother were endangered. It was felt that this provision was too broad and therefore the Church opposed the Blumenthal bill. The climax of the debate came in March 1970. Senate Majority Leader Earl Brydges, who was generally supportive of the Church position, but recognized the potential strength of abortion advocates, devised a strategy which he believed would avoid passage of any abortion legislation. He had introduced a bill that was so liberal and broad that he thought it would surely be defeated. Unfortunately, it was passed 31-26 on March 18, 1970 with the only limitation being to permit abortion on demand only through the 24th week of pregnancy.

Two weeks later that same bill was defeated in the Assembly, but only because Speaker Perry Duryea refused to count the affirmative votes of two Democrats who had "left" their votes with the Clerk of the Assembly and departed for home during the nine-hour debate but before the role call. In the next two weeks, the Bishops vigorously expressed their opposition to this bill. After another lengthy and bitter debate an upstate Democrat, George Michaels of Auburn, (who was Catholic) dramatically changed his negative vote to the affirmative and the bill passed with the minimum 76 votes. (This was to be the end of Assemblyman Michael's political career.)

6. Other Policy Issues

Beyond these four major issues and other matters addressed in the previous section, the Catholic Conference also addressed several other public policy issues during this time. Among the most important were:

a.) When the Department of Social Welfare disseminated Rules and Regulations for the operation of Hospitals on May 15, 1961, Monsignor Bryan McEntegart suggested that the Catholic Conference advocate for a distinction between "rules" and "recommendations" as had been done successfully in the child care arena.
b.) At the suggestion of Monsignor Fitzpatrick, Catholic hospitals were directed not to answer a questionnaire on religious services distributed by the Board of Social Welfare on May 9, 1962.
c.) On March 12, 1963, the Conference expressed support for exploring the possibility of using Mitchell-Lama funds for low interest loans for hospital construction (this possibility never came to pass).
d.) At a hearing held by Senator Lent in November 1968, Father Hendel spoke in support of funding for "Ghetto Medicine".
e.) From July 8-10, 1969, Monsignor John Ahern and Tom McLaughlin from the Archdiocese, Father Charlie Fahey from Syracuse, and Ed Peterson from Rockville Centre participated in an Albany Conference on Hospital and Nursing Home Cost Control. Monsignor Ahern's contributions were recognized as significant.

Chapter Three

The Carey Administration

1975-1982

A. Introduction

The gubernatorial election of 1974 brought sweeping change to state government and had significant implications for the State Catholic Conference.

Gone were sixteen years of the Rockefeller team and gone were the close relationships which Charles Tobin had established within the highest levels of the Governor's office.

On the other hand, the election of Hugh Carey provided many new opportunities for the Church in the state. For the first time in many years, New York State had a Catholic Governor and a Catholic who cared about the Church. In the areas of concern to the Catholic Conference, Governor Carey would assemble a leadership team, consisting of personal advisors new to government like Dr. Kevin Cahill, and seasoned state administrators like Bob Morgado, who were open to partnership with the Church and others to serve those in need. And very quickly, persons close to the Catholic Church found themselves in key advisory positions on health care: Monsignor Charles Fahey and Dr. Bob Collins from Syracuse and Tom Dowling from Rockville Centre were among the most visible.

At the same time, in response to the ever evolving complexity of public policy in health care and the opportunities in relationship to a new state administration, internally the Catholic Conference was enhancing its structural ability to influence public policy in the health arena.

This Chapter begins with a discussion of the evolution of the internal Catholic Conference structure as a prelude to discussion of the influence of the Church with state government.

B. Internal Organization

1. Introduction

During the Carey administration, the Catholic Conference took two major steps toward enhancing internal organizational structure and hence its ability as Conference to influence state policy.

Led by Monsignor James Cassidy, Director of Health and Hospitals for Catholic Charities of the Archdiocese of New York, leadership in the health field advocated successfully in 1975 for establishment of the Health and Hospitals Advisory committee.

The second step occurred in 1979, when Monsignor Cassidy, Sister Mary Charles, Administrator of Sisters' Hospital in Buffalo, and others advocated successfully for the establishment of the Catholic Hospital Council of New York State.

2. The Health and Hospital Advisory Council

The previous Chapter discusses the evolution of regular meetings of the Bishop's Hospital Representatives. Because the United States Catholic Conference formalized in 1970 the title of Bishops' Hospital Advisors, these sessions were referred to in the early 1970's as meetings of the Bishops' Health Advisors.

In a memorandum sent to Charles Tobin on May 2, 1975, Jim Cashen, who had been assigned as liaison to health care leaders, reported that Monsignor Cassidy had urged the Catholic Conference:

"to explore the formation of a Health Affairs Council to be composed of persons who are involved in the planning for and delivery of health care in Catholic facilities".

Monsignor Cassidy suggested that this group would be advisory to the Catholic Conference on health affairs, either initiating policy advocacy suggestions, or responding to requests for input from the Catholic Conference, should be organized like the Council of Catholic School Superintendents or Council of Catholic Charities Directors, and should meet four times a year.

Monsignor Cassidy said he would prepare a written plan for consideration by Bishop Broderick, then Chairperson of the Catholic Committee, and the other Bishops.

In a memorandum to Bishop Broderick on May 27, 1975, Monsignor Cassidy wrote:

"A number of Bishops throughout the state have requested that a more formalized group of health care representatives be developed to counsel the New York State Catholic Conference on health affairs."

He stated his belief in the need for a strong and positive voice for the Church in light of growing government control of health care in the state.

He suggested that such a Council be comprised of twenty-four members, including the Bishop's health director, a hospital administrator, and an additional health care representative from each of the eight Dioceses in the state, appointed by the respective Bishops.

He concluded that the establishment of such a Council need not preclude Bishops' Health Advisors meetings, but rather would provide a more structured body of expertise.

On February 13, 1976, Charles Tobin issued a letter of invitation to individuals selected by their Bishops to join the new group writing that:

"Bishop Broderick has asked me to invite you to serve on a special advisory committee to the State Catholic Conference and the Catholic Committee on several special issues affecting health care facilities."

He cited as an example draft Department of Health regulations relating to minimum operating and occupancy requirements as to OB/GYN services in acute care hospitals.

He acknowledged that the Department of Health had agreed to delay implementation of these regulations for a year, but predicted the issue was far from dead.

So was born the State Catholic Conference Health and Hospital Advisory Council. Its first meeting was held on February 26, 1976 and was largely introductory and organizational in nature.

April 6, 1976 Meeting

The Advisory Committee began its substantive work at its meeting of April 6, 1976 in which these matters were addressed:

1.) There was recognition of the important role played by various state advisory and regulatory bodies, and it was agreed that lists of the membership of such groups would be sent to the committee.
It was recognized that Dr. Bob Collins, closely affiliated with the Syracuse Diocese, was Vice-Chairperson of the Hospital Review and Planning Council whose membership also included Monsignor Cassidy, Reverend Saverio Mattei, the Bishop's Hospital Representative from Rockville Centre, and Sister DeChantel LaRoux from St. Mary's in Rochester.
It was further recognized that Tom Dowling, an attorney from Rockville Centre, who was very supportive of Church activities, was co-Chairperson of the Health Advisory Council of the State Health Planning Commission, and that Monsignor Fahey was a member of the committee.
2.) There was recognition that the question of "regionalization" should be a matter of great priority to the Advisory Committee in coming meetings. It was recognized that "regionalization" included planning based on population, non-duplication of services, and removal of excess costs in health delivery systems and provision of primary, secondary and tertiary levels of care.
3.) With regard to the concept of "religious need" as established in the Metcalf-McCloskey bill, it was agreed:
   a.) the principle should be used sparingly;
   b.) there was need to demonstrate the existence of religious need, and
   c.) greater emphasis should be placed on educating the Catholic community about the need to support Catholic health care institutions.
4.) It was agreed that the committee should analyze the effect of the "Way Report" on Catholic institutions, even though its implementation date had been delayed until November 1, 1976. This was the report that generated regulations about standards for OB/GYN services in acute care institutions.
5.) It was agreed that it might be helpful to establish medical-moral committees at the Diocesan level.
6.) There was brief discussion about sterilization issues.
7.) It was agreed that pastoral care programs and their funding in Catholic institutions should be a priority of the committee.
8.) It was mentioned that there would probably be proposed state legislation requiring hospitals to file 990's.
9.) The following subcommittees were established:
   a.) Regionalization, especially the effect of the Way Report on Catholic hospitals
      - Monsignor James Cassidy
      - Sister Margaret Sweeney

- Mr. Arnold Jerome

b.) Legal Issues
- Mr. Charles Tobin
- Father William Stillwell
- Sister Mary Charles

c.) Medical-Moral Committee
- Father Saverio Mattei

d.) Nursing Home Reimbursement
- Monsignor Charles Fahey
- Monsignor James Cassidy
- Dr. Bob Collins

May 13, 1976 Meeting

The committee continued its substantive work at its next meeting held on May 13, 1976. Members present at this meeting were: Monsignor James Cassidy, Monsignor Charles Fahey, Father John Cleary, Mr. Kevin Ryan, Mr. James Cashen, Sister Mary Charles, Dr. Walter Mitty, Mr. Jerome Stewart, Father William Stillwell, Mr. Edward Peterson, Father Saverio Mattei, Sister Margaret Sweeney.

The committee addressed these issues:

1.) It was agreed that Kevin Ryan and Jim Cashen would develop comparative information on hospital and nursing home care in urban centers around the country.
2.) At Monsignor Fahey's request, it was agreed that the committee would address the question as to whether the state should perhaps withdraw approval already given for development of new beds.
3.) It was agreed to discuss a plan of action to address negative consequences of the application of Way Committee Standards to Catholic hospitals.
4.) It was agreed that the committee should have an in-depth discussion of problems and issues affecting Catholic nursing homes in the state, possibly in a joint session with representatives of these institutions.
5.) It was agreed that staff should compile basic statistics on the work of Catholic institutions.
6.) The issue of sterilization was again addressed.
7.) There was discussion of a series of issues relating to reimbursement for pastoral care in institutions, and Father John Cleary from Brooklyn agreed to present materials at the next meeting.
8.) It was agreed that Monsignor Cassidy would address these issues in his presentation the following week to the Catholic Committee:
    a.) concerns about reimbursement from third party payors to Catholic hospitals and nursing homes;
    b.) concerns about application of the Way Committee Report to Catholic Hospitals;
    c.) a recommendation that each Diocese should have a medical-moral committee or Board;
    d.) a report on Bishop Dingman's report on sterilization;
9.) It was agreed that the Catholic Committee should strenuously oppose Senator Joseph Pisani's bill S8932 which would provide for the removal of artificial life-sustaining devices from certain terminally ill persons.

June 22, 1976 Meeting

Additional members attending this session beyond those present at the previous meeting were: Sister Enda Keggins and Father William Zenns. The committee addressed these matters:

1.) Monsignor Cassidy gave a brief report on the current status of the Medicare-Medicaid Rate Freeze.
2.) The committee agreed to support the HANYS position on Senator Lombardi's bill to uncouple Blue Cross from Medicaid rate scheduling.
3.) Monsignor Fahey reviewed the reassessment of long-term care beds currently being undertaken by the state.
4.) There was extensive discussion about the housing and long-term care needs of the elderly.

September 23, 1976 Meeting

New participants at this session were: Arnold Jerome and Sister Joan Kister. These matters were discussed:

1.) It was agreed that Monsignor Cassidy and Kevin Ryan would put together a workshop for hospital administrators on implications of the implementation of the Way Committee standards.
2.) Monsignor Cassidy urged members to become active in the establishment of Health Systems Agencies being created throughout to state to implement the 1975 National Health Planning and Responsibility Act.
3.) It was agreed that there would be presented at the next committee meeting proposed Program Goals and Objectives for the coming year.
4.) It was agreed that the Advisory Committee would be invited to participate in planning for the next Catholic Hospital Congress in the Archdiocese.
5.) There was brief discussion about the proposed National Conference of Catholic Charities Directors Statement on Health Insurance. In response to the suggestion that input be given to local Catholic Charities Directors, Jerome Stewart from St. Clare's in Schenectady had previously written to Jim Cashen indicating he was unsure of who the local Catholic Charities Director was.

November 9, 1976 Meeting

Members attending their first meeting were: Father Harry Barrett, recently appointed as assistant to Monsignor Cassidy, and Sister Angela Bon Tempo from Buffalo. The committee addressed these matters:

1.) Monsignor Cassidy informed the committee that it was the decision of the State Hospital Review and Planning Council not to implement the Way Committee recommendations on January 1, 1977, but rather to allow each Health System's Agency in the state to submit a plan which would include obstetrical and pediatric care. This report led to a decision to encourage the Catholic community to be involved at the grassroots level in health care planning, and that there be a statewide convening of all Catholic Health Care Facilities and Agencies to develop strategies for influencing the activities of HSA's.

2.) It was confirmed that the state had implemented significant rate reductions and it was agreed that the only response was to initiate litigation.
3.) Kevin Ryan distributed a binder which included the first series of data on state Catholic hospitals.
4.) Dr. Robert Collins was elected unanimously as co-Chairman of the Health and Hospital Advisory Committee to serve with Monsignor Cassidy.

January 13, 1977 Meeting

At this meeting, the committee addressed these matters:

1.) The committee reviewed the first draft of statistical data on Catholic hospitals developed by Kevin Ryan.
2.) The committee learned that the Health Planning Commission bed reduction plan for both acute care beds and long term care beds was being implemented.
3.) After reviewing a paper submitted by Monsignor Fahey, the committee agreed to recommend to the Public Policy Committee that the Catholic Conference support a recommendation for the modest uncoupling of Blue Cross rates from Medicaid rates.
4.) The committee reviewed and made recommendations on a working draft of a paper on sterilization developed by Father William Smith.
5.) The committee strategized on how to exert maximum influence on upcoming HSA regional convenings

March 1, 1977 Meeting

At this meeting, the committee addressed the following matters:

1.) The committee continued to review the paper on sterilization and tubal ligations developed by Father Smith.
2.) Charles Tobin discussed with the committee proposed legislation on hospital and nursing home reimbursement.
3.) The committee reviewed the section of the Governor's State of the State message relating to health care (Tom Dowling had played a major role in developing this statement.)
4.) The committee discussed ways it could utilize the statistical information on Catholic health care presence in the state.
5.) The committee affirmed that it would create the following subcommittees:
    a.) Legislation
    b.) Medical-Ethical Issues
    c.) Planning
    d.) Health Care Finances
    e.) Nursing Home Administrators
    f.) Communication
6.) It was reported that the courts had dismissed the rate suit brought by providers against Commissioner Whalen.
7.) There was substantial discussion about regional decision-making relating to OB/GYN minimum standards.
8.) The committee reviewed a proposed statement on the affirmative responsibilities of HSA's.

9.) It was reported that Charles Tobin had protested to the Assembly Health and Social Services Committee the proposed $200 million reduction in ghetto medicine and outpatient funding.

May 3, 1977 Meeting

The committee addressed the following matters at this meeting:

1.) The committee reviewed the final draft of a statement developed by Father John Cleary and Sister Joan Kister on the Church apostolate in health care.
2.) The committee reviewed a published article by Father Smith on sterilization.
3.) The committee reviewed the Health Planning Commission Administrative Program Plan for 1977-78.
4.) The committee again discussed the HSA process for reviewing OB/GYN programs in the context of the Way Committee standards. There was consensus on the approach that this issue should be addressed not at a statewide level but at a local level. The context for addressing local issues would be the right to operate on the basis of religious and ethical need established by the Metcalf-McCloskey Article 28 legislation adopted in 1964. The Catholic Conference would assist individual applicants. It was agreed that the necessary conditions for qualifying for religious need exemption would be:
   a.) proof of religious standing;
   b.) proof that the need could not be met by others of the same religious standing;
   c.) proof that there were a substantial number of the denomination to be served.
   This approach was to prove to be highly successful, as discussed in the public policy advocacy section of this Chapter.
5.) Bob Collins reported that the DOH proposed hospital operating standards would be adopted.
6.) There was discussion about the evolving work of the Medical-Moral Subcommittee.

July 26, 1977 Meeting

At this meeting, the committee addressed the following matters:

1.) The committee approved the final draft of the statement on The Role of Catholic Health care for transmission to the Bishops.
2.) It was affirmed that the regional approach to OB/GYN issues was being implemented.
3.) For the first time, the committee received a formal report of statistical information on Catholic hospitals for 1976.
4.) In reviewing a number of pieces of legislation of hospitals and health care currently before the Governor, the committee particularly supported home care legislation.

September 13, 1977 Meeting

Committee Membership was:

Archdiocese of New York:	Monsignor James Cassidy, Archdiocese
	Dr. Walter Mitty, St. Charles Hospital
	Sister Margaret Sweeney, St. Vincent's Hospital, Manhattan
Albany:	Sister Ellen Lawlor, St. Peter's Hospital, Albany
	Dr. Vitale Paganelli, Glens Falls
	Mr. Jerome Stewart, St. Clare's Hospital, Schenectady
Brooklyn:	Mr. Alvin Conway, Catholic Medical Center of Brooklyn-Queens
	Father Joseph Sullivan, Diocese of Brooklyn
Buffalo:	Sister Mary Charles, Sisters of Charity Hospital, Buffalo
	Father William Stillwell, Diocese of Buffalo
Ogdensburg:	Sister Mary Enda Kiggins, Mercy Hospital, Watertown
Rochester:	Sister DeChantal, St. Mary's Hospital, Rochester
	Mr. Arnold Jerome, St. Joseph's Hospital, Elmira
Rockville Centre:	Sister Joan Kister, St. Francis Hospital
	Father Saverio Mattei, Diocese of Rockville Centre
	Mr. Edward Peterson, Good Samaritan Hospital, West Islip
Syracuse:	Dr. Robert Collins, Syracuse
	Monsignor Charles Fahey, Diocese of Syracuse
	Sister Norman Agnes, St. Joseph's Hospital, Syracuse
Staff:	Charles J. Tobin, Catholic Conference
	James Cashen, Catholic Conference
	Kevin Ryan, Archdiocese of New York

The committee addressed the following matters at this meeting:

1.) The committee reviewed a white paper developed by Monsignor Fahey entitled "Toward a Framework for Decision Making on the Part of Catholic Health Care Leaders," in which he addressed the concepts of socialization, control of important decisions and the notion that the Church was an integral part of the voluntary sector.

2.) The committee learned that the proposed statement on Catholic health care had been approved the previous day by the State Catholic Committee. The letter transmitting this statement to the Bishops read in part:
"We wish to respectfully submit to the Ordinaries of the Diocese of New York State the need to reaffirm the attitudes and involvement of the Church in the provision of health care services to the people in their respective Dioceses".
The statement outlined the need to address critical issues relating to Catholic health care as soon as possible. It is attached as Appendix I.
In reviewing this statement, Father Joseph Sullivan from Brooklyn, who had been appointed to the committee in July 1977, raised questions about some of the assumptions articulated in the statement, and suggested that the committee organize a seminar of Catholic health care leaders around those issues.

3.) Dr. Bob Collins was elected as Chairperson of the Committee for 1977-1988, and was appointed as the representative of the committee on the State Catholic Committee. Father Saverio Mattei was elected as Vice-Chairperson for 1977-1978, with the understanding that he would serve as Chairperson for 1978-1979.

4.) Charles Tobin reported on a preliminary meeting with the Department of Health to discuss allocation of expenses and services provided in hospitals by women religious.

5.) There was brainstorming about committee priorities for the 1977—1978 program plan.
6.) There was discussion about committee membership. While originally it had been conceived that each Diocese would have three representatives, it was now felt by some that there was a need for more members.
7.) There was discussion about developing a standard contract for provision of services by women religious.
8.) The committee reviewed the State Department of Health proposed Long Term Care code.

October 24, 1977 Meeting

The committee addressed the following matters at this meeting:

1.) The committee agreed to finalize a Statement of Purpose for the next meeting.
2.) There was lengthy discussion about committee structure and membership. A suggestion that the committee henceforth be known as a Council (like the Charities Directors and School Superintendents) was not approved because of the difference that members of those groups were all Diocesan employees, which was not the case for this group. There was, however, a letter sent to the Ordinaries of the state requesting the appointment of six at-large members to the committee.
3.) There was initial discussion of a proposed convening for Catholic health care leaders throughout the state to be held in the spring of 1978.
4.) It was agreed that from time to time the committee should invite to its meetings guest experts to address specific issues.
5.) There was a lengthy discussion about issues relating to regionalization, in which it was recognized that there were problems not only with OB/GYN services but also that there were issues relating to primary health care utilization. It was agreed to appoint a subcommittee to draft a statement on regionalization. In this context, it was reported that Charles Tobin had sent a letter to Commissioner Whalen on September 23rd requesting a waiver from the Way standard based on religious need for St. Joseph's Hospital in Elmira.
6.) The committee adopted a Program Plan and Program Priorities for 1977-1978.
7.) There was a report on the Fifth Annual Archdiocesan Health Convening held on October 12, 1977 at which the speakers were Cardinal Cooke, Sister Helen Kelley from the Catholic Health Association and Patricia Cahill.

January 3, 1978 Meeting

At this meeting, the committee was joined by new member John McGiuney. It addressed the following matters:

1.) The committee reviewed at length a draft statement on regionalization developed by a subcommittee comprised of Dr. Walter Mitty, Monsignor James Cassidy, Sister Joan Kister, Mr. Jerome Stewart, Monsignor Charles Fahey, and Dr. Bob Collins. The committee affirmed the basic direction outlined in the draft statement, and suggested revisions, agreeing to discuss the revised draft at its next meeting.
In this discussion, the committee reviewed a White Paper developed by Monsignor Fahey in which he indicated that the two main purposes of regional planning were to "shrink the system" and upgrade programs professionally. He also articulated a series

of principles which he believed should underlie the Catholic Conference approach to regionalization. These principles are detailed in the section in this chapter on Public Policy advocacy.

2.) The committee debriefed on the successful Annual Health and Human Services dinner held on December 6, 1977. This was one of the many dinners when Health Commissioner Dr. Bob Whalen was an entertaining speaker.
3.) The committee recommended that the Catholic Conference reaffirm the United States Catholic Conference statement banning sterilization.
4.) The committee heard an update on the status of discussions throughout the state on OB/GYN services, learning that on October 27, 1977 Dr. Bob Whalen had granted the requested waiver to St. Joseph Hospital in Elmira, on the condition that it reduce somewhat its bed capacity. The committee also received a draft report on regionalization of OB/GYN services in Rochester.
Finally, the committee learned by memorandum from Charles Tobin that the Hospital Review and Planning Council had postponed for an extended period of time the imposition of penalties on hospitals that did not meet minimum services targets. Charles Tobin characterized this decision as "a welcome relief from an intolerable burden".
5.) There was a report on the meeting held with Governor Carey.
6.) Father Sullivan suggested that there be developed a process for discussion of the two White Papers recently developed by Monsignor Fahey relating to regionalization and the role of Catholic health leaders.
7.) With regard to committee functioning:
   a.) it was agreed to broaden the name from the Hospital Advisory Committee to Health and Hospitals Advisory Committee to reflect the broadened scope of the area;
   b.) there were recommendations for additional areas of expertise for which the committee should seek new members;
   c.) concern was still expressed that the name of the group be changed to a Council.
8.) It was agreed to discuss the revised Statement of Purpose at the next meeting.
9.) There was brief discussion about the upcoming 1978 legislative session.
10.) It was agreed to invite to the next meeting a guest speaker on Pastoral Care.
11.) There was brief discussion about an investigation of hospitals being spearheaded by Charles Hynes.

<u>February 21, 1978 Meeting</u>

At this meeting, the committee addressed the following matters:

1.) The committee approved the revised statement on regionalization and forwarded it to the Public Policy Committee, hopefully for approval and transmission to the Ordinaries.
2.) The committee reviewed various pieces of legislation which had been recently introduced.
3.) The committee accepted the recommendation from Father Sullivan on a process for discussion of Monsignor Fahey's papers.
4.) There was an update on the OB/GYN services and religious need waiver decision.
5.) The committee adopted a revised statement of purpose reading:
"The Health Advisory Committee has the following purposes:

a.) To advise and make recommendations to the New York State Catholic Committee and, through the Catholic Committee where appropriate to the Bishops, on matters relating to health as they affect Church programs, services and facilities and/or the Catholic population.
b.) To provide a forum whereby Diocesan health representatives appointed by their respective Ordinaries may meet and discuss matters of common interest so that in the process they may gain knowledge and insights on health matters and also be provided with an effective channel of inter-Diocesan information on health matters.
c.) To convene, as appropriate, representatives of the Church who are or should be involved in health matters for the objectives of:
- increasing their knowledge and information regarding Church teachings as to moral and ethical principles;
- inform them of developments which impact on their duties in the health field;
- provide a forum for the sharing of knowledge and problems which relate to their roles as Catholic health leaders.

d.) To provide Catholic health agencies, institutions and programs with a link to church structure and thinking.
e.) To help develop and synthesize Church thinking on positions which could then be relayed to or reflected in relations with public bodies – the Regional Health Systems Agencies Department of Health, and State Councils – and various professional health and trade associations such as HANYS and the State Medical Society.

6.) The committee reviewed the Governor's State of the State Health Message.
7.) The committee again discussed the addition of new members.
8.) The committee recommended to the Catholic Health Association opposition to a proposal to bar reimbursement of salaries of women religious from Medicare reimbursement.
9.) The committee discussed the content of a proposed survey on Pastoral Care.

<u>May 9, 1978 Meeting</u>

The committee addressed the following matters at this meeting:

1.) The committee approved a position paper on Regionalization of Acute Care Health Facilities recommending that Bishops consider fiscal viability as an important element in their decision making. This position paper was approved by the Public Policy Committee the following day.
2.) It was agreed that in conjunction with Charles Tobin, a sub-committee would work on a further refinement of the definition of religious need. In this discussion, it was reported that in March approval had been given for both the Catholic and non-Catholic hospital in Binghamton to retain maternity services, if both reduced their capacity. More generally, it was reported that the state had imposed an 18-month "cooling off" period on further discussions about OB/GYN services.
3.) There was discussion of various legislative proposals.
4.) A sub-committee was appointed to discuss on-going governance of the committee. (It is interesting that prior to this meeting, Sister Mary Charles had sent a letter to Bishop Head in Buffalo about the roles played by Monsignor Fahey and Dr. Collins on the committee because of their close connection with the Carey administration and their continued insistence on looking at the "big picture". Charles Tobin would reply

to Bishop Head's inquiry that this was precisely the "connected" leadership the Church needed.)

5.) Arnold Jerome and Sister Martha Gersback from St. Joseph's Hospital in Elmira, and Sister Mary Rene McNiff from St. James Mercy Hospital in Hornell were recommended as new members.
6.) The committee heard presentations from Diocesan representatives about the status of Pastoral Care in their Dioceses, and appointed a Task Force to discuss common issues and problems.
7.) The committee continued discussion of plans for a fall convening of health and hospital leadership.
8.) The committee discussed issues relating to the continued role of voluntary agencies in human services process.
9.) The committee recommended that health issues be discussed at the next Provincial meeting of Bishops.

<u>September 27, 1978 Meeting</u>

At this meeting, the committee addressed the following matters:

1.) With regard to new members:
   a.) Bishop Hubbard named to the committee Sister Margaret Sweeney from St. Peter's in Albany;
   b.) Rochester representatives requested the addition of Sister Marie Michelle Peartree, Administrator of St. Ann's Nursing Home;
   c.) The Archdiocese requested the addition of Mother Fidelus from Mt. Carmel on Staten Island;
   d.) Father William Stillwell was added as a representative from Buffalo;
2.) The committee discussed at length the formation of a State Council of Catholic Hospitals. Expressed was the belief that the Health Advisory Committee was not able to reflect adequately individual institutional concerns. It was agreed that the Hospital Association of New York State was an effective advocacy organization, but there was a desire that Catholic hospitals gain more clout with state government.
3.) After discussion about a statement on Pastoral Care, Jerome Stewart was appointed Chairperson of a sub-committee on Pastoral Care
4.) The committee discussed plans for a New York State Convocation to review the United States Catholic Conference Pastoral on Health Care.
5.) There was continuing discussion about effective governance of this committee in reaction to a report by Father Saverio Mattei, and agreement to reactivate sub-committees.
6.) There was further discussion about the proposed convening of health and hospital representatives.
7.) The committee gave input into proposed Catholic Conference Program Objectives for 1978-1979.
8.) There was continuing discussion about religious need in the determination of public need.

<u>November 14, 1978 Meeting</u>

At this meeting, the committee addressed the following matters:

1.) Sister Mary Charles was elected as committee Vice-Chairperson.

2.) There was reaffirmation of the purposes for the Annual Health and Human Services Dinner and committee members were urged to attend.
3.) Members were also urged to participate in the upcoming December 9, 1978 USCC consultation on the proposed Pastoral Letter.
4.) There was continued and lengthy discussion about the formation of a Council of Catholic Hospitals in which these matters were addressed:
    a.) there was a report on the memorandum Charles Tobin had sent to Public Policy Committee Chairperson Bishop Head indicating the hospital leadership had concerns abut the breadth of the agenda of the current committee, that there were concerns about the effectiveness of HANYS, and there was recognition there were hospital councils in other states;
    b.) there was discussion of a White Paper written in early November by Monsignor Charles Fahey entitled "The New York State Catholic Conference and the Hospital Question in New York State". In this paper, Monsignor Fahey affirmed the need for a Catholic Hospital Council, but also advocated for creation of a Health Task Force to address broader health issues;
    c.) Sister Mary Charles was appointed Chairperson of a committee on the creation of State Council of Catholic Hospitals and it was agreed to invite Bishop Head to the next meeting of the committee.
5.) After discussion, it was agreed that it was not necessary to advocate for the appearance of the words "religious need" in DOH regulation, because they were so clear in statute.
6.) It was reported that there was a determination that there would be local review of construction applications.
7.) There was discussion about the upcoming meeting with Governor Carey.

<u>December 13, 1978 Meeting</u>

At this meeting, the committee addressed the following matters:

1.) The committee reviewed the consultation on the USCC pastoral, held on December 9, 1978, which was attended by 50 persons. Since many concerns were expressed at the meeting, it was agreed to send a letter to USCC outlining recommended changes.
2.) It was reported the Committee on Creation of a Council of Catholic Hospitals would be meeting on December 28th.
3.) There was a report on the Lombardi Hearing on Reimbursement, where concern was expressed about sanctions on below-minimum occupancy, when religious need issues were at stake.
4.) The committee reviewed legislation relating to:
    a.) uncoupling of the Blue Cross rate from Medicaid;
    b.) expansion of Long Term Care;
    c.) tightening hospital regulations;
    d.) increasing reimbursement for nutrition services;
    e.) methodology for settling jurisdictional disputes on rate setting.
5.) The committee reviewed regulating length of stay for abortion services.

January 22, 1979 Meeting

New members present for this meeting were Sister Rose Frances Dunn, Mr. Richard Yezzo and Sister Mary Clare. The committee addressed the following matters at this meeting:

1.) The committee agreed to invite Monsignor James Fitzpatrick from HANYS to the next meeting to discuss legislation.
2.) The committee heard an update on activities relating to discussion of religious need in regional planning groups.
3.) The committee recommended that the Catholic Conference endorse revised regulations mandating obstetrical services.
4.) The committee agreed to send out material on evaluative criteria to be used by Catholic hospitals.
5.) It was agreed to invite the new Director of the Pope John XXIII Institute to a future meeting.

February 21, 1979 Meeting of the Ad Hoc Pastoral Care Committee

Members present for this sub-committee meeting were: Jerome Stewart (Chairperson), Father Joseph Dolan, Father Richard Leskovar, Sister Eleanor Boegel and Sister Frances Michael.

The committee developed a report making these recommendations regarding Pastoral Care Departments in Catholic facilities:

1.) The Catholic identity of an institution should be reflected in its mission statement and by-laws.
2.) The Pastoral Care Department should appear as a separate department in the institution's organizational chart.
3.) The Director of the Pastoral Care Department should be trained in Clinical Pastoral Education.
4.) The Director need not be a priest, but could be a trained woman religious.
5.) The main mission of the Department should be to bring the healing message of the Gospel to the pastoral setting.
6.) The Pastoral Care Department should develop a brochure describing its mission and activities.

It was agreed that this sub-committee would continue its work as a resource to Pastoral Care Departments.

February 26, 1979 Meeting

John Hanrach joined the committee as a new member at this meeting. The committee addressed the following matters:

1.) The committee reviewed the Preliminary State Health Plan referred by the Health Planning Commission to the Statewide Health Coordinating Committee as required by the National health Planning Act (PL 93-641). The plan addressed:
    a.) excess hospital costs;

b.) ambulatory primary care;
c.) long term care.

In related discussion, concern was expressed that an OHSM report on ambulatory care had recommended a service reimbursement cap of $50.

2.) The committee discussed with Monsignor Fitzpatrick the following issues:
   a.) ambulatory care;
   b.) Council of Health Care Financing;
   c.) a report that the Office of Health Systems Management would be the primary state Medicaid agency;
   d.) concern that there had been little dialogue between government leaders and voluntary providers in developing the State Health Plan;
   e.) a report that HANYS would propose uncoupling of rates.
3.) The committee discussed various concerns relating to long term care including:
   a.) the protection and fostering of volunteerism;
   b.) the positive response of voluntary providers to government requirements;
   c.) protection of assets of corporate entities;
   d.) the increasing momentum toward mergers;
   e.) the need for coordination between facilities and programs.
4.) There was initial discussion about hospice programs.
5.) The committee reviewed a report from Comptroller Ned Regan on the state's policies and procedures for closing excess hospital beds.
6.) The committee heard a report about the special meeting on health care sponsored by Cardinal Cooke to discuss governmental policies and financial realities that provided challenges to Catholic hospitals in the Archdiocese of New York.
7.) The committee heard a report from the Ad Hoc Committee to study a State Association of Hospitals which met just prior to the meeting. At this meeting, concern was again expressed that, as articulated by Monsignor Fahey, the Health Advisory Committee had a broad purpose and, therefore, the specific concerns of hospitals were not addressed or spread too thin. What was suggested was:
   "A strong united association of hospitals under an aggressive, knowledgeable, personable staff executive."
   Issues to be addressed included:
   a.) money – it was suggested that there be a determination of the total dues paid to the Catholic Health Association;
   b.) fair representation;
   c.) a process for election of representatives to the Council from each Diocese;
   d.) a method of determining representation to the Catholic Conference from the Council.

   It was agreed that Sister Mary Charles, Father Saverio Mattei and Charles Tobin would meet with Bishop Head to discuss those matters.

<u>April 20, 1979 Meeting</u>

At this meeting, the committee addressed these matters:

1.) The committee reviewed testimony given on April 2nd by Jerome Stewart on the first proposed State Health Plan. He expressed appreciation to state leadership for their diligence in developing the plan and also expressed at the outset support for testimony on the plan given by HANYS.
   He then addressed four areas of concern:

a.) regional autonomy;
b.) excess beds;
c.) long term care;
d.) ambulatory primary care.

2.) The committee again heard a report from the Ad Hoc Committee to study a State Association of Catholic Hospitals. Based upon a meeting of the Ad Hoc Committee held prior to this meeting involving Father Saverio Mattei, Father Harry Barrett, Jerome Stewart, Sister Mary Charles, Sister Mary Obrist and Jim Cashen, the committee addressed these issues:
   a.) how to get hospitals involved in the proposed Council;
   b.) the relationship of Bishop's representatives to this Council;
   c.) costs;
   d.) the relationship of long term care institutions to this Council;
   e.) a recommendation that the Health Advisory Council not meet again.

With this meeting, the work of the Health Advisory Committee effectively came to an end.

3. New York State Council of Catholic Hospitals

In a memorandum to Catholic hospitals throughout the state on June 19, 1979, Sister Mary Charles reported that the Ad Hoc Committee (Jerome Stewart, Monsignor James Cassidy, Sister Margaret Sweeney, Sister Enda Keggins, Ed Peterson, Arnold Jerome, Sister Mary O'Brist, Reverend Saverio Mattei and Jim Cashen) had met on June 1, 1979 to develop a proposal for creation of a State Council of Catholic Hospitals. This proposal would be considered by the Bishops in September after review by a sub-committee of Bishops Hubbard, Head and Mugavero.

November 6, 1979 Committee Meeting

Following on the Bishops' approval at their September meeting, the Ad Hoc Committee met with Bishop Head on November 6, 1979 in his role as Chairperson of the Public Policy Committee to move forward plans for creation of the Council. Issues discussed at this meeting included:

1.) It was agreed that the hospitals collectively would be responsible for paying the salary, benefits and travel expenses of the staff person. The initial annual budget was $35,000.
2.) In order for hospitals to get reimbursement for dues paid, it was important for the Hospital Council to be distinct from the Catholic Conference.
3.) It was agreed that the Chairperson of the Council would become a member of the Catholic Conference Public Policy Committee.
4.) It was articulated that the purpose of the Council was not to replicate the work of HANYS, but rather to focus on Catholic issues and to give input to the Bishops.
5.) It was agreed that the work of the Health Advisory Committee would be put in abeyance for the time being.
6.) Opposition was expressed to the proposed federal Medicare waiver.

November 14, 1979 Ad Hoc Committee Meeting

The Ad Hoc Committee met again on November 14, 1979 to finalize plans for the organization of the Council.

At this meeting, it was agreed that nominations for the Council were to be received by December 15th (Bishop Head wrote to the Ordinaries on November 27th requesting their appointments), and that the first meeting would be held in early 1980. At this meeting, it was reported that Sister Mary Charles was appointed to the Public Policy Committee from her previous role as Chairperson of the Health Advisory Committee.

February 27, 1980 Meeting

The Council of Catholic Hospitals convened for its first formal meeting on February 27, 1980.

Members were:

Archdiocese of New York:	Monsignor James Cassidy, Archdiocese
	Sister Mary Linehan, St. Joseph's Hospital, Yonkers
Albany:	Sister Mary Agnes O'Neal, St. Mary's Hospital, Troy
	Sister Ellen Lawlor, St. Peter's Hospital, Albany
Brooklyn:	Mr. Alvin Conway, Catholic Medical Center
	Bishop Joseph Sullivan, Diocese of Brooklyn
Buffalo:	Father William Stillwell, Diocese of Buffalo
	Sister Mary Charles, Sisters' Hospital, Buffalo
Ogdensburg:	Monsignor Robert Lawler, Catholic Charities
	Sister Mary Enda Keggins, Mercy Hospital, Watertown
Rochester:	Sister Martha Gersback, St. Joseph's Hospital, Elmira
	Sister Ann William Bradley, St. Mary's Hospital, Rochester
Rockville Centre:	Father Saverio Mattei, Diocese of Rockville Centre
	Mr. Edward Peterson, Good Samaritan Hospital, West Islip
Syracuse:	Monsignor Ronald Bill, Diocese of Syracuse
	Sister Patricia Ann, St. Joseph's Hospital, Syracuse

The Council addressed these matters at the meeting:

1.) Organizational Issues

a.) A presentation was given on the background and developments which led to creation of the Council;
b.) There was discussion about the definition and responsibilities of a Catholic hospital;
c.) The Council reviewed an initial draft of a proposed constitution;
d.) From a survey of potential participants, it was reported that the only question about potential membership was Cabrini Hospital, and that collectively, member hospitals had more than 10,000 beds;
e.) Sister Mary Charles was elected as Chairperson Pro-Tem.

2.) Substantive Issues

a.) There was discussion about the nature and range of issues to be addressed by the Council;
b.) There was a review of current legislative and regulatory matters.

April 25, 1980 Meeting

At this meeting, the Council addressed the following matters:

1.) The Council approved the proposed constitution and by-laws. (The finalized constitution as later amended in 1982 is attached as Appendix II).
2.) With regard to organizational business:
   a.) Sister Mary Charles was elected Chairperson and Sister Ellen Lawlor was elected Vice-Chairperson;
   b.) There was discussion of the financial status of the Council;
   c.) There was discussion about a process for developing Program Objectives for the Council.
3.) The Council discussed current legislation and other state issues, including energy costs and representation on State Boards.
4.) It was reported that the work of the Health Advisory Committee continued to be on hold.

Intervening Activities – May 1980

Following this meeting, the Catholic Conference issued a press release on May 6, 1980, which read in part:

"With the avowed purpose of uniting Catholic hospitals in New York State to strengthen their apostolate, these hospitals have banded together into a new Catholic Hospital Council under the aegis of the New York State Catholic Conference."

On May 13, 1980, Sister Mary Charles wrote to George B. Allen, President of HANYS, stating that the Catholic Hospital Council:

"had no intention to duplicate or be in opposition to HANYS"

On May 9, 1980, Alan Davitt, Catholic Conference Executive Director wrote to Sister Mary Charles and Sister Serena Branson, Chairperson of the Council of Catholic Charities Director stating that Father Charles Mulligan had withdrawn his proposal to the Public Policy Committee to create a special committee for handling health matters, which might go beyond the scope of the work of the Council.

The newly formed Council had already been seeking to find staff. Sister Mary Charles and others had had several meetings with Ken Bessette who had previously done some work with Catholic health leaders for the Catholic Conference. In response to a request that he be hired, Alan Davitt wrote to Ken:

"It is my understanding that you would function in rendering service to the New York State Council of Hospitals as a staff person of the Bishops, not as an employee of the Catholic hospitals, either individually or collectively."

On July 1, 1980, Ken Bessette began his work as Executive Secretary for the New York State Council of Catholic Hospitals.

June 17, 1980 Meeting

At its third meeting, the newly formed Council addressed these matters:

1.) The Council established meeting dates for 1980-1981.
2.) The Council also adopted a 1980-1981 Program Plan.
3.) It was ascertained that three major concerns were relationship to the Catholic Charities Directors, raising money from individual institutions, and finalizing the process of hiring Ken Bessette.
4.) Family Planning was discussed as an important issue.
5.) The need to continue to develop aggregate statistics with regard to Catholic health care in New York State was affirmed.
6.) The Council addressed several legislative matters including:
    a.) Living Will
    b.) Medicaid reduction
    c.) Operating Certificates
    d.) Definition of public need
    e.) Written discharge plans

Following on this meeting, on August 8, 1980, Sister Mary Charles wrote to the 41 member hospital executives:

"1.) to encourage support of the hospitals for actions of the Council;
2.) to report on recent Council activities and review further plans;
3.) to seek hospital data for the statistical base of the Council."

October 23, 1980 Meeting

At its meeting held on October 23, 1980, the Council addressed these matters:

1.) In terms of program priorities and the desire to establish relationship with other groups, it was agreed to seek a meeting with leadership of HANYS.
2.) Monsignor Bill, Father Callan and Sister Linehan were appointed as a sub-committee on Pastoral Care.
3.) There was agreement about the need to establish a sub-committee on communication.
4.) The committee discussed various items of legislation.
5.) It was agreed to hold the first Annual Membership meeting on June 9, 1981.
6.) The committee agreed to join HANYS in opposition to the proposed OHSM reimbursement plan, particularly the Medicare waiver.
7.) It was agreed to address the nursing home shortage at the next meeting.

Membership on the committee at the time of this meeting was as follows:

Archdiocese of New York:	Monsignor James Cassidy, Archdiocese
	Sister Mary Linehan, St. Joseph's Hospital, Yonkers
Albany:	Sister Mary Agnes O'Neill, St. Mary's Hospital, Troy
	Sister Ellen Lawlor, RSM, St. Peter's Hospital, Albany
Brooklyn:	Mr. Alvin Conway, Catholic Medical Center
	Father Joseph Sullivan, Diocese of Brooklyn
Buffalo:	Sister Mary Charles, Sisters' Hospital
	Father William Stillwell, Diocese of Buffalo
Ogdensburg:	Sister Mary Enda Kiggins, Mercy Hospital, Watertown
	Monsignor Robert Lawler, Diocese of Ogdensburg
Rochester:	Sister Martha Gersback, SN, St. Joseph's Hospital, Elmira
	Sister Ann William Bradley, D.C., St. Mary's, Rochester
Rockville Centre:	Father Patrick Callan, Diocese of Rockville Centre
	Mr. Richard Herrman, Mercy Hospital, Rockville Centre
Syracuse:	Monsignor Ronald Bill, Diocese of Syracuse
	Sister Patricia Ann, St. Joseph's Hospital, Syracuse

Program priorities for 1980-1981 were:

1.) Pastoral Care, recognizing that a system of comprehensive health care should provide care for the spiritual needs of the infirm as well as for their physical and emotional needs.
2.) A strengthened communications plan.
3.) A determination to participate with HANYS and others on policy advocacy, but not to duplicate activities of others.
4.) A commitment to share information and resources.
5.) Issue related concerns, as follows:
    a.) health care regionalization
    b.) medical-moral issues
    c.) special health needs of the elderly
    d.) legislative and administrative initiatives
    e.) health care financing
    f.) national health insurance
    g.) vocations to the health service apostolate
6.) The following sub-committees were appointed:

    Annual Membership Meeting: Sister Martha Gersback, Richard Herrman, Sister Mary Agnes O'Neill
    Communication: Father Harry Barrett, Father Patrick Callan, Father William Stillwell
    Pastoral Care: Monsignor Ron Bill, Father Patrick Callan, Sister Mary Linehan
    Shared Resources: Father Harry Barrett, Alvin Conway, Sister Ellen Lawlor

February 27, 1981 Meeting

The Council addressed the following matters at this meeting:

1.) It was agreed with regard to the Annual Membership meeting both to invite members of the Public Policy Committee and also to seek a dialogue with the Bishops.
2.) The Council reviewed an initial draft from the Pastoral Care committee of a proposed statement by the Bishops.

3.) There was discussion about communications procedures.
4.) It was agreed to distribute throughout hospitals in the state a pamphlet on conscience clause protection for employees in civil rights law relating to abortion proceedings.
5.) With regard to legislative and regulatory matters, the Council addressed these issues:
    a.) problems created by obstetrical unit under-utilization;
    b.) the high cost of maternity insurance and its impact on discouraging child birth;
    c.) future directions of HSA's.
6.) The Council discussed the current nursing home shortage.
7.) With regard to medical-moral issues, the council discussed current court cases relating to life-sustaining treatments.

April 7, 1981 Meeting

At this meeting, the Council addressed the following materials:

1.) The Council approved a Pastoral Care Statement which included the following sections:
    a.) statement of theology and objectives
    b.) integration of pastoral care activity
    c.) appointment of pastoral care personnel
    d.) training of pastoral care personnel
    e.) provision of personnel support
    f.) accountability
    g.) total Church involvement
2.) It was agreed to change the date of the Annual Membership meeting to June 16th because the Bishops would be able to join this session after their June 15th meeting.
3.) The Communications Sub-Committee asked for guidance about what message to promote in developing its recommendations. In response, it was suggested that the focus be on the unique role of Catholic hospitals in the over-all provision of health care
4.) There was a brief review of current medical-moral issues.
5.) The Council discussed ways in which it could cooperate with the Church more broadly on health related issues.
6.) The Council reviewed material from Ken Bessette on the Health Occupations Review Committee under the aegis of the State Education Department.

June 16, 1981 Annual Membership Meeting

The Council held its first Annual Membership meeting at Douglaston on June 16, 1981. The session was well attended and successful. Sister Mary Charles gave the welcome. In his opening address, Cardinal Terrence Cooke said:

"The work of Catholic hospitals is appropriate, even central to the mission of the Church".

He went on to suggest that each Catholic health facility should witness to Christ especially by living out and applying the teaching of the Church in regard to health care.

The major theme of the meeting was Catholic hospitals in New York State-An Administrator's Perspective. Sister Mary Jean Ferrier, RSM, from St. Frances in Port Jefferson gave a Hospital President's perspective.

Council member Bishop Joseph Sullivan, recently appointed Auxiliary Bishop in Brooklyn gave a Bishop's perspective. He began his talk by articulating his belief that Catholic hospitals were <u>one</u> major area of Church involvement in health care in New York. He welcomed the opportunity through his talk to begin a dialogue between Bishops of the state and hospital leaders.

As context of the dialogue, he asserted his belief the acceptance by the Church of pluralism in society ought not to require compromise on basic religious values including:

1.) life issues
2.) social justice issues
3. a religious mission statement
4.) the presence of a medical-moral committee
5.) a vigorous pastoral care program.

He then outlined what he believed ought to be expectations of Bishops of Catholic hospitals, "proposed as areas for dialogue and further delineation":

1.) Prior information about Hospital Trustees being considered for election
2.) Participation in the choice of executive leadership
3.) Reports on quality of care
4.) Notice of impending initiatives
5.) Receipt of annual audits
6.) Existence within the hospital of a mechanism to assure conformance with Catholic teaching
7.) Education and training of staff in Catholic philosophy and teaching

He concluded his remarks by quoting the challenge recently issued to those in health care ministry by Pope John Paul II.

<u>November 30, 1981 Meeting</u>

A new addition to the Council for this meeting was Sister Mary Pierre Seguin, who had replaced Sister Enda Keggins as Administrator at Mercy Hospital in Watertown.

At this meeting, the Council addressed the following issues:

1.) The Constitution was amended to provide a process for filling vacancies on the Council.
2.) The Council reviewed its relationship with the Catholic Conference.
3.) It was agreed that Monsignor Bill, Father Callan and Sister Ann William would participate in a joint meeting with the State Council of Catholic Charities Directors.
4.) It was agreed that Monsignor Lawler would develop a questionnaire on existing administrative and non-patient services as a first step in the process toward the shared services objective.

5.) It was agreed to survey hospitals and Dioceses on their involvement in Natural Family Planning services.
6.) After reviewing, at the request of Bishops, the previously approved Pastoral Care statement in light of the recently adopted USCC statement, the committee reaffirmed approval and resubmitted the proposed statement to the Bishops.
7.) With regard to communications, it was agreed that the sub-committee explore existing avenues of communication within the Catholic sector.
8.) It was agreed that there would be discussion at the next meeting about what role hospitals should play in the treatment of the terminally ill.
9.) It was agreed that there should be an education session on Catholic identity for participants in the 1982 Annual Membership meeting.
10.) The Council urged religious communities not to withdraw from the social security system.
11.) The committee addressed the following policy issues:
    a.) Bishop Sullivan agreed to develop materials on the Certificate of Need process
    b.) There was discussion of capital finance issues and mergers.
    c.) The Council adopted the following recommendations on proposed Medicaid cutbacks for presentation to the Public Policy Committee.
        - maintain current eligibility and optional services;
        - maintain at least pre-October level of funding;
        - examine eligibility so as not to burden bad debt and charity care pool;
        - maintain cash flow;
        - not restrict freedom of choice;
        - find ways to bolster philanthropic support.
12.) The Council heard an informational presentation on the situation of Haitian Detainees.
13.) The Council determined that it was not yet ready for a meeting with Commissioner of Health David Axelrod.

<u>January 22, 1982 Meeting</u>

The Council addressed the following issues at this meeting:

1.) The Council heard a report about the activities of the Public Policy committee from Sister Mary Charles and Ken Bessette:
    a.) It was reported that the Conference was in discussions with Health Department to ensure that state funds available for contracting with Article 28 facilities to provide school health services be made available for services to children attending non-public schools on an equitable basis.
    b.) It was reported that the Conference was advocating for participation in an Institute on Pregnancy in Adolescence being created in the State Department of Health.
    c.) It was reported that some members of the Public Policy Committee felt that neither this Council nor the Council of Charities Directors were addressing issues in home care, long term care and preventive care, and had appointed a sub-committee to consider the matter. The council agreed to propose to the subcommittee that it was willing to broaden its agenda to consider such matters. This approach was suggested at a meeting of the Conference Health Affairs Committee on April 5, 1982.
2.) It was agreed that the next step for the Pastoral Care Sub-committee would be to obtain information on existing policies in hospitals and Dioceses.

3.) For purposes of information, Ken Bessette reviewed planned activities by Church constituencies in support of the Human Life Federal Amendment.
4.) The Council reviewed plans for the upcoming Annual Membership meeting.
5.) With regard to the shared services initiative, it was agreed that data submitted to CHA could be helpful to this work.
6.) The Council reviewed recent Church developments promoting Natural Family Planning.
7.) It was agreed that the Council should arrange a meting with leadership of the State Department of Health, although it was recognized that there would probably be an upcoming change of administration.

April 23, 1982 Meeting

At this meeting, the Council addressed the following matters:

1.) For the 1982-1983 program year, Sister Ellen Lawlor was elected as Chairperson and Richard Herrman was elected as Vice-Chairperson.
2.) It was reported that the Pastoral Care Statement would be presented to the Bishops on May 4, 1982, and there was discussion about how best to release the statement. The statement approved by the Bishops is attached as Appendix III.
3.) It was agreed there would be a 10 percent dues increase for the coming year.
4.) The Council reached decision on the following matters:
    a.) to oppose legislation A 1222-S (to establish limitations on establishment of health care facilities);
    b.) to support the concept of unionization with conditions;
    c.) to develop a process to respond to concerns expressed by Bishop Sullivan at the previous Annual Membership meeting about the relationship of hospitals and Ordinaries.
5.) There was discussion about the future structure and activity of the Council.

May 25, 1982 Annual Membership Meeting

Bishop Harrison welcomed members to this meeting in Syracuse.

Opening remarks were made by outgoing Chairperson Sister Mary Charles and incoming Chairperson Sister Ellen Lawlor.

The keynote address on Catholic identity was given by Lawrence D. Prybel, Vice-President for Administration of the Sisters of Mercy Health Corporation.

In considering the Catholic identity of an institution, he raised six questions for consideration:
1.) Does the sponsoring group exercise influence on the philosophy, mission and governance of the organization?
2.) How are the philosophy and fundamental values of the sponsor reflected in the operations of the institute?
3.) How do the philosophy and values differ from those who are not Catholic?
4.) To what extent is the institution sensitive and responsive to community needs unlikely to be addressed by other hospitals?
5.) Are programs and services consistent with basic teachings of the Church?

6.) Are personnel policies and practices consistent with the teachings of the Church?

October 9, 1982 Meeting

For this meeting, Sister Mary Walter Boyle from Our Lady of Lourdes Hospital in Binghamton and Ed Peterson from Good Samaritan Hospital in the Diocese of Rockville Centre, were welcomed as new members.

At this meeting, the Council addressed the following issues:

1.) There was discussion about how to implement the Pastoral Care Statement approved by the Bishops.
2.) It was agreed to try to arrange a meeting with Department of Health leadership in the new administration in March 1983.
3.) Suggestions were solicited for possible appointees to what would be a new state admin.
4.) There was discussion about the proposed Intergroup Coordinating Body to address broader health issues within the Catholic Conference structure.
5.) The Council endorsed creating an inter disciplinary Teen Pregnancy Group within the Catholic Conference.
6.) It was agreed that the Shared Service Sub-Committee needed to further refine data that it had collected.
7.) There was initial discussion about the 1983 Annual Membership Meeting

December 12, 1982 Meeting

At this meeting, Robert Hendry was welcomed as a new member from Brooklyn. The Council addressed the following issues at this meeting:

1.) It was reported that the Research and Information Division of the Catholic Health Association would provide hospital services data.
2.) It was anticipated that the Public Policy Committee would approve in January 1983, the creation of a Health Coordinating Committee to address broader health care issues which reached beyond the purview of hospitals.
3.) There was discussion about:
    a.) a proposed New York State Real Property Tax Law Amendment;
    b.) the upcoming Annual Membership Meeting to be held in Buffalo on May 25, 1983;
    c.) efforts to build linkages with Catholic long term care providers, possibly through the Catholic Conference Health Coordinating Committee;
    d.) the proposed USCC Pastoral Statement on Health Care;
    e.) Medicaid Freedom of Choice issues at both the state and federal levels;
    f.) issues relating to termination of life support;
    g.) the November 13, 1982 USCC statement encouraging religious communities not to withdraw from Social Security;
    h.) a statement on employee relations developed by the Mercy Health Conference;
    i.) making contacts at the local level to follow-up implementation of the Pastoral Care Statement;
    j.) the upcoming meeting with the Commissioner of the Department of Health.

C. Influence on Public Policy

1. Introduction

More generally, and especially in the arena of health care, the Carey era was unprecedented in the annals of New York State.

Over-all, the state faced a major fiscal crisis. While the profound expansion of state government activity under the Rockefeller Administration brought many positive accomplishments, the cost of such expansion was beginning to catch up with state government as Hugh Carey became Governor on January 1975. Added to the equation was the ever growing population and economic development movement from the east coast to the southern and southwestern United States, and the severe fiscal crisis in New York City.

One of the major contributions to the state's economic crisis was the vast expansion of health care, which occurred in New York at a pace even more rapid than the rest of the country.

A presentation given by Health Commissioner Robert Whalen on January 10, 1978 documents eloquently the growth of the health care system in New York from the moment of passage of Hill-Burton Legislation in 1946 into the early years of the Carey Administration and is attached as Appendix IV.

This presentation made clear the challenges faced during this era by the entire health care community.

Just as the problems associated with health care were varied and complex, so was the response of the Church, and consequently its influence on state government.

On one hand, more so than ever before, Catholic leaders in the health care field were accepted into the inner circles of the Carey Administration as trusted advisors. Mention has been made of Dr. Kevin Cahill, Dr. Bob Collins, Tom Dowling and Monsignor Charles Fahey. In general, they took an over-all common good approach to addressing health issues. On the other hand, there were Catholic leaders whose major focus was on the survival of institutional Catholic health care or even of a particular institution.

This divergence of approach often left state government leaders with mixed messages and also led to some internal conflict. In fact, the State Council of Catholic Hospitals was created in an environment in which more parochially oriented Catholic health leaders felt that the Health Advisory Committee had too broad a focus and did not sufficiently support Catholic institutional concerns.

A central figure in this on-going drama was Monsignor Charles Fahey. For the early years of the Carey Administration, he was the Diocesan Director of Catholic Charities in Syracuse. In 1979, he assumed the role of Director of the Third Age Center at Fordham. As indicated previously, through early contacts with Commissioner Bob Whalen, he was to play a key role in the Carey administration. He was among the lead proponents of an over-all community approach to addressing health care issues.

To understand the dynamics of what was happening in relationship between the Church and state government, and within the Church itself, it is helpful to understand his thinking.

A visionary and writer, he articulated in four documents drafted rather early in the Carey Administration, his thinking about the role of Catholic Church in health care.

While these documents represent his own thinking, nonetheless they were informed by and informed his discussions with both government leadership and Church leadership. While not universally accepted by Catholic health care leaders, these views would have an enormous impact on Church advocacy in relation to health policy in the coming decades. Understanding these documents is essential to understanding the role the Church played in influencing public policy in the Carey Administration.

The first document, drafted on December 20, 1976, in anticipation of the 1977 Legislative session, addressed "the Health Care Crisis in New York in 1997." Not unlike Dr. Whalen's presentation to be given a year later, he addressed the root causes of the health care crisis in New York. Recognizing that after much debate in 1976, the state legislature had made the decision to retain Medicaid eligibility levels, but "hold the line" on costs, asking providers to absorb the increased costs of doing business, he argued that the state had to address more fundamental issues in 1977. He emphasized that there needed to be developed a rational process for reallocation of scarce dollars, that the system needed to shrink, and that there must be developed approaches for shared use of services and technologies.

He addressed more directly the role of Catholic health care in a paper written August 4, 1977, entitled "Toward a Frame of Reference for Decision-Making on the Role of Catholic Health Leaders". In this paper, he brought forward his thesis that health care delivery in the United States had become "socialized". He stated socialization was meant as:

"that on-going process which so spreads decision-making among many persons, institutions and locations in society that health care is basically a "community" or "social" activity, as opposed to that which is exclusively or even primarily that of a given service provider"

He argued that the genesis of this development was that there was recognition that health care was a fundamental right for all.

Since costs could be so beyond the reach of an individual, insurance became a necessity, followed by government subsidy, the evolution of Blue Cross and then creation of "social insurance" through Medicaid and Medicare.

Because of the expansion of third party payments, with recognition that there was no economic interest of the patient with first dollar coverage to monitor the system, there had been proliferation of the regulatory and inspection functions of government.

With the passage of PL 93-641, the National Health Planning Act of 1974, there had developed in effect a common national health policy and unitary system.

Monsignor Fahey argued that to a large extent, given this "socialization" of the provision of health care, the only decision left to an individual Catholic health care facility was the extent to which it would participate in this unitary system.

To him, then the question became, to what extent could the Church penetrate the entire system with its values, expertise and approaches.

He concluded this paper by stating: "To limit the discussion of the Catholic health apostolate to institutional survival is to miss the broader question of how can the Church make a contribution to an American culture of freedom and love in a time of ever greater independence and shrinking resources".

Monsignor Fahey became more specific about what positive roles the church could play in this context in a subsequent paper written on September 9, 1977.

In this paper, he made suggestions about the role of Catholic institutions in accepting input from the community, and also the thorny issue of addressing a climate where the consensus of the community perhaps was to have services contrary to Catholic values.

He suggested also areas where Catholic leadership might improve the system as a whole, citing pastoral care, advocacy for the poor and bringing a tone of gentleness and civility to debate as areas where Catholics could provide significant contribution to the public forum.

These underlying approaches found more tangible and practical expression in his authorship of a statement on regionalization which was approved by the Public Policy Committee of the Catholic Conference on May 10, 1978 and sent to the Bishops of the state.

The arena of regionalization was one of the areas in which the Catholic Church influenced the public policy debate about health care in the state during the Carey administration. This area is described in the following sections along with the related areas of cost-cutting, maternity services, and then other public policy issues.

2. Regionalization

Even before the passage of PL 93-641, the National Health Planning Resource Act of 1974, New York State had been a leader in developing regional planning groups. With the passage of this law, however, the evolution and eventual power of regional Health Systems Agencies became ever more important. Against this background the institutional Catholic Church weighed in on thoughts about Church participation in regional planning activities.

In what clearly was a "victory" for those concerned about the greater common good, on May 10, 1978, the Public Policy Committee approved the following principles with regard to the Church's "overall approach to the subject in the state of New York."

1.) The Church and its institutions must recognize that they have a role and a concern about the over-all well being of the state, its fiscal liability, and the equitable distribution of resources among all of its people.

2.) Catholic health facilities play an extraordinarily important role, both in the life of the Church and in the life of the communities in which they find themselves.
3.) Catholic hospitals must be recognized as a resource for the community, as well as an instrumentability for evangelization.
4.) In order for a hospital to have viability, it is necessary that it have a certain core of essential services.
5.) In the "establishment procedures" for facilities and programs in the state, there is provision that religious need be considered public need. By extension, this policy should also be observed in principles of reimbursement, as well as in program development or maintenance.
6.) When it comes to "shrinking" the system and "regionalization", there are times when it may be appropriate to use the religious need principle. However, in doing so, all implications should be carefully explored, and the principle should be used reasonably.
7.) The state is likely to call upon Diocesan authority to be a participant in the decision of whether or not religious need will be evoked and/or recognized. The religious need is not that of the hospital, but rather it is the need of the religious community of that particular area. As the chief spokesman for this religious community, the Bishop is likely to be called upon by the state authorities in determining the actual religious need in a given situation.
8.) Each Diocese should undertake a study of those facilities and likely to be affected by "regionalization" and "shrinkage" actions.
9.) Cooperation among Catholic related facilities and the Diocese should be encouraged.
10) The New York State Catholic Conference, its staff and its Health and Hospital Advisory Group should be available to provide assistance to the individual facilities as well as to the Diocese in such areas as the law, public policy, demographics and experiences of other Diocese.
11.) It should be recognized that while religious need is located in statute, it should be utilized in responsible manner. Even from a pragmatic point of view, if it is used arbitrarily, the statute itself will come under attack.

3. Cost-Cutting

Obviously, within the general environment described alone, cost cutting measures were a continuing concern. Throughout the Carey administration, the voice of the Catholic Conference was heard as a voice in opposition to cost-cutting, especially with regard to the Medicaid program in New York. That this voice was both about the needs of the poor and institutional survival, was best illustrated by the recommendations made to the Public Policy Committee by the State Council of Catholic Hospitals at its meeting on October 30, 1981:

1.) maintain current eligibility and service levels;
2.) maintain at least pre-October level of funding;
3.) examine eligibility so as not to burden bad debt and charity pool;
4.) maintain cash flow;
5.) do not restrict freedom of choice;
6.) find ways to bolster philanthropy support.

4. Maternity Care

Probably no issue between state government and Catholic health care providers was as significant as the provision of maternity services. History shows that this was an arena in which the institutional interests of the Catholic Church prevailed.

Within the context of the growing oversight of health care provision in the state, the Hospital Review and Planning Council approved a report from the Way Committee in January 1975, accepting that principles for endorsing continuance of maternity services related to:

1.) travel time
2.) quality of service
3.) availability of neo-natal services
4.) requirement of a minimum of 1500 births

This report presented significant challenges to the provision of maternity services within Catholic facilities, many of whom did not meet the required standards.

As noted above, there was continuing discussion of the Way Committee Report by the Advisory Committee to the Bishops on Health care.

Finally, it was agreed at the September 23, 1976 meeting of the Health and Hospitals Advisory Committee that it was imperative to have a meeting with representatives of all hospitals to discuss the implementation of this report.

Happily, from the perspective of institutional providers the Hospital Review and Planning Council determined at its November 1976 meeting not to implement the recommendations through state level policy-making, but to ask each of HSA's to consider this question on a regional level.

The Catholic Conference then took the approach not to address this question on a statewide basis, but rather to assist individual institutions.

In October 1977, the Church won a victory when Commissioner Whalen approved the continuation of provision of maternity services at St. Joseph's Hospital in Elmira providing that there was a reduction in bed capacity.

Later that year, when the Hospital Review and Planning Council determined to postpone financial penalties for non-compliance of achieving minimum levels of service provision, Charles Tobin termed the decision a "welcome relief from an intolerable burden".

In March 1978, the Catholic Church achieved another victory when it was determined that both the Catholic and non-Catholic hospitals in Binghamton could continue to provide maternity services, providing that there was a reduction in total bed capacity.

These decisions were to set the precedent for several other determinations in the Carey administration.

4. Other Issues

During the Carey administration, the Catholic Conference had input into several other policy issues. This input reflected both the influence of those who looked to the greater common good and also those who had more narrow institutional concerns.

Examples of this involvement were:

1.) In 1976, providing input to state considerations about "the definition of death";
2.) At several times throughout this time period, advocacy about sterilization services;
3.) Developing at its March 1, 1977 meeting a statement about the Affirmation of Responsibilities of HSA's;
4.) In 1979, advocating for equal opportunity for funding for health services for children in non-public schools;
5.) Advocacy on issues relating to length of stay for abortion services;
6.) Advocacy on issues relating to ambulatory care;
7.) Advocacy on development of discharge plans.

Chapter Four

The Cuomo Administration

1983 – 1994

A. Introduction

Just as the Cuomo administration was gearing up after the Governor's election in November 1982, the recently created Catholic Hospital Council was experiencing growing pains or perhaps even an "identity crisis".

The next section of this Chapter describes the organizational evolution of the Council from January 1983 – June 1984, and also its interactions with the new Cuomo administration.

The subsequent section describes in detail the work of the Council from July 1984 until the end of the Cuomo administration in December 1994. Many observers term this time period the most productive in the history of the Council.

B. Internal Organization - 1983-1984

1. Leadership, Membership, Staff

   a. Leadership

   Sister Mary Charles Dever, President of Sisters of Charity Hospital in Buffalo, had played a major role in the creation of the Council and had exercised strong leadership in her two-year term as Chairperson. Having completed her term, she was succeeded in May 1982 by Sister Ellen Lawlor, R.S.M. from St. Peter's Hospital in Albany. Sister Ellen would guide the Council's evolution over the next two years and preside over its revitalization in 1984.

   b. Membership

   During this 18-month period, membership on the Council was:

   Archdiocese of New York
   Monsignor James Cassidy: Archdiocese of New York
   Sister Mary Linehan: St. Joseph's Hospital, Yonkers
   Mr. George Meitch: Archdiocese

   Albany
   Sister Ellen Lawlor: St. Peter's Hospital, Albany
   Mr. Jerome Stewart: St. Clare's Hospital, Schenectady

   Brooklyn

   Bishop Joseph Sullivan: Diocese of Brooklyn

Mr. Alvin Conway: Catholic Medical Center
Mr. Robert Hendry: Catholic Medical Center

Buffalo
Father William Stillwell: Diocese of Buffalo
Sister Mary Charles Dever: Sisters' Hospital
Sister Margaret Mary Hughes: St. Jerome Hospital, Batavia

Ogdensburg
Monsignor Robert Lawler: Catholic Charities
Sister Mary Pierre Seguin: Mercy Hospital, Watertown

Rochester
Sister Martha Gersbach: St. Joseph's Hospital, Elmira
Sister Ann William Bradley: St. Mary's Hospital, Rochester
Sister Mary Rene McNiff: St. James Mercy Hospital, Hornell

Rockville Center
Mr. Richard Herrmann: Mercy Hospital, Rockville Center
Mr. Edward Peterson: Good Samaritan Hospital, West Islip

Syracuse
Monsignor Ronald C. Bill: Diocese of Syracuse
Sister Mary Walter Boyle: Lourdes Hospital, Binghamton

c. Staff

During 1983, Ken Bessette continued as staff person to the Council. He left in late 1983 to pursue other career opportunities. For the first half of 1984, the staff position was vacant, as the Council sought to better understand its mission and role. Richard McDevitt was hired as Executive Secretary of the Council effective July 1, 1984.

2. Activities

a. Introduction

As indicated above, the major focus of the Council was on its own internal development. In addition, the Council continued its Annual Meetings, initiated what was to become an Annual Meeting with the Commissioner of the Health Department, interacted regularly with the Catholic Conference and addressed other matters during this eighteen month time period.

b. Organizational Evolution

Following on a strong start, by early 1983, the Council was beginning to examine its mission and purpose.

A first step in this process was convening on February 11, 1983 a meeting of Catholic Hospital Executives from throughout the state to discuss:

1.) the future of the respective Catholic hospitals in light of local conditions;
2.) the impact of regionalization on the future of Catholic hospitals.

Results of this session were reported at the Council meeting on February 18, 1983.

At its April 29, 1983 meeting, the Council engaged in a brief informal evaluation of its activities and concluded that its linkages to the Church were good, but that a better job needed to be done in disseminating information about its work to hospitals and to the Catholic community more generally.

The entire meeting of the Council held on September 8, 1983 was focused on determining Council priorities for the coming year. Each member was asked to come to the meeting with a list of issues which the individual felt the Council should address. The Council determined that the following were the priority issues which should be addressed and assigned lead persons to each issue as indicated:

Regionalization – Monsignor James Cassidy
Long Term Care – Sister Mary Linehan
Ethical Issues – Monsignor Robert Lawler
USCC Bishop's Pastoral – Sister Mary Walter Boyle
Hospice – Richard Herrmann
Reimbursement – Alvin Conway

It was further agreed that at each meeting standing agenda items and reporting responsibility would be as follows:

State Hospital Review and Planning Council: Richard Herrmann, Sister Mary Walter Boyle
Legislation: Ken Bessette
Blue Cross/Blue Shield: Monsignor James Cassidy, Sister Mary Walter Boyle
Catholic Charities: Monsignor Robert Lawler, Monsignor Ronald Bill
Department of Health: Ken Bessette

Following up this session, Monsignor Lawler wrote to Council members asking them to define ethical issues which they were facing, to identify particular issues on which the Council should focus, and to recommend advisors to assist the discussion.

At its meetings on November 4, 1983 and December 16, 1983, the Council utilized this agenda framework and made noteworthy progress as follows:

1.) with regard to long term care issues, agreed to invite Lloyd Nurick, the Executive Director of the New York State Association of Homes for Aging to a future meeting;
2.) identified the following ethical issues which the Council might address:
    a.) organ transplantation
    b.) definition of death
    c.) in vitro fertilization

d.) allocation of resources
e.) issues relating to mental illness
f.) DNR orders

3.) expressed concern about proposed hospice regulations, which if implemented, would create difficulties for hospitals;
4.) heard regular updates on activities of the Department of Health, State Hospital Review and Planning Council, and Blue Cross/Blue Shield;
5.) interacted with the State Council of Catholic Charities Directors on issues relating to mental health funding, a proposed teen pregnancy hotline and the establishment of the Maternity and Early Childhood Foundation.

Despite these positive steps, however, concern about the future directions of the Council, especially in the absence of a staff person, had reached the point where the Council convened on February 16-17, 1984 a special session entitled, "A Search for Identity". This session was facilitated by Father Ken Lasch, a consultant for planning in the Diocese of Paterson, New Jersey. The purposes of this session were:

1.) to define issues of Council responsibility at the federal, state and local level;
2.) to develop mechanisms to develop support of Council activities from Catholic institutions;
3.) to organize leadership and support staff to implement Council decisions and recommendations.

As reported by Sister Ellen at the June 1, 1984 meeting, through this session the Council came to the following conclusions:

1.) that the "true" Council was every Catholic hospital in the state;
2.) that the existing structure which had been called the Council really should be viewed as the "Steering Committee";
3.) that the entire Council should be convened semi-annually;
4.) that the Steering Committee had responsibility for the planning function for the Council;
5.) that the local Ordinaries should be much more involved in the work of the Council;
6.) that the role of Executive Secretary to the Council needed to be more precisely defined.

Through the process, in essence, the Council was revitalized and ready to enter into one of its most active periods.

c. Annual Meetings

In this time period, the Council continued its practice of holding Annual Meetings.

On May 25, 1983 about 100 persons attended the third Annual Meeting of the Council in Buffalo. The morning keynote address was given by Father John Paris, S.J., Associate Professor of Ethics at Holy Cross College. He addressed theological, medical and legal concerns regarding the care and treatment of terminally ill patients. In the afternoon session, following a liturgy celebrated by Bishop Head, the group was addressed by Health Commissioner Dr. David Axelrod.

The fourth Annual Meeting, held in New York City, was unique in that the agenda was comprised of presentations of case statements on areas of common concern. It was intended that these presentations would be a jumping off point for ensuing discussion of those issues throughout the coming year.

Presentations were given as follows:

Abortion: Bishop Sullivan
Aging: Sister Mary Linehan
Pastoral Care: Sister Mary Walter Boyle
Teenage Pregnancy: Sister Margaret Mary Hughes
Health Education: Sister Ellen Lawlor
Parish Relationships: Mr. Edward Peterson
Inter-Institutional Coordination: Sister Martha Gersbach
Multi-Institutional Planning: Mr. Jerome Stewart

At this meeting, welcoming and overview remarks were also given by recently appointed Archbishop John O'Connor of New York, Bishop Sullivan and Alvin Conway.

d. Meeting with State Leadership

During this time period, the Council initiated what was to become an important part of its annual activity: meeting with the Commissioner of the State Department of Health. The first such meeting was held with Dr. David Axelrod on April 29, 1983. He gave Council members an overview of his perspective on the status of health care in the state and also his perspective on Catholic health care. In sum, he indicated:

1.) his belief that Catholic hospitals were integral to the future of health care delivery in the state;
2.) his commitment that he would not press regionalization where moral values were impacted;
3.) his belief that because of cost concerns, health care providers needed to turn ever more toward provision of non-institutional services.

On October 23, 1983, leadership from the Catholic Hospital Council participated with other Catholic Conference leaders in a meeting with Governor Mario Cuomo. In an environment where there was general concern that health care did not seem to be a priority of the Cuomo administration, Sister Ellen Lawlor addressed concerns about the need for adequate access to health care, opposition to measures that would restrict opportunities for Catholic providers, and the need to emphasize the importance of the voluntary sector.

e. Interaction with Catholic Conference

During this time period, there continued to be important interaction with the State Catholic Conference.

At the February 18, 1983 meeting, it was reported that after much back and forth discussion which had occurred ever since the establishment of the Catholic Hospital Council, the State Public Policy Committee had determined to establish a cross-cutting Health Affairs Coordinating Committee, and also, given that the imposition of the construction moratorium was a "fait accompli" and that advocacy would be fruitless, to take "no position" on this measure.

At the November 4, 1983 meeting, it was reported that the Public Policy Committee had addressed health care financing and the Teen Pregnancy hotline.

It was reported at the December 16, 1983 Council meeting that the Public Policy Committee had determined that in addition to the presence of Sister Ellen Lawlor on the Committee as Council Chairperson, that the Council should also be represented by the Vice Chairperson as an at large member, and also that there had been discussions about the process to replace Ken Bessette as staff person.

Finally, on June 11, 1984, Council President Sister Ellen Lawlor made a presentation to the Bishops of the state, addressing:

1.) the aging of the population in the state;
2.) health care needs of the poor;
3.) medical/moral issues:
    a.) issues around dying
    b.) genetic testing
    c.) in vitro fertilization

f. Other Activities

The Council in this time also addressed several other important issues as follows:

1.) continued to discuss ways to promote the USCC statement on health care;
2.) had representatives attend a joint statewide meeting with Chaplains in Catholic hospitals;
3.) finally, at the December 16, 1983 meeting after many years of effort, and through the good work of Catholic Medical Center, learned that statistical data had been produced relative to the range of services and persons served statewide, by Diocese and by individual hospital.

C. Internal Organization – July 1984-December 1994

1. Introduction

With the revitalization process described in the previous section, began what was perhaps the most vital and effective era of the work of the Council. Almost immediately, in June 1986, the Council became the Catholic Health Care Council with members representing the many different Catholic health care services.

This renaissance was engineered by a series of strong leaders serving as Council Presidents. Staff brought new energy and focus to the work of the Council.

While the Council itself was clearly leaders of all Catholic hospitals, the Executive Committee served as an effective "Steering Committee".

The Executive Committee established a variety of subcommittees to focus more in depth on specific areas of concern.

The tradition of Annual Meetings continued throughout the decade.

Council leadership participated in on-going meetings with leadership in state government, with special emphasis on the Annual Meeting with the Commissioner of Health. Annual meetings were expanded in length and scope. Regional meetings of members were initiated to inform, solicit advice and advocate for member issues at the state level.

The Council became an ever more integral part of the Catholic Conference and related to it in many different ways. Council informational vehicles included monthly staff reports to members and creation of "Catholic Healthshare" a quarterly publication to members that described model programs by Catholic health care providers in New York State.

The Council was influential in public policy advocacy which resulted in some clear legislative victories, a series of on-going issues to which the Council gave input, and a series of advocacy actions to prevent imposition of restrictions on Catholic health care delivery.

These activities are described in turn.

2. Leadership, Membership, Staff

a.) Leadership

Following on the successful work of Sister Ellen Lawlor to bring to conclusion the self-study process, Richard Herrmann became Council President in June 1984. He was CEO of Mercy Hospital in Rockville Centre and served a two year term, including shepherding the Council through its transition to become the Catholic Health Care Council.

He was succeeded in the fall of 1986 by Mr. Alvin Conway, CEO of Catholic Medical Center of Brooklyn/Queens. Mr. Conway was succeeded at the June 1988 Annual Meeting by Sister Mary Rene' McNiff, CEO of St. James Mercy Hospital in Hornell who had already been serving as Council Vice-Chair, and as a member of the State Catholic Conference Public Policy Committee, and who also had been Chairperson of the Legislation and Regulation Sub-Committee of the Council. At the May 31/June 1, 1990 Annual Meeting, Mr. Peter Capobianco, CEO of St. Mary's Hospital in Amsterdam was elected Council President and Mr. Ken Knutsen from Rockville Centre was elected as Vice-Chairperson. In September 1990, Sister Mary Logan was elected as Vice-Chairperson to replace Ken Knutsen who had resigned from the Council. Finally, for the 1993-1995 term, Sister Marie Castagnaro, CEO of St. Joseph's Hospital in Elmira, was elected President and Mr. James Cameron Vice-President.

b.) Membership

As indicated above, it was recognized that the membership of the Council was every hospital CEO. When the By-Laws of the organization were broadened in 1986 to include Catholic health care entities beyond hospitals, so too was the membership broadened to include nursing homes and certified home health care agencies. Yet, it was the Executive Committee that directed the affairs of the Council and so are listed here by Diocese and years of service the members of the Executive Committee, recognizing that it too was broadened when the By-Laws were changed.

Archdiocese of New York

Monsignor James Cassidy: Archdiocese (1984-1986)
Sister Mary Linehan: St. Joseph's Hospital, Yonkers (1984-1986)
Mr. George Meitch: Archdiocese (1984-1988)
Ms. Virginia Pelligrino: Archdiocese (1984-1986)
Sister Mary McCaffrey: Benedictine Hospital, Kingston (1986-1989)
Sister Rita Kerr: Franciscan Sisters of the Poor Health System (1986-1989)
Mr. James Reynolds: (1987-1990)
Ms. Mary Jo Mitchell: St. Agnes Hospital, White Plains (1989-1991)
Mr. Roger Weaving: Archdiocese (1992-1994)
Sister Joan Regan: Good Samaritan Hospital, Suffern (1988-1994)
Mr. James Cameron: Kateri Residence, New York (1990-1994)

Albany

Sister Ellen Lawlor: St. Peter's Hospital, Albany (1984-1986)
Mr. Jerome Stewart: St. Clare's Hospital, Schenectady (1984-1994)
Mr. Peter Capobianco: St. Mary's, Amsterdam (1986-1994)
Mr. Jim Reynolds: Villa Immaculate, Albany (1987-1989)
Sister Joseph Mary Brecanier: Teresian House, Albany (1987-1994)

Brooklyn

Bishop Joseph Sullivan: Diocese of Brooklyn (1984-1994)
Mr. Alvin Conway: Catholic Medical Center (1984-1991)
Mr. Robert Hendry: Catholic Medical Center (1984-1986)
Sister Katherine Herron: Homecare (1986-1990)
Mr. Tom Chardavoyne: Catholic Medical Center (1986-1992)
Sister Mary Louise Kelly: (1986-1987)
Mr. James Fay: Catholic Medical Center (1992-1994)
Sister M. Luke Amarol: Madonna Residence (1992-1994)

Buffalo

Sister Margaret Mary Hughes: (1984-1986)
Monsignor Henry Gugino: Catholic Charities (1984-1994)
Mr. James Kuechle: Catholic Charities (1986)
Mr. Daniel Kenney: Brothers of Mercy Rehab Center, Clarence (1986-1994)
Sister Mary Joel Schimscheimer: Kenmore Mercy Hospital (1986-1994)
Ms. Carol Kennedy: Catholic Charities (1992-1994)

Ogdensburg

Sister Mary Pierre Sequin: Mercy Hospital, Watertown (1984-1989)
Sister Mary Paschal Hill: Mercy Rehabilitation Center (1984-1986)
Mr. William Dooley: Mercy Rehabilitation Center, Tupper Lake (1986-1991)
Mr. William O'Rielly: St. Joseph's Nursing Home, Ogdensburg (1989-1994)
Mr. James Wesp: Mercy Rehabilitation Center, Tupper Lake (1992)
Mr. Paul Scarpinato: Mercy Rehabilitation Center, Tupper Lake (1993-1994)
Ms. Chandler Ralph: Mercy Health Center, Watertown (1992-1994)

Rochester

Sister Mary Rene McNiff: St. James Mercy Hospital, Hornell (1984-1994)
Sister Martha Gersbach: St. Joseph's Hospital, Elmira (1984-1986)
Sister Mary Alice Roach: St. Mary's Hospital, Rochester (1986-1987)
Sister Karen Elaine Dillon: Mercy Health Center, Auburn (1987-1988)
Mr. Patrick Madden: St. Mary's Hospital, Rochester (1987-1994)
Sister Linda Ann Palmisano: Mercy Health Center, Auburn (1988-1994)
Sister Marie Castagnaro: St. Joseph's Hospital, Elmira (1988-1994)

Rockville Centre

Mr. Richard Herrman: Mercy Hospital, Rockville Centre (1984-1992)
Mr. Edward Peterson: Diocese of Rockville Centre (1984-1985)
Mr. Daniel Walsh: Good Samaritan Hospital, West Islip (1985-1994)
Mr. Kenneth Knutsen: Good Samaritan Nursing Home (1986-1990)
Sister Mary Logan: Diocese of Rockville Centre (1986-1992)
Monsignor Alan Placa: Diocese of Rockville Centre (1992-1994)
Sister Agnes Stumpf: Nursing Sisters Home Visiting (1992-1994)

Syracuse

Sister Mary Walter Boyle: Lourdes Hospital, Binghamton (1984-1985)
Monsignor Ronald Bill: Catholic Charities (1984-1985)
Sister Rose Vincent: St. Elizabeth's Hospital, Utica (1985-1994)
Mr. Jim Abbott: St. Joseph's Hospital, Syracuse (1985-1989)
Mr. Robert Mack: St. Camillus, Syracuse (1986-1990)
Sister Margaret Tuley: Our Lady of Lourdes Hospital, Binghamton (1987-1989)
Sister Eloise Emm: Diocese of Syracuse (1992-1994)
Mr. Terrence Gorman: St. Luke's Home, Oswego (1992-1994)

c. Staff

Instrumental in the success of the Council during this decade was the work of Richard N. McDevitt who was hired as Executive Secretary of the Council effective July 1, 1984. Richard had background as a nursing home administrator, as a participant in Church and community activities, and on the Albany political scene. His outgoing personality and warmth fostered the internal growth of Council participation and helped enhance its influence with state government. In the late 1980's staff support was provided by Conference lobbyist Father Ken Doyle. In 1993 and 1994, Sister Doris Smith assisted with some activities.

3. Activities

a. Executive Committee

As indicated above, even thought it was recognized in the 1984 Council revitalization that membership on the Council included all Catholic Hospital CEO's, nonetheless the Executive Committee retained its important role as the "Steering Committee" for the work of the Council. Committees on Legislation and Regulation, Finance, Hospice, Mission Effectiveness, and Communications were established. During the Presidencies of Alvin Conway (1986-1988) and Sister Rene McNiff (1988-1990), the Executive Committee moved to create a subcommittee structure to carry out much of the work of the Council.

In the early 1990's, the committees became less active and at the end of the time period, significant attention was given to the structure and functioning of the Council. In fact, at the November 23, 1993 Executive Committee meeting, it was agreed that only the Executive and Legislative and Regulation Committees were standing committees.

Reported in this section are only those matters which the Executive Committee exclusively addressed. Most of the work of the Council is described in subsequent sections of this Chapter.

i.) Evolution of the Council

No more important decision was made by the Council during this decade that the decision to broaden membership thus transforming the Catholic Hospital Council into the Catholic Health Care Council. First discussion of the possibility of extending membership invitations to all Catholic providers: (Nursing Homes, Certified Home Health Care programs, Long-term Home Health Care programs, Hospice programs, and Alcohol Rehabilitation programs) occurred at the September 13, 1985 Executive Committee meeting. A Task Force was formed to research information relative to this possibility. At the October 22, 1985 Executive Committee meeting, it was agreed to first canvass hospitals on their openness to this possibility, and if there was interest, then to canvass Catholic Nursing Homes on their interest in joining the Council. At the March 5, 1986 Executive Committee meeting, there was agreement that the name would be changed to the New York State Catholic Health Care Council if the group were to be expanded. Based upon positive survey results and further discussion, the Executive Committee voted to recommend this transformation to the Bishops. In late June, the New York State Catholic Health Care Council was formally created. In the summer of 1986, Richard McDevitt outlined for the Executive Committee how its membership could be expanded from 18-24. In March 1987, he was able to report that the expansion was complete and the Executive Committee had its full component of members.

ii.) Council Objectives

A major role of the Executive Committee was to agree upon Goals and Objectives at the beginning of each program year. These statements are detailed here and give a good flavor of how the work of the Council evolved over time.

1984-1985 Objectives

1.) Establish regional groupings to foster the work of the Council;
2.) Improve public recognition of Council activities and awareness more generally of Catholic health care;
3.) Establish Legislative Program;
4.) Further develop process for discussion of 1984 case statements.

1985-1986 Objectives

1.) Establish Legislative Program;
2.) Strengthen internal working relationships with the Catholic Conference;
3.) Develop a report on the Pro-Life nature of Catholic health care;
4.) Broaden understanding of the work of the Council;
5.) Establish working committees;
6.) Conduct Annual Meeting.

1986-1987 Goals

1.) Establish Legislative Program;
2.) Broaden recognition of Council activities;
3.) Link Catholic diocesan, parish, school, social service and health care activities;
4.) Broaden relationship within the Conference and with government;
5.) Establish working committees;
6.) Implement recommendations of a Pro-Life response.

1987-1988 Goals

1.) Establish 1988 Legislative Program;
2.) Update Statistics Profile;
3.) Develop a news digest and other vehicles to communicate activities of Council;
4.) Monitor working committees;
5.) Work collaboratively within the Catholic Conference;
6.) Advocate for the necessity of Catholic health care.

1988-1989 Goals

1.) Recommend that each region and Diocese explore possibilities for linkages around health care ministry;
2.) Survey existing resources to help with Council activities;
3.) Increase federal advocacy;
4.) Establish a permanent Strategic Planning Committee.

1990 Goals

1.) Recommend that each region and Diocese (Bishops, clergy, parishes, institutions and social agencies) explore linkages and develop educational sessions in order to sensitize each other to the issues facing the Church's health care ministry and meet the needs of sick people;
2.) Recommend that advocacy be a greater priority for both Church leadership and institutions;
3.) Increase federal advocacy;
4.) Develop leadership training programs for both Diocesan and religious congregation personnel

H. 1991 Goals

1.) Strengthening Catholic Leadership

a.) Mission Effectiveness

1.) Sponsorship participation in Council decision-making activities;
2.) Offer education for mission effectiveness in New York State sponsored by the Council
3.) Leadership development – CEO's and management staff;
4.) Special Projects fund for Catholic health care services;

2.) Council Reorganization

a). Consider a name change such as Catholic Health Association of New York State;
b.) Establish a Council Committee for mission effectiveness;
c.) Create new activities for inclusion of health systems and religious sponsors;
d.) Develop a mechanism for measuring effectiveness, such as a survey of health systems and religious sponsors;
e.) Enhance the role of the Council on Medical Ethics matters through consultation and direction to the Conference's Public Policy Committee
f.) Consider new venues for Council activities through an increase in Council assessment to members.

1992-1993 Objectives

Following up a Planning Committee meeting held on March 2, 1991, Richard McDevitt wrote to Council President Peter Capobianco outlining his thoughts for the future functioning of the Council.

In essence, this memorandum articulates Council objectives for 1992-1993 as follows:

1.) Public Policy Development

To advise the Catholic Conference on matters of state health policy, act as a voice for the Catholic health ministry on public issues of concern, and promote broad membership participation in the process.

2.) Council Regional Meetings

To stimulate collaborative efforts between and among Catholic health entities and provide information to and feedback from Catholic Health Care Council members at a Diocesan or regional level.

3.) Committee Reorganization

To strengthen the present configuration of Council advisory committees by restructuring membership including:

a.) Restructuring the Executive Committee by replacing inactive members, and adding mission effectiveness coordinators, and representatives of sponsors and health systems;
b.) Restructure the Legislation and Regulation Committee by adding new members and add a charge to plan Albany lobbying visits;
c.) Disband the Communications Committee;
d.) Change the status of the Hospice Committee to an Ad Hoc Advisory Committee;
e.) Establish a Mental Health Directors Standing Committee;
f.) Establish a Standing Committee on Mission Effectiveness;
g.) Reconvene the Finance Directors Committee
h.) Create a subcommittee of the Executive Committee to perform the functions of the Planning Committee.

4.) Major Council Meetings

To provide opportunities for Council members to participate in group functions, including the Annual Members Meeting and an Annual Meeting with the Commissioner of Health.

5.) Major Council Communications

To inform and articulate Council activities, public policy comments, and the needs of the Church's health ministry in New York State through:

a.) Catholic Healthshare
b.) Executive Secretary's written reports
c.) President's Report
d.) Statistical Survey

6.) Council Structure

To examine issues related to membership, functioning and finances.

1994-1995 Objectives

The thrust of this planning initiative was fully recognized in the creation of Council Objectives for 1994-1995, as follows:

1.) Enhance advocacy and representation on public policy issues of concern to the Catholic health ministry in New York State, both within the Church and before public bodies;
2.) Assess Council membership meetings to maximize the best use of Council resources and current membership needs;
3.) Organize Council committees and advisory groups insuring effective operating and wide participation by Council members;
4.) Study current Council communications and upgrade Council efforts where possible;
5.) Encourage regional networking efforts between Catholic health care providers and other Church entities in the state.

iii.) Case Statement Follow-up

As previously reported, the major focus of the 1984 Annual Meeting had been presentations of Case Statements, which would serve to stimulate further discussion of the issues raised at individual institutions or Diocesan gatherings. It was reported in the previous Chapter that in 1984 subsequent to the Annual Meeting five Dioceses had held convenings on the case statements. The Executive Committee had asked that there be developed a survey of specifically what activities had been undertaken. Based upon this survey and the appointment of an Ad Hoc Task Force at the January 31, 1985 Executive Committee meeting to stimulate this effort, it was reported at the September 13, 1985 meeting, that follow-up sessions had been held or would soon be held in the Albany, Buffalo, Brooklyn and Rockville Centre Dioceses.

iv) Regionalization

The Executive Committee was to continue its focus on the need for regionalization of activity throughout the entire decade 1984-1994. Monsignor Bill presented a proposal to the Executive Committee at its March 23, 1985 meeting to fully develop a regionalized organizational structure over the next three-four years. At the May 20, 1985 meeting, it was reported that regional gatherings had been held in Brooklyn/Queens, the Hudson Valley area of the Archdiocese, and Albany. A further evolution of the concept occurred in late 1989 with the recommendation that each Diocese establish a Diocesan Commission on Health. In September 1990, it was reported that Buffalo, Albany and the Archdiocese had had gatherings around this possibility and that the Rockville Centre Diocese was about to establish such a Commission. On February 21, 1994, the Catholic Hospitals of New York came together for a

Networking Strategy Session. As previously reported, this continuing focus on regionalization was a priority in the 1984-1995 Council objectives.

v.) Mergers and Acquisitions

Already in this time period, there was beginning focus on what was to become a major issue in the late 1990's and into the new century. The past ten years had seen the evolution of numerous Catholic health care systems in the United States. In this time period and beyond, there would be focus on the continuing development of systems, as well as mergers and acquisitions in local communities. The Council helped its members by addressing those issues. At its September 13, 1989 meeting, the Executive Committee heard a report on a Catholic Health Association Conference on Mergers. The Council sponsored its own Conference on mergers, acquisitions and joint ventures on January 24, 1990, and later reviewed a memorandum of understanding on joint activities shared by Mercy Health Center and the House of the Good Samaritan Hospital in Watertown.

vi.) Other

Over this time period, there were other major areas addressed by the Executive Committee at one or more meetings. Included were:

1.) At its December 13, 1985 meeting, developing recommendations for appointments to health advisory bodies within the Cuomo administration;
2.) At its April 7, 1987 meeting, hearing a presentation from Dan Sisto, President of the Hospital Association of New York State, at which he addressed:

    a.) hospital reimbursement issues
    b.) clinic rate legislation
    c.) Medicaid income eligibility levels
    d.) rural health care concerns

3.) At its December 9, 1987 meeting, discussing issues relating to health care personnel and also head injury treatment;
4.) At its September 13, 1989 meeting, discussing problems with implementation of new Utilization Threshold regulations;
5.) At the same meeting, determining to undertake an inventory of existing Catholic alcohol and substance abuse treatment programs;
6.) At its September 26, 1990 meeting, discussing concerns about implementation of the new Nursing Home Code and rate methodology;
7.) At its January 3, 1992 meeting, suggesting that there be held a meeting of the 43 Catholic hospitals in the state to develop a common response to the requirement to develop Community Service Plans;
8.) On December 18, 1992, convening a session with the Catholic Health Association on the experience of developing Community Service Plans in New York State.
9.) At its meeting on November 3, 1993, the committee reviewed proposed surrogate decision-making legislation and a draft Catholic Conference statement on universal health care.

b. Working Committees

i.) Committee on Legislation and Regulation

The Predecessor of this working committee was the Legislative Task Force of the Council.

Illustrative of the work of the Legislative Task Force were recommendations emanating from its meetings on March 5, 1985 and October 13, 1985 which included:

March 5, 1985

1.) Continuation of bad debt and charity care;
2.) Need for guidelines for Determination of Death and Do Not Resuscitate orders;
3.) Enact malpractice insurance reform;
4.) Opposition to establishment of publicly traded hospitals and nursing homes in New York State.

October 13, 1985

1.) Opposition to allowing public traded corporations to establish health facilities in the state;
2.) Support for proposals for coverage of the medically indigent;
3.) Support for malpractice reform;
4.) Support for NYPHRM II;
5.) Support for adequate levels of payment for Alternate Care patients;
6.) Support for an increase in the Maternal and Child Health Block Grant
7.) Opposition to the deregulation of Diagnostic and Treatment Centers;
8.) Support for a $5 clinic rate increase;
9.) Support for increased authorization for Distressed Hospital Funds;
10.) Support for the Alcohol Rehabilitation Demonstration program;
11.) Support for funding for alternatives to hospitalization.

Other work of this Task Force is reflected in later sections in this Chapter on Annual Budget and Legislative recommendations.

The Legislation and Regulation Committee came into being on January 28, 1987 as part of the continuing effort to improve the functioning of the Council. From its inception it was the most important working committee of the Council. For its first several meetings, it was chaired by Sister Rene McNiff. When she assumed the position of Council President in 1988, the committee was chaired by Jerry Stewart from St. Clare's Hospital in Schenectady.

Over this time period, members included:

Thomas Chardavoyne, Emily Christi, Lawrence Cusiak, Timothy Finan, Sister Virginia Hanrahan, Dr. James McCormack, Diane McKenna, Sister Rene McNiff,

George Meitch, John Moraban, Sister Kevin Patricia, Joseph Pofit, Sister Mary Alice Roach, Sister DeChantel Row, William Smith, Arthur Sutton.

At this first meeting, Sister Rene discussed the charge to the committee that it provide a "working body" of comment and review of Council activities for the Executive Committee.

Following this overview, the committee heard a presentation from Pamela Rehak of the Assembly Ways and Means Committee on budget issues, from Darrell Jeffers of the Council on Health Care Financing on principles for reimbursement, from David Abernathy of the Department of Health who spoke about the proposed prenatal network, long term care insurance and graduate medical education, and from JoAnn Constantino of the Senate Health Committee on various prenatal care access bills.

At its meeting held on May 13, 1987, at the recommendation of the Legislation and Regulation Committee, the Executive Committee agreed:

1.) To support the proposal of the Council on Health Care Financing, regarding principles for reimbursement;
2.) To support various prenatal care initiatives;
3.) To continue to advocate for increased access to the Medicaid program;

At its meeting held on September 10, 1987, the committee:

1.) Asked the Catholic Conference to consider steps that would demonstrate the support of the Bishops for a suitable resolution to the Governor's veto of Hospital Reimbursement Legislation;
2.) Suggested changes to draft testimony to be given to the Department of Health Task Force on Health Revenue;
3.) Commented on draft 1987-88 Council plans and activities which would be presented to the Executive Committee in October;
4.) Commented on HANYS legislative priorities presented by Bob Murphy;
5.) Heard a presentation from Marilyn Desmond from the Department of Health on the Elderly Pharmaceutical Insurance Coverage (EPIC) program;
6.) Discussed code and governance issues with Tom Hartman from the Department of Health (see later discussion of section 405.2 regulations).

The committee addressed these issues at its December 2, 1987 meeting:

1.) <u>Legislative Concerns</u>
    a.) Hospital Reimbursement
    b.) Medicare Assignment
    c.) Health Care Proxy Legislation

2.) <u>Regulatory Concerns</u>
    a.) Hospital Governance
    b.) Head Injuries
    c.) Access for Medicaid Recipients

3.) Budget Concerns
   a.) Ways and Means Committee Testimony
   b.) Medicaid Eligibility
   c.) Health Care Personnel

At its meeting on November 16, 1988, the committee addressed these issues:

1.) Heard an update from Richard McDevitt on the state budget deficit;
2.) Heard a report on the report of the National Commission on Health Care Ministry;
3.) Reviewed testimony given by the Mercy Health System of Western New York before the Assembly Health Committee on November 3, 1988 in relation to the hospital occupancy crisis, recommending expansion of the RHCF capacity as part of the system;
4.) Heard a report from Tom Chardavoyne on creation of a Public Health Council subcommittee on enforcement (see later discussion of 405 issues);
5.) Heard a presentation from Margaret Sellers, health budget specialist for the Senate Finance Committee, on various fiscal issues.

At its meeting on June 22, 1989, the committee addressed these issues:

1.) Agreed that the Council should immediately create an ad hoc committee on finance consisting of six to eight finance staff members to advise the Council and prepare comments related to upcoming hearings on acute care reimbursement and to reissue a financial survey to assist its efforts;
2.) Recommended that there be convened meetings of Catholic sponsored Nursing School and Mental Health Program directors;
3.) Continued to monitor the Department of Health enforcement study;
4.) Expressed reservations about proposed legislation to establish life care communities;
5.) Met with Brian Hendricks, Department of Health, Gary Fitzgerald, Senate Finance and Sandra Mazlich, Assembly to address legislative and regulatory concerns.

At its meeting on September 7, 1989, the committee addressed the following issues:

1.) Heard a presentation from Nicholas Mongiardo on the newly created Division of Long Term Care within the Department of Health;
2.) Heard a presentation from James Donnelley, project director, Utilization Threshold Regulations, responding to various recommendations which the Catholic Conference had previously made;
3.) Heard a proposal from three Department of Health representatives on the Governor's UNY*CARE proposal;
4.) Responded to a request from Bishop Head for advice on the Catholic Conference position on the morning-after pill, and recommended opposition to its being made readily available.

At its meeting on December 7, 1989, the committee addressed these issues:

1.) State Issues
   a.) Governor's State of the State
   b.) Budget recommendations
   c.) Medicaid Threshold regulations
   d.) Medicare Part A "Carve out " and rate revisions
   e.) Nurse Aide Training Requirements
   f.) Organ Procurement Legislation
   g.) Public Policy Forum January 12, 1990
   h.) Medical Waste Requirements
   i.) Nursing Home Reserve Bed Requirements

2.) Federal Issues
   a.) Catastrophic coverage revisions
   b.) "Promise to Protect Medicare"
   c.) Upcoming Catholic Health Association meetings

3.) Council Plans and Activities-1990

With this meeting, the work of the Committee on Legislation and Regulation effectively came to an end for a time. It had been a very effective forum for raising issues during the tenure of Al Conway and Sister Rene.

Toward the end of this time period, the committee was revitalized and met again on February 23, 1994 to address budget issues.

ii.) Hospice Committee

Members:

Over this time period, members included:

Mimi Bacilek, Sister Delores Castellano, Kathleen Coffey, Mary Cooke, Kathleen Cregan, Jean Dennis, Patricia Farrington, Sister Annelle Fitzpatrick, Natalie Glass, Richard Herrmann, Sister Mary Louise Kelly, Jerry Martin, Paulette McDonald, Sister Patrice Murphy, Sister Margaret O'Bierne, Kathleen Perry, Francis Redding, Sister St. Gerard, Sister Margaret Tuley, Christopher Wurth.

From the earliest inception of the Hospice movement, the Council had been interested and concerned. Activities in relation to Hospice were reported in an earlier section of this Chapter.

In the first formal meeting, the Advisory Committee on Hospice Development held in early March 1987 at St. Vincent's Hospital in Manhattan, the committee recommended:

1.) Continuing discussion with the State Department of Health about the Conference proposal on "Future Hospice Development in New York State";

2.) Review of current regulation and the draft of the State Health Plan on Hospice;
3.) Continuing expansion of Hospice services including ways to separate Hospice services from present plans which limit the provision of Hospice services to certified providers.

At the May 13, 1987 Executive Committee meeting, it was agreed that the Conference should pursue a joint convening with the State Department of Health on Hospice development.

At its November 3, 1987 meeting, the committee:

1.) Made comments on the State Health Plan Hospice section, which were forwarded by letter to the Department ;
2.) Endorsed the Executive Committee decision to delay a future Hospice Conference because of lack of support for it by the State Hospice Association;
3.) Discussed the impact of AIDS on Hospice services.

On November 18, 1987, the Council sent a letter to the State Department of Health with concerns and suggestions about their proposed plan, and followed up with a meeting with Nancy Barhydt of Department of Health on April 4, 1988.

At its meeting on January 26, 1989, the committee adopted this Statement of Purpose.

1.) To provide the Catholic Health Care Council with commentary and recommendations on legislation and public policy as it pertains to Hospice services and the care of terminally ill patients and families;
2.) To develop networks between the Catholic health care community and those concerned with the care of the terminally ill for the purpose of advocating Hospice on a state and national level.

At this meeting, the committee agreed that its legislative priority at the federal level was a cost of living increase to the Medicare rate and at the state level to seek Hospice deficit funding legislation.

As a follow-up, the Council Executive Committee at its meeting on February 15, 1989 determined to expand the committee and develop a statement on Hospice Care.

Following another meeting with Nancy Barhydt, on April 11, 1989, Chris Wurth from St. Peter's in Albany, the Chairperson of the Hospice Committee, requested that the Council endorse the following recommendations relating to Hospice Medicare Legislation:

1.) Cost of Living Increase in Medicare rates retroactive to 1986;
2.) Allow certain expensive palliative services to be reimbursed outside the per diem rate;
3.) Include Hospice as a provider of the new 80 hour in-home respite benefit and establish a separate per hour payment for this benefit;

4.) Advocate that Medicare rates be the floor, not the ceiling for State's Medicaid rates.

At its meeting on April 27, 1989, the committee again made plans for November Hospice Recognition month and recommended that there be developed a brochure on Hospice services.

At its meeting on October 30, 1989, the committee addressed the following issues:

1.) Joint ventures
2.) Utilization thresholds
3.) The work of hospital ethics committees
4.) Federal budget issues
5.) Sabbath/Sunday activities (November 18-19)
6.) The State Hospice Deficiency Act

At its meeting on April 6, 1990, the committee addressed the following issues:

1.) Endorsed HR 3880
2.) Recommended expansion of Medicaid hospice benefit
3.) Asked that there be inclusion of a hospice-related item in the 1991 Catholic Conference legislative agenda.

Following this meeting, the committee experienced a hiatus in its activities.

On August 6, 1993, the Council endorsed S.5605 legislation to create a State Hospice Council.

iii.) Communications Committee

A continuing priority of the Council was to better inform member institutions and the Catholic community more generally about its work. To facilitate this effort, an Advisory Committee on Communications was first established on March 23, 1987.

Over this time period, members included:

James Bierfeldt, Thomas Chardavoyne, Frank DeRosa, Eric Feldman, Mary Jo Mitchell, Donald Molinelli, Donna O'Brien, Anne Pelino, Joan Waldrop.

At its first meeting, and a subsequent meeting on April 27, 1987, the committee addressed these issues:

1.) Recommended several ways that the upcoming meeting with the Commissioner of Health could produce positive publicity;
2.) Discussed ways the Council could forward opposition to legislation authorizing publicity traded corporations to do business in the state;
3.) Recommended that the Council develop a brochure and a digest or newsletter.

Following on a survey of member institutions during 1988 about available resources to assist in developing communications materials, through the generosity of St. Mary's Hospital in Amsterdam, the regular newsletter Catholic Healthshare was established in April 1989.

At its meeting on November 9, 1989, the committee addressed these issues relating to a communication plan for 1990:

1.) Catholic Hospital Sunday Designation
2.) Legislative Recognition
3.) Parish connections
4.) Public Service Announcements

At its meeting on March 22, 1990, the committee addressed these issues:

1.) Heard an update from Joan Waldrop on Catholic Healthshare;
2.) Reviewed a draft statement developed by the Hospice Committee for use in the Hospice Sunday/Sabbath effort in November;
3.) Suggested that there be publicity about maternal and child health efforts during October Respect Life month;
4.) Discussed other public information opportunities;
5.) Met with George Yamin, a communications specialist who had joined the Catholic Conference staff on a project basis.

The committee continued discussion of these priorities at its next meeting held on May 18, 1990.

With this session, and the focus of the Council under Peter Capobianco returning to the work of the Executive Committee, the activities of this committee came to a conclusion.

iv.) Ad Hoc Committees and Convenings

Throughout this decade, the Council from time to time established short-term ad hoc committees or convened various sub-groups constituencies. These activities included:

1.) The establishment in spring 1986 of an ad hoc Finance Committee to advise the Council on reimbursement legislation;
2.) The establishment in December 1988 of an Ad Hoc Planning Committee, comprised of Richard McDevitt, Patrick Madden, Daniel Kenny and Sister Mary Joel Schimscheimer to develop recommendations for short range 1989 Council planning and to begin preparations for a strategic planning process for the long term;
3.) A convening of the Mental Health Directors of Catholic Health care facilities on September 20, 1989 for a meeting with Commissioner Surles of the State Office of Mental Health to discuss the timetable for ARMS implementation, a "white paper" on OMH outpatient plans, and a Council of Catholic Charities Directors' paper on the future of residential services for mentally ill persons;

4.) The establishment of a Council Committee on Mission and Philosophy which first met on October 27, 1992. This committee was established as a result of the work of the Ad Hoc Planning Committee which had identified a need to strengthen bonds with religious sponsors and promote mission effectiveness integration throughout the Council structure;
5.) A convening of a Finance Directors meeting on June 7, 1993 to discuss issues of common concern.

v. Conclusion

The height of the committee era of the Council was the mid-to-late 1980's. With the Presidency of Peter Capobianco in 1990 and the hiring of John Kerry as Catholic Conference Director in 1991, the focus of the work of the Council shifted back to the Executive Committee, and also to increased advocacy with the legislature. At the end of this time period, there was discussion about reestablishing working Committees, particularly the Committee on Legislation and Regulation.

c. Annual Meetings

Regular parts of each Annual Meeting were the Annual Business Meeting the election of officers when necessary, an oral presentation of the President's report, and distribution of the written annual statistical report. Also during these meetings, the Council often conferred awards, both an award in honor of Monsignor James Fitzpatrick and also Catholic Health Leadership Awards.

Each year in this time period, the Council continued its practice of convening an Annual Meeting, commencing with the fifth Annual Meeting, as follows:

1985 Annual Meeting

Ministry, Medicine and Momentum

Date: June 28-29, 1985
Place: Sagamore, Lake George
Program:
- Father James Lloyd, Iona
  "The Occupation and Vocation of the Catholic Health Executive"
- Bishop Joseph Sullivan, Brooklyn
  "Catholic Hospitals: Strategy for Survival"
- Panel on Case Statement Implementation
- Panel on Role of Physicians in Catholic health care
- Panel on Multi-systems and their potential impact in New York State

Awards: Monsignor James Fitzpatrick Award – Senator Tarky Lombardi

1986 Annual Meeting

Competition, the Elderly and Ethics

Date: June 26-27, 1986
Place: Gideon Putnam Hotel, Saratoga

Program - Professor David Kinzer, Harvard
"Competition and Challenges to Survival of Non-Profits"
- Monsignor Alan Placa, Rockville Centre
"Corporate structure and Catholic identity in a changing environment"
- Father John Conner, S.J., Loyola-Chicago
"Moral Issues and the Elderly"
- Professor Bart Collopy, Fordham
"Social Aspects of Aging

Awards: Monsignor James Fitzpatrick Award – George Allen

1987 Annual Meeting (First for expanded Catholic Health Care Council)

Date: June 22-23, 1987
Location: Gideon Putnam Hotel, Saratoga
Program: - Daniel Russell, Executive Director, Eastern Mercy Health care Corporation
"The Need for Collaboration Among Catholic Health care Providers"
- Sister Elizabeth McMillian, Catholic Health Association
"Catholic Health Care Identity in a Time of Change"
- Regional Reports on Collaborative Efforts
- Diocesan Workshops-Collaboration and Integration

Awards: Monsignor James Fitzpatrick Award: Monsignor Edward Melton, Rockville Centre

1988 Annual Meeting

Ethics and Economics, Mission and Margin

Date: May 31-June 1, 1988
Location: Sagamore, Lake George
Program: - John Curley, President and CEO, Catholic Health Association
Keynote Speaker
- Dr. David Axelrod, Commissioner of Health
- Workshops
* Spirituality in Nursing
* Administrator as Minister
* National Trends in Care of the Elderly

Awards: Monsignor James Fitzpatrick Award: John Curley, CHA

1989 Annual Meeting

The Mission is Service, the Mission is People

Date: May 31-June 1, 1989
Location: Harrison Conference Center, Glencove, Long Island
Program: - Sister Helen Burns
"Report of U.S. Commission on Catholic Health Care Ministry"
- Father Russell Smith, Pope John XXIII Center
"Ethical Issues Affecting the Care of the Terminally Ill"

- William Cox, Catholic Health Association
  "Federal Issues"

Awards: Monsignor James Fitzpatrick Award: Monsignor James Cassidy, Archdiocese
Catholic Health Leadership Award: Jim Abbott, St. Joseph's Hospital, Syracuse

1990 Annual Meeting

Mission and Function: The Dynamic Team

Date: May 31-June 1, 1990
Location: Woodcliff Lodge, Rochester
Program:
- Patrick Philbin, Management Consultant, on Strategic Planning
- Father John Haughey, Georgetown, on Spirituality
- David Gould, United Hospital Fund, on Nursing Shortage
- Julie Trocchio, Catholic Health Association, on Federal Issues
- Nancy Healey, Catholic Charities, Rockville Centre, on Parish Nurse
- Eric Stonebill and Dick Chapman, Harris Beach Law Firm, on Legal Issues

Awards: Monsignor James Fitzpatrick Award: Sister Margaret Sullivan, St. Vincent's, Manhattan
Catholic Health Leadership Award: Sister Joseph Teusi, Cabrini, Manhattan

1991 Annual Meeting

"A Decade of Caring"

Date: September 19-20, 1991
Location: White Plains
Program:
- Father James Hug, Executive Director, Center for Concern
  "A Decade of Caring"
- Bishop Edward Head, Diocese of Buffalo
  "A Bishop's View of Health"

Awards: Monsignor James Fitzpatrick Award: Bishop Head

1992 Annual Meeting

Community, Commitment, Challenge

Date: November 12-13, 1992
Location: Holiday Inn, Binghamton
Programs:
- Bishop Thomas Costello, Syracuse
  " Community, Commitment, Challenge"
- Panel – National and State Health care Reform
- Dr. Mark Chassin, Health Commissioner

Awards: Monsignor James Fitzpatrick-Richard Herrman, Mercy Hospital, Rockville Centre
Catholic Health Leadership Award-Sister Sheila Marie Walton, Buffalo Mercy Hospital

1993 Annual Meeting

Reform and Reflection: Implications for Catholic Health Ministry

Date: October 7-8, 1993
Location: Niagara Falls
Program:
- "Implications of National Health Reform"
  * Sister Maryanna Coyle, Chairperson, Catholic Health Association
  * Ms. Patricia King, United States Catholic Conference
  * Mr. Tim Eckels, Catholic Health Association
- Mr. Philip Karp, Catholic Health Association
  "Integrated Delivery Networks"
- Father Joseph Kukura, Catholic Health Association
  "Ethical Issues Related to Integration"
- Bishop Joseph Sullivan
  "Universal Health Care"

Awards: Monsignor James Fitzpatrick Award: Sister Ellen Lawlor
Catholic Health Leadership Award: Mr. Albert Condino, Our Lady of Victory, Buffalo

1994 Annual Meeting

Implications of Health Care Reform and Managed Care for the Catholic Health Ministry

Date: October 20-22, 1994
Location: New York City
Program:
- Dr. Charles Daugherty, Creighton
  "Ethics and Managed Care"
- Dr. Kenneth Cummings, Kansas City
  "Physician Relationships"
- Mr. David Foshage, Daughters of Charity Health Care System
  "Networking and Managed Care"

Awards: Monsignor James Fitzpatrick Award: Monsignor James Murray, Catholic Charities, Archdiocese
Catholic Health Leadership Awards: Peter Capobianco, St. Mary's, Amsterdam, Sister Maureen Joyce, Catholic Charities Albany
Monsignor Alan Placa, Diocese of Rockville Centre

d. Annual Commissioner's Meeting

During the Carey administration, Catholic health care leadership had begun to meet regularly with leadership from The Department of Health. Initial sessions were held with Dr. Robert Whalen when he was Deputy Commissioner, and then when he became Commissioner. Relationships with his successor, Dr. David Axelrod were positive from

the beginning. Under the leadership of Dr. Kevin Cahill, it was Monsignor Charles Fahey and a Long Island Catholic layman Tom Dowling who interviewed him and recommended his hiring. Throughout his tenure, Dr. Axelrod was very close to Sister Serena Branson, Albany Diocesan Director of Catholic Charities. Throughout this period, Council leadership met regularly with Dr. Axelrod, then briefly after Dr. Axelrod's stroke, with Lorna McBarnette, Executive Deputy Commissioner and then in the early 1990's with new Health Commissioner Dr. Mark Chassin. This section chronicles those meetings.

It is interesting to note that a tone was given to these meetings early on when Richard McDevitt met on July 31, 1984 with Dr. James McCormack, Executive Director of the State Health Planning Commission. The issues discussed were Pastoral Care for the elderly and aging, stewardship and SPARKS, but Dr. McCormack's encouragement to the newly hired McDevitt was significant. He said:

> "The Bishops have clout".
> "You will have people's attention".
> "Government leaders respect the experience and expertise of Charles Tobin and Alan Davitt".

<u>Presentations at Dr. Axelrod Meeting – April 14, 1985</u>

- Impact of Proposed 1986 Reimbursement Process on Catholic Hospitals - George Meitch, Archdiocese
- Legislation - Thomas Chardavoyne, Catholic Medical Center of Brooklyn
  1.) Medicaid
  2.) Malpractice Reform
  3.) NYPHRM
  4.) Alternatives to abortion
  5.) Opposition to deregulation of Diagnostic and Treatment Centers
- MFP Development - Daniel Walsh, Good Samaritan Hospital, West Islip
- Special Catholic Programs and Services - Sister Mary Charles McCarthy, Benedictine Hospital, Kingston

This session was followed by a dinner and reception hosted by Albany Bishop Howard Hubbard.

<u>Presentations at Dr. Axelrod Meeting – April 8, 1986</u>

- Regulation Issues – Carolyn Scanlon, St. Peter's Hospital, Albany
- Confidentiality – Sister Angela Bon Tempo, St. Mary's Hospital, Troy
- Reimbursement Issues – Dan Rinaldi, Catholic Medical Center of Brooklyn
- Hospice Issues – Richard Herrman, Mercy Hospital, Rockville Centre

<u>Presentations at Dr. Axelrod Meeting – March 9, 1987</u>

- The Breadth and Significance of Catholic Health Care – Sister Angela Bon Tempo, St. Mary's Hospital, Troy
- Access to Health Insurance – Sister Virginia Hanrahan, Dominic Sisters Family Health Services

- Prenatal care issues – Dan Walsh, Good Samaritan Hospital, West Islip and Sister Ann Malloy, St. James Mercy Hospital, Hornell
- Nursing Shortage and Quality of Care – Jerome Stewart, St. Clare's Hospital, Schenectady

Presentations at Dr. Axelrod Meeting – Spring 1998

- Governance Issues – Anthony Maddalone, St. Peter's Hospital, Albany
- RUGS Reimbursement – Thomas Chardavoyne, Catholic Medical Center of Brooklyn/Queens
- Prenatal Care – Patricia Cahill, Alliance for Catholic health care, Archdiocese Health Care Proxy – Richard McDevitt.

Presentations at Commissioner Axelrod Meeting – April 1989

- Health Personnel and Nursing Schools – Sister Angela Bontempo, Sisters of Charity Hospital, Buffalo, Randy Starks, St. Clare's Hospital, Schenectady
- ALC and Long Term Care Policy Coordination – James Introne, Loretto, Syracuse
- Primary Care Initiatives – Peter Capobianco, St. Mary's Hospital, Amsterdam, Tom Hall, St. Mary's Hospital, Brooklyn
- Legislation, Budget and Regulatory Topics – Daniel Walsh, Good Samaritan Hospital, West Islip, Rose Hogan, Mercy Rehabilitation Center, Auburn

Presentations at Commissioner Axelrod Meeting – April 4, 1990

- Health care Management in New York State – Daniel Walsh, Good Samaritan Hospital, West Islip, Kenneth Knutsen, Good Samaritan Nursing Home
- Health Care Personnel Issues – Jerome Stewart, St. Clare's Hospital, Schenectady
- Access to Health Care – Patrick Madden, St. Mary's Hospital, Rochester

Presentations at Meeting with Acting Commissioner Lorna McBarrett – April 1991

Unfortunately in late 1990, Dr. Axelrod had suffered a severe stroke and became incapacitated. Governor Cuomo had appointed Executive Deputy Commissioner, Lorna McBarnette as Acting Commissioner. At the meeting held with her and her senior staff, Council presentations were made by Joseph Pofit of St. Peter's Hospital, Albany, Sister Luke Amoral of Madonna Residence in Brooklyn, Mark Ackerman of St. Vincent's Hospital in Manhattan and Thomas Chardavoyne of Catholic Medical Center of Brooklyn/Queens.

Presentation by John Kerry to Health Commissioner Nominee - Dr. Mark Chassin, October 4, 1991

At a meeting held with Health Commissioner Nominee Dr. Mark Chassin on October 4, 1991, Conference Executive Director John Kerry stressed the significant role Catholic health care played in New York State, and the long history of collaborative efforts between the state and Catholic health care providers and addressed several specific issues, including: early intervention care legislation, medical malpractice reform, school-

based health clinics, advanced directives, health personnel policies, and the Prenatal Care Assistance Program.

Presentation by Dr. Mark Classin at Annual Meeting – November 13, 1992

Newly appointed Health Commissioner Dr. Mark Chassin attended the Catholic Health care meeting in Binghamton on November 13, 1992, and made brief overview remarks about his work. At this same session, Dr. Axelrod was formally recognized by the Council for his many contributions to the state and to Catholic health care.

Presentations at Meeting with Commissioner Classin – April 12, 1994

The Council returned to its regular practice of meeting annually with the Commissioner of Health through a meeting held in Albany on April 12, 1994. The setting was somewhat more informal than in meetings held previously with Commissioner Axelrod. Issues addressed included: capital debt refinancing, nursing home rebasing, surrogate decision-making legislation, Article 28 governance survey recommendations, acute bed need methodology, school-based clinics, HIV new born testing and hospital case mix.

e. Relationship to Catholic Conference

i.) Introduction

Throughout its entire history an important part of the work of the Council was its participation in and influence on Catholic Conference activities. Just as the structure and functioning of the Council evolved over time, so did that of the Catholic Conference. In its inception, the Catholic Conference was run by Charles Tobin Sr., on a part-time basis from his law firm with part-time secretarial help. His son, Charles Tobin, Jr. continued the same approach. Alan Davitt was hired as the first full-time professional staff member of the Catholic Conference in 1968, assuming the position of Executive Secretary of the Council of Catholic School Superintendents. From the time he became Executive Director of the Catholic Conference in 1979, he began to broaden the focus of the work of the Catholic Conference. This broadening of approach was important because the focus of decision-making in state government was also broadening. Many of the mutual activities reported here came into being during Alan's tenure from 1979-1991. The work of the Conference was further transformed when John Kerry became Executive Director in 1991 and brought about a greater emphasis within the State Public Policy Committee and, Catholic Conference on work with the state legislature. This section traces the many areas of cooperative activity between the Council as constituent subgroup of the Catholic Conference itself from 1984-1994 roughly in chronological order.

The activities in this relationship can be described in two categories: ongoing activities including annual development of Conference legislature priorities, annual development of budget priorities, and testimony before Legislative and Executive bodies and other activities including presentations to government leadership, participation in Conference events and activities such as joint health convenings, Commission on the Elderly, AIDS Task Force, Congressional Delegation meetings and Ad Hoc Task Force on Medicaid and Communities of Religious Women. These are described in turn.

ii.) Catholic Conference Legislative Priorities

During the 1980's, the annual Catholic Conference Legislative Agenda and legislative advocacy became broader and more important. Examples of health care legislative priorities included:

1985 Legislative Priorities

1.) Maintain charity and uncompensated care funds in NYPHRM (NYPHRM I enacted January 1, 1983)
2.) Increase Medicaid income eligibility levels
3.) Provide funding for alternatives to abortion
4.) Increase ambulatory clinic rates
5.) Increase funding for alternate hospital care programs (chronic care management, long-term home health care)
6.) Increase funding for alcohol and substance abuse programs
7.) Increase funding for hospice care

1986 Legislative Priorities

1.) Enact malpractice insurance legislation
2.) Improve home care oversight
3.) Enact HYPHRM II
4.) Maintain uncompensated care funds
5.) Oppose publicly traded ownership
6.) Improve RUGS
7.) Establish DRG's for rural areas

1989 Legislative Priorities

1.) Oppose Medicaid funding of abortions
2.) Oppose Medicaid co-payment options
3.) Oppose hospital ownership by publicly traded corporations
4.) Endorse the concept of "uncoupling" Medicaid from other reimbursement rate setting
5.) Endorse the concept of a "provider regulatory protection act" to ensure sufficiency of state funds prior to implementation of new regulation
6.) Support the mandating of health insurance coverage for inpatient alcohol rehabilitation
7.) Support legislative restrictions on public smoking

1990 Legislative Priorities

1.) Support for health personnel activities
2.) Support for measures to increase quality health care for persons with AIDS
3.) Support for measures to increase access to health care
4.) Support for expanded primary care services
5.) Support for adequate hospital reimbursement legislation
6.) Support for various items of regulatory reform

7.) Oppose Medicaid funding for abortions
8.) Support expanded funding for Adolescent Pregnancy Prevention and Services programs
9.) Oppose health facility ownership by publicly traded corporations
10.) Support Task Force on Life and Law proposal on organ transplantation

1993 Legislative Priorities

1.) Develop New York State Universal Health Care Coverage Plan
2.) Implement adequate and comprehensive hospital reimbursement legislation
3.) Support creation for a Physically Impaired Infant Compensation Fund
4.) Renewal of Supplemental Low Income Prospective Payment Act (SLIPPA)
5.) Oppose Medicaid funding for abortions
6.) Oppose ownership of health facilities by publicly traded corporations
7.) Enact statewide community rating and open enrollment health insurance legislation
8.) Enact Medicaid repayment legislation

1994 Legislative Priorities

Ensuring access to adequate health care
1.) Enact legislation for universal access to necessary, equitable and ethical health care
2.) Provide funding for Maternity and Early Childhood Foundation
3.) Provide expanded primary health care services for children
4.) Create an Impaired Infant Compensation Fund

Providing Services for the frail and special population
1.) Provide expanded funding for AIDS services
2.) Enact Nursing Home Medicaid Rate Rebasing
3.) Guarantee access to appropriate long-term care
4.) Protect the ability of non-profits to provide service

1995 Legislative Agenda Priorities

Ensuring Access to Health Care
1.) Enact universal access
2.) Create Impaired Infant Compensation Fund
3.) Rebase Medicaid Nursing Home Rate
4.) Expand Medicaid presumptive eligibility
5.) Provide effective primary health care

Providing Services for the Frail and Special Needs
1.) Ensure access to long-term care
2.) Provide additional funds for services to mentally ill persons
3.) Expand funding for HIV/AIDS program

iii.) Catholic Conference Budget Letters

In similar fashion, the Catholic Conference became more sophisticated in developing annual budget letters sent to the Governor in December to give input to his work developing the Executive budget and sent to the legislature in March to provide input into their deliberations. Examples of recommendations from the Health Care Council included:

March 5, 1986 Budget Letter to Legislators

1.) Increase clinic rates and emergency room relief
2.) Raise Medicaid income eligibility levels to 100 percent of poverty level
3.) Utilize state funds to supplement federal Maternal and Child Health Block Grant
4.) Increase funding for home care program
5.) Increase funding for perinatal care

December 1988 Budget Letter to Governor

1.) Separate health care personnel labor relations costs from reimbursement rate
2.) Increase hospital ALC rates
3.) Increase home health care Medicaid rates

December 15, 1989 Budget Letter to Governor

1.) Expand access to health care for the uninsured
2.) Expand home-based family support programs for frail persons
3.) Increase Medicaid rates for outpatient hospital clinics
4.) Increase hospice home care rate

March 1990 Budget Letter to Legislature

1.) Oppose hospital capital payment cuts
2.) Oppose capping nursing home rates
3.) Oppose cutbacks in local assistance mental health funds
4.) Increase home health care training grants

March 1991 Budget Letter to Legislature

1.) Implement NYPHRM IV where practical and affordable
2.) Eliminate proposed "productivity" adjustments and permanent payment lag suggestions
3.) Recognize that nursing home payments are already capped at 5 percent in 1991
4.) Oppose Medicaid co-payment requirement
5.) Oppose managed care provisions that create a two-tiered health system
6.) Oppose increase of 14 percent on gross revenue assessment

March 1992 Budget Letter to Legislature

1.) Oppose Medicaid co-payment requirement
2.) Oppose Medicaid payment lags

3.) Oppose Nursing Home Reserve Bed Payment reduction
4.) Oppose increase in provider assessment

December 1992 Budget Letter to Governor

1.) Expand primary care development, especially for children
2.) Exclude from assessment revenues derived from investment income from charitable donations
3.) Eliminate Medicaid co-payments
4.) Establish an Office of Minority Affairs within the Department of Health
5.) Enhance support for public health prevention measures
6.) Increase funding for programs targeted at pregnant teenagers and women such as the Prenatal Care Assistance Program and the Maternity and Early Childhood Foundation

March 1993 Budget Letter to Legislature

1.) Oppose various hospital rate reduction and payment delay proposals
2.) Oppose various proposed cutbacks to home care and personal care
3.) Oppose various nursing home rate reduction and payment delay proposals
4.) Oppose Medicaid co-payment requirement

June 30 1993 Letter to Legislature on NYPHRM V

1.) Support primary care, with exception of objectionable services
2.) Continue uncompensated care and distressed hospital funds
3.) Continue Supplemental Low Income Patient Adjustment (SLIPA) funds
4.) Oppose reductions in reimbursements
5.) Support enhanced medical and professional health education training

December 1993 Budget Letter to Governor

1.) Expand primary care development, especially for children
2.) Exclude from assessment revenues derived from investment income from charitable contributions
3.) Eliminate Medicaid co-payments
4.) Establish an Office of Minority Affairs within the Department of Health
5.) Enhance support for public health prevention and treatment program
6.) Increase support for programs targeted at pregnant teenagers and women
7.) Develop education efforts directed to the public health consequences of violence and violence prevention
8.) Oppose Medicaid funding of abortions

December 15, 1993 Special Session Letter to Legislature

1.) Support two-year extension of NYPHRM V, with exclusion of school based health clinic objectionable services and elimination of expansion of Child Health Insurance Program upper age limit from 12 to 16
2.) Support Community Mental Health Reinvestment program
3.) Support expansion of CHIRP

March 1994 Budget Letter to Legislature

1.) Oppose limitation of Medicaid coverage for inpatient psychiatric services to 60 days
2.) Oppose reduction in emergency room services rates
3.) Oppose reduction in hospital capital payments
4.) Oppose limitation of ALC reimbursement to 15 days
5.) Oppose elimination of regional variations in bad debt and charity rates
6.) Oppose elimination of Wage Equalization Factors (WEF) for nursing homes
7.) Oppose change in basis for rate increase calculation for hospitals

iv.) Legislative Testimony

Yet another ongoing way in which the Health Care Council participated in and supported the work of the Catholic Conference was assisting in the development of and often delivering testimony before the Legislative and Executive Department. Examples of this activity included:

1.) Testimony given in September 1987 before the Health Department Task Force on Health Personnel.
2.) Testimony given on November 3, 1988 by the Mercy Health System of Western New York on the hospital occupancy crisis recommending expanding RCHF capacity.
3.) Testimony given on March 27, 1989 before the Assembly Republican Task Force on hospital costs by Robert J. Stanley, St. Agnes Hospital, White Plains.
4.) Testimony given on July 26, 1989 by Sister Dolores Castellano of Mercy Hospital in Rockville Centre before the Assembly Republican Task Force on Hospice Services for Children.
5.) Testimony given on September 20, 1989 by Dan Rinaldi of Catholic Medical Center of Brooklyn before the New York State Legislative Council on Health Care Financing.
6.) Testimony given before the Assembly Health Committee on January 11, 1990 by Tom Hall from St. Mary's Hospital in Brooklyn and Donna O'Brien from the Alliance for Catholic Health care in the Archdiocese on primary care.
7.) Testimony given on November 7, 1990 by Father Charles McCarron from Rockville Centre, before an Assembly Hearing on residential alternatives for people with AIDS.
8.) Testimony given on November 18, 1992 by John Kerry and Dan Rinaldi before the New York State Legislative Council on Health care Financing in which they stated:

"The present reimbursement system in the state is extremely complex and comprehensive. It is past the point of complexity. We must have a stable revenue base and a less complex system."

v.) Government Leadership Meetings

During this ten-year period, leaders from the Council were important participants in regular meetings with state government leadership. Such meetings were generally of two types: Catholic Conference meetings with the Governor, and meetings with

legislative leadership during the Catholic Conference Public Policy Forum which was instituted in 1986. Examples of such meetings included:

1.) During the meeting of Catholic Conference leadership with Governor Cuomo on November 19, 1984, on behalf of the Council, Sister Ellen Lawlor addressed these issues:
   a.) uncompensated care
   b.) hospice
   c.) alternate programs to hospitals
   d.) alcohol and substance abuse services
   e.) Governor's Life and Law Task Force
   f.) selective marketing
2.) For the leadership meeting with Speaker Stanley Frank and Senate Majority Leader Warren Anderson on March 5, 1985, health issues addressed were:
   a.) charity and bad debt
   b.) Medicaid eligibility levels
   c.) selective marketing
3.) At the Catholic Conference meeting with Governor Cuomo held on December 5, 1985, issues addressed were opposition to publicly-traded corporations establishing health care services in the state, malpractice insurance reform and support of hospice care.
4.) The health care agenda for meetings with legislative leaders at the 1988 Catholic Conference Public Policy Forum included:
   a.) Prenatal Care Assistance Program
   b.) AIDS
   c.) health personnel items
   d.) cost of implementing Part 405 code changes
   e.) release of hospital labor compensation funds
   f.) general health finance issues
5.) For the 1992 Public Policy Forum, health issues addressed included:
   a.) Early Care legislation and federal matching funds
   b.) compensation for physically impaired newborns
   c.) long-term care insurance

vi.) <u>Presentations to Bishops and Public Policy Committee</u>

Over this decade, leaders of the Catholic Health Care Council made two presentations to the Board of Bishops and two presentations to the State Catholic Conference Public Policy Committee.

<u>Presentation to Bishops' September 8, 1989</u>

Presenters were:

1.) Kevin Ryan, President; Our Lady of Mercy, Bronx, on the environment of health services in New York State for Catholic sponsored facilities and agencies.
2.) Sister Doris Angelica, a former Catholic Health Association employee, on the recent report of the National Commission on Health care Ministry entitled "Catholic Health Care Ministry: A New Vision for a New Century".
3.) Sister Sheila Walsh, from Mercy Hospital in Buffalo, on networking.

In addition to these presentations, the Health Care Council Executive Committee addressed recommendations to the Bishops at this meeting which included:

1.) to improve awareness of Catholic health care by upgrading the role of the Diocesan Coordinator of Health Affairs and establishing regular meetings
2.) to improve understanding of ethical issues by regular meetings
3.) to support leadership formation within Catholic health care
4.) to give priority to advocacy on health care issues

Presentation to Bishops on June 10, 1994

Presenters were:

1.) Bishop Joseph Sullivan, Brooklyn "Implications of National Health Reform for the Catholic Church in New York State"
2.) Patricia Cahill, Archdiocese of New York "Networking Experience and Sponsorship Consideration"
3.) Sister Maureen Joyce, Albany "A Local Diocesan Model of Collaboration: the Albany Integrated Delivery Network"
4.) Richard Barnes, Catholic Conference "Physician Assisted Suicide"

Special Issue Presentation, Public Policy Committee February 16, 1989

On behalf of the Health Care Council, Dr. Joseph Cimino, an experienced health care planner and administrator gave a presentation on "Demand and Access to Health in New York State"

Presentation to Public Policy Committee December 13, 1990

Council Chairperson Peter Capobianco made a presentation to the Public Policy Committee in which he made numerous recommendations about the proposed Catholic Conference brochure on health care proxy and also identified Health Care Council priorities for the coming year.

1.) implementation of NYPHRM IV
2.) state coverage of nursing home OBRA requirements
3.) broader access to health care
4.) regulatory reforms
5.) malpractice liability legislation

vii). Health Convenings

Nationally there had been much discussion of the need for greater collaboration between Catholic health care organizations and Catholic Charities organizations.

Against this background, the Conference established in the fall of 1984 a Health Convening Planning Committee comprised of Conference staff and leadership form the Hospital Council and Council of Catholic Charities Directors.

At its first meeting held on November 15, 1984, the Planning Committee recommended holding such a convening whose purpose would be:

"To foster an opportunity for interdisciplinary cooperation among the various Catholic agencies which are providing health care and related supportive services to elderly and disabled persons".

The Catholic Conference Health Convening was held in Syracuse on May 31, 1985. It featured keynote presentations by Monsignor Charles Fahey of the Third Age Center at Fordham on the Church and Frail Persons and by Sister Margaret John Kelly formerly of the Catholic Health Association, on collaborative ministry.

Workshops focused on:

1.) parish-based and community-based programs
2.) health care for persons with mental retardation and developmental disability
3.) Medicare and Medicaid
4.) Catholic Identity

In its last act, the Health Affairs Coordinating Committee described in the previous section (Sister Dorothy Burns, Richard Herrman, Sister Catherine Herron, Millie Shanley, Jim McCormack, Sister Margaret John Kelly, Vinnie DeFazio and Sister Rita Kerr) met on July 2, 1985 and recommended that each Diocese hold its own health convening. This group developed a blueprint for such convenings which was approved by the Public Committee on October 23, 1985.

This time period was "bookended" by such a collaborative meetings with the decision to hold a joint Catholic Health Care Council – Catholic Charities meeting in Albany on April 13, 1994. This session, again focused on collaboration, featured these presentations:

Patricia Cahill, Archdiocese of New York: "Motivation for Collaborative Church Efforts"
Michael Dowling, Governor's Office: "Health Reform in New York State"
Philip J. Karst and Father Joseph Kukura, Catholic Health Association: "Integrated Delivery Networks"
Bishop Joseph Sullivan: "Collaboration and Church Cultures"

Workshops enabled local representatives from each individual Diocese to come together to discuss collaborative processes at the local level.

Both of these events were preliminary state activities which prepared the way for participation in the more formal national New Covenant approach toward collaboration developed later in the 1990's.

viii.) Commission on the Elderly

Monsignor Charles Fahey had served as Diocesan Director of Catholic Charities in Syracuse from 1967-1979. During this time, he had fostered considerable interest among Catholic Charities organizations in services to older persons. During the late

1970's, there had been several calls for establishing a vehicle through which the Church could more comprehensively address issues relating to older persons. In 1979, Monsignor Fahey became Director of what he would name The Third Age Center at Fordham. From 1984-1986, established through a generous gift from George and Marie Doty, the New York State Catholic Conference Commission on Elderly became the vehicle through which the Catholic Conference would formally address such issues. Over this period of time, leaders in Catholic health care throughout the state were involved in activities which led to production of a Final Report and Parish Manual, which made multi-faceted recommendations for Church response to a growing elderly population.

ix.) AIDS Task Force

The Council participated in an Ad Hoc AIDS Committee established by the Conference, commenting particularly on proposed AIDS mandatory testing through a July 1991 memo, and also interacting with the State Department of Health on whether mandatory testing would be required in the PCAP program. (DOH was flexible on this matter) Also in August 1990, the Council assisted in development of a Memorandum of Understanding with the Department of Health on Standards of Care for AIDS patients in RCHF's.

x.) Congressional Delegation Meetings

The Council gave input to the Catholic Conference Congressional Delegation meetings:

1.) at March 19, 1986 meeting, Cardinal O'Connor addressed issues relating to capital reimbursement and tax-exempt bonds
2.) for the February 17, 1987 meeting, Ted Druhot from St. Vincent's was to address several federal issues, but the meeting was cancelled
3.) for the 1988 meeting, it was recommended that the Bishops address Medicare Reimbursement and Long Term Care issues
4.) at the November 1989 meeting, Bishop Sullivan addressed Medicare A cuts, capital costs and medical education costs
5.) for the 1990 meeting, the Council also recommended focus on tax-exempt bonds

xi.) Task Force on Medicaid and Communities of Religious Women

In March 1991, Monsignor Fahey wrote to ask Conference leadership to re-examine its approach to public benefits for religious communities. After intermittent discussion, the Council participated in the establishment in April 1994, of an Ad Hoc Committee on Medicaid eligibility for Communities of Religious Women. At the meeting of the Planning Committee held on September 7, 1994, plans were finalized for a seminar to be held early in 1995.

D. Influence on Public Policy

1.) Introduction

During this time, the Council and Conference were involved in advocacy on a series of major public policy issues. While some of these efforts have been referenced earlier in this Chapter, the focus here is on these efforts. Described in turn are issues in which the Council and Conference achieved major successes; major issues of ongoing concern; issues in which there was defense of the ability of Catholic health care to provide services and other various issues of concern.

2.) Major Accomplishments

During this time period, the Council and Conference enjoyed major accomplishments in relation to three public policy initiatives: establishment of the Adolescent Pregnancy Preventive Services Program, expansion of the Prenatal Care Assistance Program, and enactment of Health care Proxy Legislation.

a.) Adolescent Pregnancy Prevention Services

Early in the Cuomo administration, the Catholic Conference expressed grave concern that the Governor increased funding for Family Planning Services by $10 million. In response to this expression of concern, the Governor included in his 1985 budget a proposal for a new program Adolescent Pregnancy Preventive Services in the amount of $2 million. This program was consistent with Catholic social teaching and over the ensuing years would provide continuing funding for maternity and early childhood services.

b.) Prenatal Care Assistance Program

Since the Roe v Wade Supreme Court decision and the passage of legislation legalizing abortion in New York State in the early 1970's, there had basically been stalemate for 20 years between pro-choice and pro-life forces in New York State. The tensions which had existed surfaced again in debate in the late 1980's and early 1990's about proposals to extend income eligibility for the Prenatal Care Assistance Program. The issue was whether abortion services would be included in the expanded program. Significant Catholic Conference participation influenced this debate.

Within the context of the Governor's Decade of the Child initiative, and more general concern in the Cuomo administration about human services and health care, the Governor introduced a program bill in January 1988 to expand income eligibility limits in the Prenatal Care Assistance Program to 185 percent of the poverty level. Sensitive to the position of the Catholic Conference, the Governor excluded in his proposal provision of abortion services for the population whose income was 100 percent to 185 percent of poverty, although in the program as it had existed to date, these services were included. On February 8, 1988, Alan Davitt wrote to Director of State Operations Hank Dullea, asking him to thank the Governor for taking this approach. Later that same month, Conference lobbyist, Father Ken Doyle wrote to Gary Fitzgerald in Senate Finance asking him to

support the Governor's approach. In August, the Governor's office recognized that Catholic Conference support of this proposal had been helpful, but nonetheless the bill did not pass.

The Catholic Conference decided to ask the Governor to continue this approach in his 1989 program bill, despite significant Assembly opposition to the non-abortion approach. Meanwhile, there was debate within the Catholic Conference as to whether this proposal, even with provision of the opportunity to obtain abortion services would actually lead to an increase in abortions, with some staff citing relevant studies from other states, arguing that the availability of good prenatal services reduced incidence of abortions. In the end, this argument was rejected by the Public Policy Committee.

As debate continued, one interesting moment came when Father Doyle went to see Senator John Marchi, an intellectual leader of the Senate, to ask him to remain firm on the non-abortion provision. When asked how the session went, an advocate from another agency who had accompanied Father Doyle, indicated he thought things had gone along well, but he wasn't quite sure, because the entire meeting had been conducted in Italian.

With support from some advocacy groups who were usually opposed to the Catholic Conference position on abortion, the expansion of the Prenatal Care Assistance Program with the exclusion of abortion services was passed into law in 1989.

Immediately, pro-choice advocates brought suit on the constitutionality of exclusion of abortion services through the suit which came to be known as Hope v Perales. Both the lower court (in 1991) and the Appellate Division ruled that this legislation was indeed unconstitutional, but in 1997 the State Court of Appeals reversed that decision, and upheld the constitutionality of the law and the Catholic Conference position.

c.) Health Care Proxy

With increasing complexity of technology, and several landmark crises on decisions about the right to die, there was increasing recognition of the need to bring greater structure and rationality to this type of decision-making.

In 1987, the Governor's Task Force on Life and Law, whose creation had been applauded by the Health Care Council, brought forward so-called health care proxy legislation, to define the process through which a designated representative could make decisions for an incapacitated individual.

Tracy Miller, Executive Director of the Task Force first presented this proposed legislation to the Executive Committee at its meeting on October 8, 1987.

From its moral perspective of respect for life, the Catholic Conference would be heavily involved in discussion of this legislation for the next three years.

On February 4, 1988, Father Doyle testified on this proposed legislation before a joint meeting of the Senate and Assembly Heath Committee.

He indicated that a fundamental problem, which the Catholic Conference had with the bill, was its presumption of absolute patient autonomy about life and death decisions.

He suggested four amendments to the bill:

1.) "All such decisions shall be made in accordance with accepted medical practice."
2.) "Notwithstanding a health care proxy, nutrition and hydration shall always be provided to a patient, with the following exceptions: artificial nutrition and hydration may be withheld or withdrawn in the following circumstances:
   a.) when inevitable death is imminent, which for the purposes of this provision shall mean when death is expected, by reasonable medical judgment, within a few days, or
   b.) when the provision of artificial nutrition and hydration cannot be physically assimilated by the patient, or
   c.) when the burden of the provision of artificial nutrition and hydration itself shall outweigh its benefit, provided that the determination of burden shall refer to the provision itself and not to the quality of the continued life of the patient.

   Even in the exceptions listed in a.), b.), c.) artificial nutrition or hydration shall not be withheld or withdrawn if it is needed for comfort or for the relief of pain.

3.) Notwithstanding a health care proxy, life-sustaining treatment and artificial nutrition and hydration must be provided to a pregnant patient unless, to a reasonable degree of medical certainty, as certified on the patient's medical chart by the attending physician and an obstetrician who has examined the patient, such procedures will not maintain the patient in such a way as to permit the continuing development and live birth of the unborn child or will be physically harmful to the patient or prolong severe pain which cannot be alleviated by medication.

4.) When the application of a health care proxy requires an act or omission contrary to the moral/ethical principles of a health care provider at which the principal is a patient or resident, the institution shall have the right to allow for the transfer of the patient to another facility and shall incur no liability for its refusal to carry out the terms of the health care proxy, provided that the institution shall inform the proxy of its decision not to participate in such an act or omission.

Based upon amendments included in Governor's Program Bill #76 in 1989, the Public Policy committee adopted a position at its April 6, 1989 meeting of "no objection". Key issues discussed in regard to this bill continued to be institutional conscience language, inclusion of objective medical standards and provision of routine care and medical treatment.

On June 19, 1990, Alan Davitt wrote to Senator Ralph Marino, Chairman of the Rules Committee on A-7459-A Gottfried et al, Health Care Proxy.

He indicated that the Conference would not oppose the legislation provided that the following amendments were accepted:

1.) further amend institutional conscience protection to include policies based not only on religious beliefs but also on moral principles;
2.) extending conscience protection to individual providers;
3.) adding language with regard to transfer, that if the agent were unwilling or unable to do so, the institution may intervene to accomplish the transfer or seek judicial relief;
4.) better definition of the commencement of the agent's authorization;
5.) making clear limitations on the authority of the proxy.

In his concluding comments, Mr. Davitt indicated that the Conference wished "to enunciate its strong objection, not to the bill as such, but to the legal status quo already operative in New York State in which 'absolute' or 'unlimited' patient autonomy is preserved."

Amended health care proxy legislation was passed on June 1990. While not completely successful in attaining all its objectives, the Conference had exerted considerable influence on final language in the bill. The Conference then set about activities to educate Catholic providers and the Catholic community on its perspective on this legislation. In the fall of 1990, the Conference distributed a brochure on the health care proxy. At the February 7, 1991 Public Policy Committee meeting, at the recommendation of the Health Care Council Executive Committee, it was agreed to supplement the original brochure, in light of the just adopted federal patient self-determination act, by developing written institutional guidelines and organizing regional meetings of providers.

3.) Issues of Ongoing Concern

While these victories were achieved, the Conference continued to be involved in on-going dialogue and discussion about other issues of similar importance.

a.) Definition of Death

Following on numerous previous discussions about determination of death, at its January 24, 1985 meeting, the Public Policy committee heard presentations on Determination of Death by Thomas Ford, a Rockville Centre attorney, and Jerome Stewart, President of St. Clare's Hospital in Schenectady.

They indicated their belief that the recent New York State Court of Appeals decision on brain death was acceptable to providers, consistent with New York legal interpretations, and "not threatening to present Catholic medical or ethical practices."

It was mentioned that the Public Policy Committee had previously taken a positive position on the proposed determination of brain death.

In response to this presentation, Sister Ellen Lawlor asked that there be a canvas to ascertain how many facilities possessed guidelines on DNR and the Determination of Death and which ones utilized the Harvard Criteria.

On October 8, 1987, Tracy Miller from the Governor's Life and Law Task Force updated the Executive Committee on the following issues: Determination of Death, DNR orders, organ transplants, and the Health care Proxy.

b.) Surrogate Decision-Making

Following on passage of Health care Proxy legislation in 1990, the Task Force on Life and Law put forward so-called Surrogate Decision-Making legislation.

Monsignor Alan Placa from Rockville Centre gave a presentation about this proposed legislation at the annual meeting of the Bishops with their Public Policy Committee on June 8, 1992.

He began by indicating that the current status of the law was that, if a patient had not executed a Health Care Proxy, determinations about treatment (particularly about withholding or withdrawing "life sustaining treatment") had to be made by a court of competent jurisdiction which had to find that there was "clear and convincing evidence" of the patient's wishes concerning the treatment.

The purpose of the proposed legislation was to provide for a patient who had not executed a "Health Care Proxy", the appointment of a "surrogate decision-maker" who could make decisions about the patient's health care, including decisions about withholding or withdrawing "life sustaining treatment".

He identified four areas of critical importance to the Catholic Conference.

1.) How is "incapacity" determined"?
2.) Who will serve as surrogate?
3.) By what standard must the surrogate make decisions?
4.) Special standards for withdrawing/withholding Life-Sustaining Treatment.

Thus began discussion on important legislation which has lasted to the present day. The Catholic Conference has through all this time opposed this legislation while seeking to gain amendments to make the bill acceptable.

While most of the important developments would occur during the Pataki administration and are reported in the next Chapter, these further developments occurred during the Cuomo administration:

1.) On January 13, 1993, Bishop Howard Hubbard of Albany testified before the Assembly Health Committee, raising the following issues of concern about the proposed Surrogate Decision-Making legislation:
   a.) again, concern about the presumed "absolute autonomy" of the patient;
   b.) the proposed standard of judicial review;
   c.) the definitions of life-sustaining treatment;
   d.) the role of bio-ethics;
   e.) the definition of a health care professional
2.) At its meeting on February 24, 1993, the Health Care Council Executive Committee, in response to a request for input from the Catholic Conference, indicated that it was not ready to endorse the proposal and raised the following concerns:
   a.) the scope of surrogates as defined;
   b.) the treatment of chronically disabled in the end of life decision-making including non-incapacitated situations;
   c.) the definition of terminal illness;
   d.) the absence of hospice programs;
   e.) the role and function of ethics committees;
   f.) the ability to transfer patients in dispute situations;
3.) The Health Care Council made a presentation to the Public Policy Committee at its meeting on May 27, 1993, in which it indicated its recognition of the need for such legislation and support for the concept. It addressed seven continuing areas of concern:
   a.) scope of surrogates defined is too broad;
   b.) definition of terminal illness is imprecise;
   c.) role and function of ethics committees as described appears to raise issues about further litigation and compliance for some facilities;
   d.) hospice programs are not included;
   e.) the proposal to replace the "clear and convincing" standard with regard to life-sustaining treatment;
   f.) how to differentiate the treatment of chronically disabled in end-of-life decision-making situations;
   g.) possible disputes about transferring patients

4.) On April 6, 1994, John Kerry wrote to Senator Tully outlining twelve areas of concern about the bill, basically replicating and elaborating on the comments noted above. He suggested in his June 6, 1994 letter to the Governor specific proposed amendments to address those twelve concerns.

And so the discussion would continue.

C.) Federal Catastrophic Health Care Bill

One of the many on-going battles in the state between the Catholic Conference and pro-choice advocates in this time frame was over provision of Medicaid benefits including abortion to persons up to 100 percent of the poverty level. In New York State, benefits were provided only up to the income limits for the over-all program, generally about 85 percent of poverty.

With the passage of the Medicaid Infant Mortality Amendments as part of the federal catastrophic Health Care Bill PL 100-360, there was question as to whether New York State was required to implement coverage up to 100 percent, or whether this was an option. This decision was further complicated by state passage of Assemblyman Jim Tallon's Family Access bill which provided access to Medicaid of those up to 100 percent of the poverty level for families (but not single pregnant women).

On January 7, 1988, Father Doyle wrote to Senator Tarky Lombardi suggesting language to solve this dilemma. "Pregnant women shall be eligible for medical assistance for those pregnancy-related services during their pregnancies that are federally reimbursable under the Medicaid program."

In the end, this situation was resolved, when the State did enact enabling legislation to cover women up to 100 percent of poverty under Medicaid, but provided coverage excluding abortion services from 100 percent to 185 percent of poverty level under the Prenatal Care Assistance Program as previously discussed.

D.) Universal Access to Health Care

Because of increasing concern about rising health care costs and lack of coverage even in the business community, health care moved to the front of the national agenda in the late 1980's. In response, Governor Cuomo put forward his UNY*CARE proposal in 1989. This notion was also to become a main focus of the Clinton administration in its early years.

The Catholic Conference moved quickly to enter the national debate.

At its September 13, 1989 meeting, the Executive Committee heard a presentation from representatives of the Department of Health on the Governor's UNY*CARE proposal.

By June 1991, there was concern that there needed to be a more coordinated response within the Conference, especially between the Health Care Council and the Council of Catholic Charities Directors, toward advocacy on the UNY*CARE proposal.

These developments led to the decision in December 1992 to establish within the Conference a Universal Health care Task Force. The purposes of this study group were to:

1.) review and describe the environment of health policy within New York State, particularly in regard to medically underserved and uninsured population.
2.) formulate principles for legislation;
3.) comment on relevant state legislation;
4.) consider ways to disseminate information on this issue;
5.) consider recommendations for the Church and public bodies.

The first meeting of this Task Force was held on March 13, 1993 in Albany.

Members of the Task Force were:

Chairperson: Bishop Joseph Sullivan, Brooklyn

Archdiocese:

Mr. John DePierro, Sisters of Charity Heath System, Staten Island
Sister Louse Gurley, Benedictine Hospital, Kingston
Ms. Patricia Cahill, Alliance for Catholic Health Care
Mr. William Smith, Cabrini Nursing Home, Dobbs Ferry
Sister Virginia Hanrahan, Dominican Sisters Family Health Services
Mr. James Cameron, Kateri Residence, Manhattan

Albany

Mr. Jerome Stewart, St. Clare's Hospital, Schenectady
Ms. Mary Ellen Ladoucer, Human Life Coordinator
Dr. James McCormack

Brooklyn

Bishop Joseph Sullivan, Diocese
Ms. Mildred Shanley, Catholic Medical Center

Rockville Centre

Mr. Daniel McGowan, Catholic Charities
Mr. Daniel Walsh, Good Samaritan Hospital, West Islip

Syracuse

Sister Kathleen Natwin, Our Lady of Lourdes Hospital, Binghamton

At this session, the Task Force got itself organized and heard presentations from Dan Sisto of HANYS and Health Commissioner Dr. Mark Chassin. Dr. Chassin indicated that the state had decided to abandon its own proposals for universal access to health care, but rather would fold its work into the national effort.

At its April 1, 1993 meeting, the Task Force heard presentations from Commissioner Chassin, Patrick Madden, CEO of St. Mary's Hospital in Rochester, and Robert Veino from the Department of Health on ERISA issues.

At its May 6, 1993, the Task Force adopted the following set of undergirding principles:

1.) universal access
2.) concern for the poor
3.) respect for life and dignity
4.) comprehensive benefits
5.) pluralism
6.) equitable funding
7.) cost constraint
8.) quality

At its July 13, 1993 meeting, the Task Force agreed it was important to review its statement in the light of the recently released USCC statement on universal health care, and also discussed current NYPHRM proposals.

At its November 12, 1993 meeting, the Task Force heard again from Dan Sisto, reviewed its past statements, and developed comments on the Clinton Health Plan.

At its meeting on April 6, 1994, the Task Force heard presentations on the status of federal policy discussion from Patricia King from USCC and Ken Raske from the Greater New York Hospital Association, and finalized its recommendations on federal issues.

This action effectively brought to conclusion the work on the Task Force.

4.) Threats to Provision of Catholic Health care

While the Conference and Council were giving attention to these important matters of broad concern, in ever-increasing fashion during this time period they were forced to address threats to their ability to provide services consistent with Catholic ethical and religious beliefs

a.) Part 405 Governance Regulations/Passive Control

In spring 1987, the Statement Department of Health published proposed regulations following changes in federal requirements in fall 1986. The goal of the changes was to update the code and strengthen enforcement actions. The intent of the proposal was not to change the not-for-profit law for establishment situations. These were the comments made to the Health Care Council Committee on Legislation and Regulation at its meeting on September 10, 1987 by Thomas Hartman, Director of Standards Development Group for the State Department of Health.

Early review of these proposed Part 405.2 regulations on governance by Catholic Conference attorneys resulted in a determination that:

1.) the proposed regulations were inconsistent with New York statutes governing the responsibilities and liabilities of corporate directors;
2.) they were also inconsistent with current state public policy, as expressed by the Governor's Advisory Commission on Liability Insurance;
3.) they were inconsistent with the Department's Statement of Intent;
4.) they put forward standards which Directors could not possibly meet.

On October 21, 1987, Richard McDevitt presented testimony to the State Hospital Review and Planning Council Code Committee. He first asserted the Catholic Conference contention that the proposed regulations were inconsistent with existing not-for-profit law. He next outlined how canonical responsibilities were fulfilled in Catholic hospital governance. He then set forth the reasons that the proposed regulations would impair the ability of Catholic health care sponsors to meet their obligations under canon law.

On November 6, 1987, Catholic Conference representatives met with Department of Health officials to further discuss these proposed regulations. It was agreed that language in the proposed regulations relating to approval of by-laws would be removed. It was agreed that Monsignor Alesandro from Rockville Centre would help the Conference respond to a request to create a list of "minimal Canon law requirements".

On January 14, 1988, Alan Davitt wrote to Peter Millock, General Counsel to the Health Department, expressing opposition to the provision in the proposed regulations relating to by-laws approval, pointing out that it was not consistent with existing statutes.

On January 19, 1988, an Ad Hoc Governance Committee of the Health Care Council met in New York City. Present were Monsignor Jack Alesandro, Sister Mary McCaffrey, Mr. Robert Iseman, Ms. Patricia Cahill, Mr. Stuart Pearl and Mr. Richard McDevitt.

It was agreed that at the upcoming January 27, 1988 meeting of the Code Committee of the Hospital Review and Planning Committee, Monsignor Alesandro would present a "Principles of Canon Law" requirements statement, and Mr. Iseman would present the legal and operational aspects of the Catholic perspective. Key areas of concern were: approval of debt, approval of operating budgets and selection of CEO's.

Through the good work of this group, when the revised regulations were adopted, they generally enabled Catholic facilities to comply with Canon law requirements.

Richard McDevitt stated that this group provided brilliant legal and Canon law expertise that was timely and critical to one of the most significant public policy health regulatory achievements of the decade.

Following adoption, the Conference developed a memorandum of guidance which was distributed on September 3, 1988. It urged attention to the following matters:

1.) understand the extent and nature of a religious sponsor's Canonical obligations;
2.) examine certificate of incorporation and by-laws to determine whether any civil law responsibility is reserved to the sponsor;
3.) determine the civil law powers that should be reserved;
4.) determine the civil law authority that can be reserved by the sponsor without the sponsor's being deemed to be the "operator" of the hospital;
5.) develop a formal, written, approved statement of mission;
6.) determine the proper method for reserving the necessary civil law authority;
7.) determine whether the certificate or by-laws should expressly limit or, remove concurrent authority of the Board in areas reserved to members;
8.) determine to whom the civil law authority be reserved;
9.) determine how amendments to the certificate and by-laws can best be accomplished.

While this matter was resolved satisfactorily, the issue of governance was again raised in the Cuomo administration, this time under the concept of "passive control".

This new threat first surfaced through a memorandum submitted to the Establishment Council of the Public Health Council by Peter Millock on July 28, 1993. He raised the question as to whether the state's policy and process for establishment of hospitals was being undermined through the creation and exercise of "passive control" and also as to whether therefore the establishment process should be modified.

Following up this memorandum the Chairpersons of HANYS and the Hospital Trustees wrote on August 6, 1993 to Mort Hyman, Chairperson of the Public Health Council, asking for review of the entire establishment process, although advocating that the not-for-profit sector be enabled to continue to operate effectively and preserve their mission.

In response to this new threat, at its meeting on November 23, 1993, the Executive Committee approved use of Special Project Funds to hire Robert Iseman to help the Conference and Council respond to this threat.

On recommendation of a subcommittee of the Executive Committee convened to assure a coordinated response to a survey which the Public Health Council had determined to undertake to help it better understand the nature and extent of "passive control", Mr. Iseman wrote to all Catholic institutions on December 15, 1993 recommending that they make a good faith effort to comply with the request to complete the survey, based on a good faith interpretation of the survey, and without asking the Department of Health for further clarification.

This matter was to be continued over into the Pataki administration.

b.) <u>FRIA Litigation</u>

An advocacy organization in New York City, FRIA, brought suit against a nursing home charging that nursing homes excluded black and Hispanic patients in defiance of state and federal law.

A special task force organized to study this issue made recommendations in May 1985 requiring nursing homes to keep records of patients accepted or prohibiting discrimination in Medicaid admissions.

In response to the concern about possible impact on Catholic nursing homes, Charles Tobin researched the question and wrote to Alan Davitt on November 18, 1986 that under New York State law:

1.) an institution under religious auspices has the right to exercise preference in selecting persons of that faith;
2.) while an institution may give preference to Catholics, it may not discriminate among Catholic applicants, such as black Catholics, Spanish-speaking Catholics, etc.;

3.) such homes are not permitted to discriminate in any other manner.

c.) Doctors and Hospitals - Abortion

A second issue emanating from the code changes proposed in 1987 following 1986 changes in federal requirements related to conscience exemption for abortion. The proposed code deleted this conscience exemption and also immunity from liability for a physician who refused to give advice about abortions.

When challenged about these omissions, State Health Department indicated that the first omission was in error and would be restored. They indicated that the second deletion was recommended by family planning advocates who maintained recent case law had made this provision illegal. Upon further research, this provision too was restored.

d.) School Based Health Clinics

A continuing matter of controversy throughout this time period was a series of proposals to establish or expand school-based health clinics. While the Catholic Conference certainly supported expansion of primary health care services for children, it was concerned about the extension of reproductive health services including abortion.

Following a meeting with Jim Cultrara, staff to the Senate Education Committee, the Conference on November 25, 1991 recommended the following amendments to the Tully bill to bring it in life with USCC principles:

1.) exclude distribution of contraceptive devices and contraception and abortion counseling;
2.) provide autonomy to community advisory boards;
3.) mandate parental involvement and consent.

e.) Opposition to Publicly Traded Corporations

From both a moral perspective that health care is not a business commodity, but also a fundamental human right, and also from a quality of service perspective, the Catholic Conference consistently supported throughout this decade the continuing prohibition in New York State of health services by publicly traded stock corporations.

Richard McDevitt eloquently articulated this position in testimony given before the Code and Legislation Committee of the Public Health Council on July 26, 1985.

In May 1987 at a “roundtable” held in Albany, Mr. McDevitt represented the Council’s view that legislation to remove this prohibition was “unnecessary and without substantial benefit”.

Throughout this time frame, the Conference annually wrote letters to legislators expressing opposition to this type of bill.

5.) Other Public Policy Activities

Throughout this time frame, the Council and Conference also gave input into public policy discussions in a variety of ways. Examples included:

a.) Through a personal letter to Governor Cuomo on June 10, 1985, Cardinal O'Connor emphasized the need for the state to enact "effective and fair" medical malpractice insurance.
b.) At its May 13, 1987 meeting, the Executive Committee determined to express opposition to proposed prepaid health plans for home relief recipients, because of concerns about equity, quality, continuity of care, freedom of choice and incentives for potential providers.
c.) At this same meeting, the Committee agreed to comment on various bills relating to nursing education.
d.) In January 1990, Sister Angela Bontempo from Sisters Hospital in Buffalo, was appointed to the Public Health Council, and would become a voice for the Catholic Conference in that role.
e.) In June 1990, the Conference distributed information on use of "morning-after" pills in Catholic Hospitals, based upon a "consultation" with the Pope.
f) Working with Reverend Dan Hahn from the State Council of Churches in late 1990, Richard McDevitt played a key role in organizing a series of meetings for a Coalition of Interfaith Nursing Home Administrators, in recognition that religious sponsored long term care service providers for frail elderly were experiencing common signs of operational stress that threatened stability and future development. This group organized a Legislative Day on April 30, 1991.
g.) The Council obtained information in November 1991 from attorney Joe McGovern that interest income from donations could be excluded from gross revenue that was the basis of assessments.
h.) In the spring of 1994, Council representatives engaged in conversations with Department of Health legal staff abut the requirement in an appendix of standard contracts that there be no discrimination on the basis of sexual orientation.
i.) In what would become a major issue in ensuing years, the Conference distributed information on the Quill v Valco decision ruling against assisted suicide.

Chapter Five

The Pataki Administration

1995 – 2004

A. Introduction

A centerpiece of the administration of Governor Hugh Carey was its focus on health care. Top leadership on the Carey team were called upon to rationalize a delivery system which had expanded rapidly under Governor Nelson Rockefeller, to integrate still evolving Medicaid and Medicare programs, and to address allied issues relating to mental health, alcohol and substance abuse, etc.

While there were important developments in health care delivery during the Cuomo administration, such as initiation of the NYPHRM system, and the beginnings of Medicaid managed care, the focus of this administration was more on the human services delivery infrastructure.

With the election of Governor George Pataki in November 1994, for a variety of reasons, health care again became a major focus of the state administration. Indeed, within the first two months of the administration, Lieutenant Governor Betsy McCaughey released a report proposing dramatic reductions in the Medicaid program. Beginning with submission of an 1115 Medicaid waiver request to the federal government in March 1995, the expansion of Medicaid managed care was to have a dramatic impact on health care delivery in general and on Catholic participation in health care.

While the administration was focusing on these issues, opponents of Catholic health care in the public policy arena launched a series of initiatives which were designed to restrict Catholic participation in health care delivery unless Catholic providers were willing to compromise on basic ethical beliefs.

The Catholic Conference and health care providers responded aggressively to these challenges and opportunities.

While making these major efforts, Catholic Conference staff and Catholic health care leaders also addressed a series of internal organizational issues.

This organizational evolution is described first in this Chapter.

Then, the various ongoing activities of the Council are detailed.

The major portion of this Chapter, however, focuses on the very important public policy developments in the Pataki administration and the Church's response to them.

B. Internal Organization

During this ten-year period, there were four distinct phases in the organizational development of the Catholic Health Care Council, which are described in turn.

1. The End of the McDevitt Era, January 1995-June 1996

   a. Organizational Overview

   As described previously, Richard McDevitt had served as staff person to the Council since July 1984. During his tenure, the Council had gone through a series of organizational adjustments, partially in response to the hiring of John Kerry as Conference Executive Director in July 1991.

   This transition process for the Health Care Council effectively began at the February 1, 1995 Executive Committee meeting when a study group was appointed to review the structure and functioning of the Executive Committee. In August 1995, John Kerry requested that the Council adopt a By-Laws Amendment clarifying that the Executive Secretary of the Council work directly for the Conference Executive Director.

   During the spring of 1996, there was brief discussion of adding a financial analyst staff position to the Conference and Council. Richard McDevitt developed a draft job description, and there was even discussion about one possible candidate to fill such a position, but this notion was dropped with the reorganization of the Conference staff in September 1996.

   As part of this Conference staff reorganization process, Richard McDevitt was assigned other responsibilities and no longer had a primary role with the Health Care Council.

   For much of the 1996-1997 program year, the Council was without a primary staff person, although its work was supported by John Kerry, Richard Barnes and Richard McDevitt, as needed. In May, 1997 Martha Pofit was hired on a part-time basis. She had been serving as a Vice President at HANYS. She brought to the Council a keen analytical mind and a great organizational ability, together with her significant health policy experience. With her moving to a full-time status in the fall of 1997, the Council, which had been functioning at a minimal level in what was essentially a staff hiatus, was ready to function in re-energized fashion in the fall of 1997.

   b. Leadership

   Sr. Marie Castagnaro completed her two-year term as Council President with the completion of the Annual Meeting held in New York City on October 6-7, 1995. She was replaced by Jim Cameron, administrator of the Terrance Cardinal Cooke Health Center in New York City, who had been serving as Council Vice-Chairperson. He would steer the Council successfully through a difficult transition period. Dan Walsh was elected as Vice-Chairperson.

c. Membership

During this two-year period, Executive Committee members included:

Archdiocese
Ms. Mary Healey-Sedutto, Archdiocese
Ms. Joan Regan, Good Samaritan Hospital, Suffern
Mr. James Cameron, Terrence Cardinal Cooke Center, Manhattan

Albany
Mr. Jerome Stewart, St. Clare's Hospital, Schenectady
Mr. Peter Capobianco, St. Mary's Hospital, Amsterdam
Sr. Joseph Mary Brecanier, Teresian House, Albany

Brooklyn
Bishop Joseph Sullivan, Diocese
Sister Annelle Fitzpatrick, Catholic Medical Center
Sister Philip Ann Bowden, Ozanam Hall of Queens

Buffalo
Monsignor Henry Gugino, Catholic Charities
Ms. Carol Kennedy, Catholic Charities
Mr. Patrick White, St. Joseph's Hospital, Cheektowaga

Ogdensburg
Mr. Paul Scarpinato, Mercy Rehabilitation Center, Tupper Lake
Mr. William O'Rielly, St. Joseph's Nursing Home, Ogdensburg

Rochester
Sister Marie Castagnaro, St. Joseph's Hospital, Elmira
Mr. Paul Shepherd, St. James Mercy Hospital, Hornell

Rockville Centre
Monsignor Alan Placa, Diocese
Sister Agnes Stumpf, Nursing Sisters Home Visiting
Mr. Daniel Walsh, Good Samaritan Hospital, West Islip

Syracuse
Sister Rose Gleason, St. Elizabeth's Hospital, Utica
Mr. Terrence Gorman, St. Luke's Home, Oswego
Sister Eloise Emm, Diocese

2. Martha Pofit, July 1997 – June 1998

a. Organizational Overview

The structure of the Health Care Council during the 1997-1998 program year represented yet another approach to find an effective working model for the Council. Constructed in large part by Martha Pofit, who brought a working knowledge of the organizational structure of HANYS, this structure represented

an effort to be broadly inclusive not only of Dioceses, but also of individual institutions and Diocesan systems throughout the state.

The Executive Committee met four times during the 1997-1998 year.

As will be described later, it spawned the Task Force on Preservation of Catholic Health Care.

When Martha Pofit left her position with the Catholic Conference in June 1998, it was time to restructure again.

b. Leadership

Jim Cameron served as President until the October 16, 1997 Annual Meeting.

At that meeting, the following officers were elected for the 1997-1998 program year:

Chair: Mr. Daniel Walsh, Good Samaritan Hospital, West Islip
Vice-Chair: Dr. Karl Adler, St. Vincent's Hospital, New York
1st Vice-Chair: Mr. James Corrigan, Sisters of Charity Hospital, Buffalo
2nd Vice-Chair: Mr. William McGuire, Catholic Medical Center, Brooklyn
Secretary/Treasurer: Sister Maureen Joyce, Catholic Charities, Albany

c. Membership

Members of the Executive Committee were:

Archdiocese
Dr. Karl Adler, St. Vincent's Hospital, Manhattan
Mr. Frank Calamari, Calvary Hospital, Bronx
Mr. James Cameron, Cardinal Cooke Health Care Center, Manhattan
Mr. Tom Dee, Benedictine Hospital, Kingston
Mr. Brian Fitzsimmons, St. Vincent's Hospital, Harrison
Mr. Jeffrey Frerichs, Cabrini Medical Center, Manhattan
Sister Virginia Hanrahan, Dominican Sisters Family Health Services
Mr. Gary Horan, Our Lady of Mercy Medical Center, Manhattan
Mr. Paul Rosenfeld, St. Elizabeth Ann Nursing Home, Staten Island
Ms. Mary Healey-Sedutto, Archdiocese

Albany
Mr. Steven Boyle, Mercy Care, Albany
Sister Pauline Brecanier, Teresian Home, Albany
Mr. Edward Murphy, Seton Health System, Troy
Sister Maureen Joyce, Catholic Charities, Albany

Brooklyn
Sister Philip Ann Bowden, Ozanam Hall of Queens
Mr. William McGuire, Catholic Medical Center
Bishop Joseph Sullivan, Diocese
Mr. Mark Lane, Fidelis Care New York

Buffalo

Mr. James Corrigan, Sisters of Charity Hospital, Buffalo
Monsignor Henry Gugino, Catholic Charities
Ms. Carol Kennedy, Catholic Charities
Mr. Patrick Wiles, St. Joseph Hospital, Cheektowaga
Mr. Robert Stanek, Mercy Health System, Western NY

Ogdensburg

Mr. William O'Reilly, St. Joseph's Nursing Home, Ogdensburg
Mr. Paul Scarpinato, Mercy Rehabilitation Center, Tupper Lake

Rochester

Sister Marie Castagnaro, St. Joseph's Hospital, Elmira
Mr. Stewart Putnam, St. Mary's Hospital, Rochester
Mr. Paul Shepherd, St. James Mercy Hospital, Hornell

Rockville Centre

Monsignor Alan Placa, Diocese
Sister Agnes Stumpf, Nursing Sisters Home Visiting Service
Mr. Daniel Walsh, Good Samaritan Hospital, West Islip
Ms. Donna O'Brien, Catholic Health Network of Long Island

Syracuse

Sister Rose Vincent Gleason, St. Elizabeth's Hospital, Utica
Mr. Terrence Gorman, St. Luke's House, Oswego
Mr. Michael Guolby, Our Lady of Lourdes, Binghamton
Mr. Ted Pasinski, St. Joseph's Hospital, Syracuse

3. Ron Guglielmo – Transition Period, September 1998 – December 2000

a. Organizational Overview

Ron Guglielmo was hired by John Kerry as the Executive Secretary to the Catholic Health Care Council effective September 3, 1998.

He had most recently been a staff member of the New York State Council on Health Care Financing, with responsibilities for drafting and negotiating major health care reform and financing legislation. In addition to his expertise in health care and knowledge of the Albany scene, and his warm and engaging personality, Ron brought to the Conference much needed skill in information technology.

The structure of the Health Care Council during this time period was created in reaction to its organization during 1997-1998. It was felt that too much staff time had been required to sustain the large Executive Committee and then the Task Force on Preservation of Catholic Health Care.

Hence, it was determined that the work of the Council would be carried out through a series of Officers' Conference Calls. This was the modality of Council operation

from the fall of 1998 through the end of 2000. Throughout this time, the officers and staff considered a series of proposals for a revised structure of the Executive Committee.

In July 1999, consideration was given to creating also subcommittees on Policy Review, Long Term Care and Home Care, but no action was taken at that time. Also at this time, the By-Laws of the Council were suspended pending revision, and it was agreed that the Executive Committee would meet quarterly. The Executive Committee actually met only once during this time period, on April 27, 2000. In August, comments were solicited on a proposed plan of organization developed by Conference staff member Rick Barnes. Finally, on October 11, 2000, agreement was reached for restructuring the Executive Committee.

Based upon the recommendation of an ad hoc committee comprised of Dr. Karl Adler, Monsignor Alan Placa, Michael Costello, John Kerry, Richard Barnes and Ron Guglielmo, the Executive Committee adopted a new Statement of Organization replacing the By-Laws and incorporating the following substantive changes to the structure of the Council:

1.) Council membership would be explicitly extended to include the eight Dioceses, Fidelis Care of New York and related health care organizations.
2.) Standing committees of the Council, comprised of up to 10 members would be established for acute care, long-term care, continuing care, religious sponsorship and health education.
3.) The Executive Committee, then a 24 person body, would be replaced by a 15 member Executive Committee comprised of:
    a.) six representatives from the Standing Committees
    b.) eight Diocesan representatives
    c.) one Fidelis representative
4.) Two Executive Committee members would be elected by the Council members at the Annual Meeting to serve one-year terms for the offices of President and Vice-President.

b. Officers' Conference Calls

At the first Officer's Conference Call held on December 2, 1998, it was announced that Dan Walsh had accepted a new position and was resigning as Council Chairperson. He was replaced by Dr. Karl Adler, who would Chair the Council throughout this time period.

Participants in the regular Officers' Conference Calls during this time period were:

Archdiocese of New York
Dr. Karl Adler, St Vincent's Hospital, Manhattan
Ms. Mary Healey-Sedutto, Archdiocese
Mr. David Campbell, St. Vincent's Hospital, Manhattan
Sister Virginia Hanrahan, Dominican Sisters Family Health Care

Albany
Sister Maureen Joyce, Catholic Charities

Brooklyn
Bishop Joseph Sullivan, Diocese
Mr. William McGuire, Catholic Medical Center
Mr. Mark Lane, Fidelis

Buffalo
Mr. James Corrigan, Sisters' Hospital, Buffalo
Monsignor Henry Gugino, Catholic Charities

Ogdensburg
Mr. John Gray, Diocese
Monsignor Robert Lawler, Diocese
Mr. William O'Reilly, St. Joseph's Nursing Home, Ogdensburg

Rochester
Mr. Jack Balinsky, Catholic Charities

Rockville Centre
Monsignor Alan Placa, Diocese
Mr. Ron Aldrich, Catholic Health Care System of Long Island

Syracuse
Father Bob Stephenson, Catholic Charities
Mr. Dennis Manning, Catholic Charities

c. Executive Committee Membership

Membership of the Executive Committee at the meeting held on April 21, 2000 was the same as that listed in the previous section with these exceptions:

The new officers were:

Chair: Dr. Karl Adler, St. Vincent's, Manhattan
Vice-Chair: Mr. James Corrigan, Catholic Health System, Buffalo
1st Vice-Chair: Mr. Ron Aldrich, Catholic Health Services of Long Island

Albany:
Dr. Mark Donovan had replaced
Mr. Edward Murphy at Seton Health System, Troy

Brooklyn:
Mr. William McGuire had left the Committee

Buffalo:
Mr. Dale St. Arnold of the Catholic System joined the Committee
Ms. Carol Kennedy, and Mr. Robert Stanek had resigned from the Committee

Ogdensburg:
Mr. Paul Scarpinato had resigned from the Committee

Rochester:

Mr. William Connors had replaced Mr. Paul Shepherd at St. James Mercy Hospital, Hornell

Mr. Stewart Putnam had resigned from the Committee

Rockville Centre:

Mr. Ron Aldrich of Catholic Health Services of Long Island had joined the Committee

Mr. Keith Kurtland had replaced Sister Agnes Stumpf of Nursing Sisters of Home Visiting Services

Mr. Daniel Walsh had resigned from the Committee

Syracuse:

Mr. John O'Neill had replaced Mr. Michael Goulby at Our Lady of Lourdes Hospital in Binghamton

4. Ron Guglielmo-The Revitalized Council, January 1, 2001 – December 2004

a. Organizational Overview

Following on the approval in October 2000 for restructuring of the Executive committee and for the establishment of subcommittees, the Council settled into what would be its organizational mode for the next four years.

Basically, the Council functioned through what was termed Leaders' Conference Calls. Those on the calls resembled closely what was envisioned as the Executive Committee. For the first part of 2001, conference calls were held on a monthly basis. In the summer of 2001 it was agreed that the monthly calls would continue during the legislative session, but for the remainder of the year, calls would be organized as needed.

For the first four months of 2001, a major focus of the conference calls was working on the establishment of subcommittees. By April, members had been recruited for three such committees: a Continuing Care Committee, a Long Term Care Committee and, a Religious Sponsorship Committee.

Despite this new energy for a subcommittee structure, however, the committees really never took hold. The reasons were several. It was hard to develop a specific focused agenda. Since the health care institutions were independent entities, and usually not associated with Dioceses, there wasn't the tradition of collegial participation which helped undergird the work of other Conference constituent groups. Continuing financial pressures cut down on the ability of representatives to travel to meetings. For all these reasons, Ron Guglielmo took the approach that he would discuss specific matters as those arose with appropriate ad hoc groups, and that he would assure various constituencies were represented on the Leaders' Conference Calls. Thus, it was really those calls that were at the heart of the functioning of the Council.

Another important factor in the work of the Council was a change in Catholic Conference leadership. John Kerry resigned as Executive Director in August 2001. Richard Barnes, who had been serving as Counsel, was appointed as interim Director and then as permanent Director in January 2002. Having been the author of the revised plan of organization, he was most familiar with and supportive of the work of the Council.

b. Leadership

As specified in the statement of organization adopted in October 2000, each year all the members of the Council would elect at the Annual Meeting a Council President and Vice-President.

At the October 2000 Annual Meeting, Dr. Karl Adler was elected as President and Mr. Tom Dee was elected as Vice-President. Dr. Adler had been serving as Council leader for several years and would continue his significant involvement even with a change in his responsibilities within the Archdiocese of New York. Tom Dee was President of Benedictine Hospital in Kingston and would become a central figure in bringing continuity to the work of the Council over the next four years.

In mid 2001, Ron Aldrich, who had recently been appointed as President of Catholic Health Services of Long Island took over as President and would serve a two year term in that role, with Tom Dee continuing as Vice-President. Ron brought a wealth of experience, and warm, gracious leadership to the Council on the State Catholic Conference Public Policy Committee.

Tom Dee stepped into the Presidency in the fall of 2003 and agreed to serve as President also for 2004-2005, while also representing the Council on the State Catholic Conference Public Policy Committee. Marianne Gillen, an effective advocate for hospice care, was elected Council Vice-President for 2003-2004. Sister Jane Iannucelli from the Archdiocese was elected Vice President for 2004-2005.

c. Participants in Leaders' Conference Calls

During this four-year period, participants in Leaders' Conference Calls included:

Archdiocese of New York
Dr. Karl Adler, Archdiocese
Mr. David Campbell, St. Vincent's Hospital, Manhattan
Mr. Mark Ackerman, St. Vincent's Hospital, Manhattan
Ms. Mary Healey-Sedutto, Archdiocese
Mr. Tom Dee, Benedictine Hospital, Kingston
Sister Virginia Hanrahan, Dominican Sister Family Health Services
Mr. Jim Cameron, Catholic Healthcare System (2003)
Sister Mary Kevin Phillips, St. Vincent's, Manhattan (2003)
Sister Jane Iannucelli, Sisters of Charity Center, Bronx (2003)
Monsignor Harry Barrett, NY Medical College (2004)

Albany
Sister Maureen Joyce, Catholic Charities

Brooklyn
Bishop Joseph Sullivan, Diocese

Buffalo
Mr. Dale St. Arnold, Catholic Health System
Monsignor Henry Gugino, Catholic Charities
Monsignor Robert Zapfel, Diocese (2002)
Sister Sally Maloney, Catholic Health System (2003)
Sister Peggy Gorman, Catholic Health System (2004)

Ogdensburg
Monsignor Robert Lawler, Diocese
Mr. William O'Rielly, St. Joseph's Nursing Home, Ogdensburg
Mr. Andy Peterson, St. Joseph's Nursing Home, Ogdensburg (2004)

Rochester
Mr. Jack Balinsky, Catholic Charities

Rockville Centre
Mr. Ron Aldrich, Catholic Health Services, Long Island
Monsignor Alan Placa, Diocese
Ms. Marianne Gillen, Catholic Health Services, Long Island
Monsignor Dennis Regan, Catholic Health Services (2003)
Mr. Pat Scollard, Catholic Health Services of Long Island (2003)

Syracuse
Mr. Dennis Manning, Catholic Charities
Mr. Matt Babcock, St. Elizabeth's Hospital, Utica (2004)

Fidelis
Mr. Mark Lane, President and CEO

C. Ongoing Activities

1. Annual Membership Meetings

1995 Annual Meeting

Date: October 6-6, 1995
Location: Grand Hyatt Hotel, New York
Speakers: Health Commissioner, Dr. Barbara DeBuono
"Managed Care in New York State"
▪Panel on Regional Networks
Dr. Mary Healey-Sedutto, Archdiocese
Monsignor Alan Placa, Rockville Centre
Mr. Peter Capobianco, St. Mary's Hospital, Amsterdam
▪Panel on Ethical Issues
Sister Margaret John Kelly, St. John's University
Mr. Gary Horan, Our Lady of Mercy Hospital, Manhattan

Father Germaine Kopaceyncki, Pope John XXIII Center

Awards: Monsignor James Fitzpatrick Memorial Award: Sister Margaret John Kelly
Catholic Health Leadership Award: John DePierro, Sisters Hospital, Buffalo

Note: Conference participants joined in the celebration of the liturgy
By Pope John Paul in Central Park

1996 Annual Meeting "Ethics of Managed Care"

Date: September 24-26, 1996
Location: Otesaga Hotel, Cooperstown
Speakers: Sister Carol Taylor, Holy Family College
Mr. Peter Maddox – Incarnate Word Health System
Bishop Joseph Sullivan, Brooklyn
Ms. Mary Healey-Sedutto, Archdiocese
Monsignor Alan Placa, Rockville Centre
Mr. Mark Lane, Fidelis
Awards: Monsignor James Fitzpatrick Award: Sister Marie Castagnaro, St. Joseph's Hospital, Elmira
Catholic Health Leadership Award: Mr. Richard McDevitt

1997Annual Meeting

Date: October 16, 1997 (held in conjunction with HANYS Annual Meeting)
Location: Sagamore Hotel, Bolton Landing
Speakers:
- New York State Catholic Conference Legislative Agenda
  John Kerry
  Kathy Gallagher
  Martha Pofit
- Catholic Health Association and Federal Advocacy
  Bill Cox
- Building a Network, CHC - Archdiocese
- Fidelis – Mark Lane

Note: Following this session, it was agreed that it was not a good idea to combine this session with the HANYS Annual Meeting, because attendance suffered.

1998 Annual Meeting Horizon 99 – The Future of Catholic Health Care

Date: November 12, 1998
Location: Crown Plaza Hotel, LaGuardia, New York
Speakers:
- Father Michael Place, President, Catholic Health Association
- Task Force on Preservation of Catholic Health Care
  Mr. Daniel Walsh, Chairperson, Catholic Health Care Council
  Ms. Mary Healey-Sedutto, Archdiocese
- Public Relations Strategy
  Mr. Joe Zwilling, Archdiocese
  Representative of the Weiser Group

Note: A follow-up meeting for those from upstate unable to attend this Session was held in Rochester on December 15, 1998

1999 Annual Meeting "Continuing the Health Care Mission"

Date: June 3, 1999
Location: The Immaculate Conception Center, Douglaston
Speakers:
- Keynote Address: "Continuing the Catholic Health Care Mission"
  Bishop Joseph Sullivan, Brooklyn
- Discussion of Recent Activity
  Panel on mergers, acquisitions
  Panel on uninsured
  Monsignor Alan Placa, legislation and regulation
- Panel discussion on Health Care Reform Act
  moderated by Dr. Karl Adler

Note: At this meeting, Council By-Laws were suspended pending restructuring

2000 Annual Meeting "From Continuums of Care to Continuums of Service"

Date: October 11, 2000
Location: Sagamore Hotel, Bolton Landing
Speakers:
- Dr. Karl Adler – Presidents' Report
  Weiser Media Kit
  Executive Committee Restructuring
  Proposal to Establish Committees
  Legislation and Regulation
- Presentation by Mr. John Kerry
- Presentation by Dr. Michael Brescia, Calvary Hospital
  "Palliative Care"
- Presentations on Continuums of Service
  Mr. Brian Mulligan, Dr. Anthony Lechich, New York
  Mr. Dennis Manning, Syracuse
  Dr. James McCormack, Albany
  Ms. Nancy Simmons, Rockville Centre

2001 Annual Meeting Joint Session with the State Council of Catholic Charities Directors

Date: October 22-23, 2001
Location: Holiday Inn, Utica
Speakers:
- Keynote Speaker
  Father Kevin O'Rourke, Center for Ethics and Public Policy,
  Loyola University, Chicago
- Father Michael Place, Catholic Health Association
- Bishop Joseph Sullivan, The New Covenant
- Panel on aftermath of 9/11
- Presentations on Collaboration
- Sister Anne Bryan Smollin

Note: As a follow-up to this session, there was held an "Affinity Meeting" of New York State health care leaders and Catholic Charities leaders held in Chicago on August 2, 2002 as part of the joint CHA-CCUSA Annual meeting. The topic was assisted living. There were also discussions about a joint

meeting in fall 2002 of health care, charities and education leaders, but that meeting did not occur.

2002 Annual Meeting Ministry to the Uninsured

Date: October 27-28, 2002
Location: Otesaga Hotel, Cooperstown
Speakers: Mr. Bruce Vladeck, HCFA
Mr. Michael Rodgers, Catholic Health Association
Mr. Ray Sweeney, HANYS
Ms. Rima Cohen, GNYHA
Mr. Dan Rinaldi, Benedictine Hospital
Monsignor Dennis Regan, Diocese of Rockville Centre
Monsignor Charles Fahey, Fordham
Mr. Ron Aldrich, Council President

2003 Annual Meeting Planning to Access and Meet Community Needs

Date: September 22-23, 2003
Location: Otesaga Hotel, Cooperstown
Speakers: Mr. Jim Tallon – United Hospital Fund
Panel: Practice Considerations in the Planning Process
Panel: Collaboration on Rehabilitation
Panel: Providing Resources to Meet Community Needs
Mr. Michael Costello: Albany Catholic Charities, et al, V. Serio
Bishop Joseph Sullivan
Senator Ray Meier: Senate Medicaid Reform Task Force

2004 Annual Meeting

Because participation had been quite low at the previous two annual meetings, Council leadership decided not to hold an Annual Meeting in 2004 and to study the best way of bringing the membership together. Issues were travel cost in tight fiscal times, continuing emergence and expansion of health systems and their impact on available time, the continuing participation by many Catholic institutions in HANYS, and continuing participation in Catholic Health Association activities.

2. Annual Commissioner's Meeting

As previously reported, during the Cuomo administration, leadership from the Catholic Health Care Council had met annually with Health Commissioners Axelrod and Chassin.

While there was interaction between the Health Care Council and top leadership in the Department of Health during this time period, it was not as regular as it had been during the Cuomo administration.

In early May 1995, John Kerry sent a letter to newly appointed Health Commissioner Dr. Barbara DeBuono, setting forth recommendations for nominations to the State Hospital Review and Planning Council and the Public Health Council. At that same time, Richard

McDevitt had a meeting with new Executive Deputy Commissioner Karen Schimke to apprise her of the presence of Catholic health care services in New York State.

The Executive Committee first met with Commissioner DeBuono and her leadership staff in Albany on August 30, 1995. Presentations were made on the following issues:

1.) Publicly traded for-profit ownership of health facilities in New York State;
2.) Long term care reimbursement;
3.) NYS Medicaid Managed Care Policy
4.) Regulatory reform in NYS.

Commissioner DeBuono made a presentation on Medicaid Managed Care at the 1995 Annual Meeting held in Cooperstown on October 6, 1995.

As described below, throughout the remainder of the 1990's, there were numerous interactions with Health Department leadership on issues relating to Medicaid Managed Care, governance, definition of death, etc., but there were no formal meetings.

On June 10, 1999, the Catholic Conference sent a letter to the Senate in support of the nomination of Dr. Antonia Novello as the Health Commissioner, which addressed some apparent misconceptions by others of her position on various life issues.

Meetings scheduled with the new Commissioner for November 12, 1999 and February 18, 2000 were postponed because of conflicts in her schedule.

Finally, the Executive Committee was able to meet with Commissioner Novello on May 11, 2000. These matters were discussed:

1.) Emergency Rape Services and Conscience Protection Legislation;
2.) Medicaid Managed Care rates;
3.) Labor shortage issues;
4.) Opposition to establishment of for-profit health care services in the state;
5.) Various other legislative and regulatory issues.

While there continued to be much contact with the Governor's office, the Commissioner's office and top leadership within the Department of Health, there were no more formal Commissioners's meetings.

3. Budget Advocacy

Throughout this time period, the Council gave great priority to budget advocacy.

1995

Internal conference memos and the Conference Budget letter show that the major Conference budget priorities for 1995 were:

1.) Opposition to proposed Medicaid reductions;
2.) Managed care issues;
3.) Impaired Infant Compensation Fund

These specifics were detailed in the April 11, 1995 Catholic Conference budget letter to the Legislature:

1.) Hospital Restorations
   - the trend factor
   - NYPHRM base enhancements
   - primary care enhancements
   - psychiatric and substance abuse patient days
   - aid to distressed hospitals
2.) Nursing Home Restorations
   - nursing home trend factors
   - the over 300-bed adjustment
   - health personnel adjustments
   - adult day care
   - lift the moratorium on nursing home bed construction
   - separate grouping for the indirect cost component of hospital based nursing homes
   - 1989 nurse salary adjustment for nursing homes
   - grants for health personnel recruitment and retention
3.) Other Long Term Care Program Restoration
   - health care trend factor for home health care and personal care
   - long term home health care
   - assisted living programs
   - uncompensated care payments to home health care agencies
   - adult dental care

1996

As outlined in a January 8, 1996 memorandum from Richard McDevitt to John Kerry, key health care concerns in the Governor's proposed budget were:
1.) $800 million in provider reimbursement reductions for hospitals;
2.) $650 million in nursing home rate reductions;
3.) $420 million Medicaid funds reductions for home care;
4.) a proposed reduction of $163.5 million in hospital bad debt and charity pool funds;
5.) proposed Block Grants for Indigent Medical Care and community long term care programs;
6.) reductions of $183.2 million in medical education payments.

During the spring of 1996, Governor Pataki introduced sweeping legislation – the Health Care Reform Act (HCRA), which basically moved the state from a fixed rate to negotiated rate system. On June 20, 1996, the Executive Committee adopted the following recommendations on HCRA:

1.) Continue all payor add-ons for uncompensated care pools and medical education at their current level.
2.) Remove the 9 percent assessment for hospitals and for public goods finance.
3.) Demonstrate a strong state commitment to Medicaid as a reliable payment source.
4.) Maintain the capital pass-thru rules for Medicaid reimbursement and permit transition to charges in capital finance for other payors.

5.) Oppose the Home Relief Block Grant; limited demonstration programs may be acceptable.
6.) Continue support for SLIPA funds.
7. CON reform is desirable with some qualification about eliminating public need and capital financing rules.
8. Support inclusion of integrated delivery provider networks.
9. Amend relevant sections concerning institutional and health plan conscience protections for religious sponsored centers.

1997

On January 30, 1997, Monsignor Alan Placa of Rockville Centre testified before the Joint Fiscal Committees on the Governor's proposed Medicaid budget.

Monsignor Placa expressed grave concern that the Governor proposed to further reduce Medicaid and to authorize Medicaid negotiated rates outside of managed care. He indicated that new proposed cuts on top of those already imposed would have a total impact of $345 million on Catholic health care facilities in the state. He expressed concern about continued Medicaid funding for abortion and also about evidence that the practice of partial birth abortion was occurring in New York State.

When the budget was finally adopted in July, the Catholic Conference could claim victory with the decision to phase out assessments, to restore some proposed cuts, to increase Medicaid Managed Care premiums by $20 million, and to provide funds for abstinence education.

1998

At its meeting on January 9, 1998, the Executive Committee adopted these 1998-1999 State Budget Priorities:

1.) A Year to Fix Lingering Problems
   a.) HCRA refinement and transform the 8.18 percent surcharge to a covered lives assessment;
   b.) Medicaid Managed Care;
      - Provide proper premiums
      - Start-up funds for HIV and Mental Health
2.) A Year to Validate Important Principles
   a.) Promote integrated delivery system certificates (incentives, access to capital);
   b.) Reject publicly traded entities in health;
3.) A Year to Reduce the Uninsured
   a.) Implement Federal Children's Health Insurance in a way that will make the most difference;
   b.) Expand small business subsidy.

On January 28, 1998, Bishop Howard Hubbard of Albany testified before the Joint Fiscal Committees on the Governor's proposed budget on Medicaid.

He offered a six-point plan for the 1998-1999 Medicaid budget:
1.) Protection of children, with emphasis on enrolling children in insurance programs.

2.) Protection of consumers in managed care, through responsive appeals processes, charity care funding, and restoration of managed care premiums to a full level.
3.) Protection of vulnerable populations, through HIV and mental health programs, services for out-of-wedlock and teen pregnancy, and anti-smoking promotion.
4.) Stewardship, through long range planning.
5.) Support for the continuing commitment of the not-for-profit health care ministry through rejection of publicly traded providers, establishing charitable foundations for conversions and conscience protections.
6.) Affirmation of life through health policy, through ending Medicaid funded abortions, banning partial birth abortions, and prohibiting human cloning, and putting in place protections for end-of-life circumstances.

1999

Through its conference call held on February 2, 1999, the Executive Committee adopted these budget related priorities for 1999:

1.) Budget
    a.) Provider assessments
    b.) Medicaid reductions
2.) HCRA Renewal
    a.) Indigent care
    b.) Graduate medical education
    c.) Other pool items: workforce training, insurance subsidies, public health items, quality grants, debt restructuring funds, etc.
    d.) Surcharges and covered lives assessment mechanisms
3.) Uninsured
    a.) Child Health Plus expansion
    b.) Greater New York Hospital Association/1199 proposal
    c.) MSSNY proposal

On February 3, 1999, Paul Chodkowski, President and CEO of St. Clare's Hospital in Schenectady testified before the Joint Fiscal Committees on the Governor's proposed budget on health and Medicaid.

He addressed these areas of coverage:

1.) Necessary services for the poor and vulnerable: In light of growing numbers of uninsured persons, and the resulting growth in uncompensated care for the poor and indigent, the Governor's proposals would have a negative impact of about $100 million on Catholic health care providers.
2.) Continued commitment to the poor and indigent, through outreach to enroll eligible families in Child Health Plus.
3.) Systemic approach for the uninsured, through utilization of tobacco settlement funds.
4.) Public health initiatives, including HIV/AIDS and mental health, resources relating to out-of-wedlock and teen pregnancy and support to address the complications of smoking on illness and death.

This testimony reflected a major change in the approach to advocacy by the Council. Government leaders made it clear that HANYS and NYASHA were effectively

advocating for generic provider issues. They urged the Catholic Conference not to duplicate those efforts, but rather to focus on specifically Catholic issues. This enabled the Council to move from an institutional orientation to a mission orientation. This change was mirrored by changes in membership to involve more mission officers from institutions.

Through its Officers Conference Call on September 7, 1999, the Council discussed these issues relating to HCRA renewal:

1.) Financing mechanism – transform surcharge;
2.) Funding priorities;
    a.) Indigent care
    b.) Subsidized insurance – small businesses
    c.) Support for inner city and rural "safety net" hospitals
    d.) Graduate medical education
    e.) System transition support
    f.) Public health programs
3.) Coverage for the uninsured;
    a.) Expansion of Child Health Plus to parents and/or uninsured adults under Title XXI for uninsured adults
    b.) Use of tobacco money or pool resources for coverage subsidies
    c.) Expand the use of purchasing alliances
4.) Indigent care pool mechanism;
    a.) Refine measures if needed
    b.) Revise distribution formula
5.) System Supports
    a.) Guarantee funds
    b.) Payment issues
    c.) Dispute resolution system

On November 19, 1999, the Catholic Conference issued a press release, indicating that:

"New York State's Catholic Bishops are urging Governor George Pataki and legislative leaders to renew the 1996 Health Care Reform Act (HCRA), with modifications, in order to expand access to adequate health services and to uphold the sanctity of every human life."

The Catholic Conference urged enactment of provision that would "balance the health care needs of all communities" with "cost-reducing market initiatives" including:

1.) Financing care for the indigent;
2.) Enhancing health care in rural and underserved areas;
3.) Expansion of affordable insurance;
4.) Development of ethical research protocols;
5.) Targeting New York's share of tobacco settlement funds to health and social services.

Again, the Catholic Conference was successful in many areas in relation to its advocacy on HCRA. Provisions in HCRA 2000 signed by Governor Pataki on December 31, 1999 included:

1.) Long-term stabilization of the Medicaid laws;
2.) Full funding of the indigent care pool;
3.) Increase in funding for high need and rural hospitals;
4.) Restructured rural hospital funding programs;
5.) Expanded funding for low and moderate income uninsured adults;
6.) Continued funding for graduate medical education;
7.) Restructured workforce training grants;
8.) Health insurance demonstration for home care workers;
9.) Use of tobacco funds for expansion of EPIC.

2000

Happily, as opposed to the previous several years, the Governor's 2000 Executive Budget proposal did not contain major cuts in health care, nor new initiatives, given that HCRA 2000 had just been signed into law.

Nonetheless, leadership of the Council decided that it would be helpful for the Conference to testify at the budget hearings.

On February 14, 2000, Monsignor Alan Placa, Secretary to the Bishop for Health Affairs, Diocese of Rockville Centre, testified before the Joint Fiscal Committees on the Governor's Budget proposals regarding health, Medicaid and aging.

He advocated for:

1.) Expansion of pre-natal care for low-income pregnant women;
2.) Continued commitment to children's health through expanded Child Health Plus outreach efforts;
3.) Expansion of coverage for the uninsured;
4.) Affirmation of life through health budget policy;
    a.) End Medicaid funded abortions
    b.) Ban partial birth abortions
    c.) Prohibit human cloning
    d.) Increased provision of compassionate palliative and hospice care for the dying
    e.) Increased funding for abstinence education
    f.) Increased funding for AIDS and mental health;
5.) Full and adequate payment rates for providers;
6.) Commitment to financial stability for essential health care institutions;
7.) Funding for special needs of the elderly;

Once again, together with other advocates, the Catholic Conference was successful on many of its advocacy initiatives, including these outcomes of the 2000-2001 budget deliberations:

1.) Expansion of Prenatal Care Assistance Program (PCAP) income eligibility to 200 percent of federal poverty level;
2.) Expansion of Medicaid coverage to low-income women for breast and cervical cancer treatment;
3.) Education of women about heart disease;
4.) Criminal background checks for nursing home and home care employees.

2001

In early budget discussions, the Governor's failure to address the workforce shortage was a priority concern.

On February 12, 2001, Conference Executive Director John Kerry testified before the Joint Fiscal Committees on the Governor's budget proposals on health, Medicaid and aging.

He advocated for:

1.) Expansion of access to Medicaid and Child Health Plus;
2.) Adequate reimbursement for services to Medicaid beneficiaries;
3.) Initiatives to address the health care work force shortage crisis;
4.) Affirmation of life through health budget policy, reaffirming the recommendations put forward the previous year.
5.) Expansion of services to aging New Yorkers, again reaffirming the recommendations put forward the previous year.

The budget adopted in late July provided for restoration of the modest Medicaid cuts that had been proposed, but, unfortunately, provided no additional funds for work force recruitment and retention. (The Conference had not formally joined the coalition, but had supported the platform of Workforce Investment Now (WIN) Coalition, participating in the February 6, 2001 Lobby Day).

2002

On February 11, 2002, Sister Virginia Hanrahan from Dominican Sisters Family Health Services testified before the Joint Fiscal Committees on the Governor's proposed health and Medicaid budget.

She emphasized the need for measures to address the staffing shortage in home health care programs, pointing out how cost efficient these programs were, and expressing concern that those services were excluded from the enhanced financial package for other health services passed earlier in the session.

In addition, she urged continued efforts to expand opportunities for low and moderate income individuals to access health care and insurance coverage.

Other issues addressed were:

- need for expanded AIDS services
- request for support for the Maternity and Early Childhood Foundation
- adequacy of provider payments to nursing homes
- imposition of assessments on nursing home receipts
- additional funds for health workforce recruitment and retention

2003

On February 10, 2003, Peter Capobianco testified before the Joint Fiscal Committees on the proposed budget on health care. He addressed these major topics:

Uninsured
Peter expressed the Council's opposition to:
1.) Remove eligibility from 22,000 participants in the Family Health Plus program;
2.) Shift 234,000 recipients from Medicaid to Child Health Plus;
3.) Increase fees and co-payments in the Elderly Program Insurance Coverage (EPIC);

Inadequacy of Payments to Providers
Peter expressed opposition to proposed cuts which would have impact on Catholic providers.
1.) Hospitals $95 million
2.) Nursing Homes $40 million
3.) Home Care

Life Issues
Peter advocated for increased funds for abstinence education programs and removal from the budget of Medicaid funding for abortions.

2004

Through its Leaders' Conference Call held on February 10, 2004, the Council addressed these initial budget concerns for the 2004-2005 budget, which were conveyed to legislators by a letter from the Conference:

1.) Provider assessments on hospitals, nursing homes and continuing care institutions;
2.) Nursing home wage equalization factor update and elimination of coupled rate adjustment;
3.) Proposed service/beneficiary cuts:
    a.) dental and vision services in Medicaid and Family Health Plus
    b.) transfer of enrollees from Medicaid to Child Health Plus
    c.) elimination of Family Health Plus Outreach
4.) Long-term care reforms, including restriction on eligibility for Medicaid and expansion of long-term care insurance options.

4. Legislative Advocacy

The Council engaged in legislative advocacy through contributing to the annual Catholic Conference Legislative Agenda and in other ways.

a. Legislative Agenda

1995 LEGISLATIVE AGENDA

Ensuring Access to Adequate Health Care

- Universal access to necessary, equitable and ethical health care;

- Creation of impaired infant compensation fund;
- Development of a nursing home reimbursement method that is adequate and equitable;
- Primary health care services for children, excluding contraceptives and abortion counseling, referrals and services.

1996 LEGISLATIVE AGENDA

Ensuring Access to Adequate Health Care

- Universal access to necessary, equitable and ethical health care;
- Creation of impaired infant compensation fund;
- Support for continued prohibition of ownership of hospitals and nursing homes by publicly traded stock corporations;
- Primary health care services for children, excluding contraceptives and abortion counseling, referrals and services;
- Ensuring adequate reimbursements for hospital services;
- Ensuring adequate minimum periods of hospital stays for childbirth.

1997 LEGISLATIVE AGENDA

Ensuring Universal Access to Necessary, Equitable and Ethical Health Care

- Ensuring the continued provision of Catholic health and human services through strengthened legal protection of deeply held religious beliefs and civil rights;
- Opposition to state Medicaid reductions;
- Creation of impaired infant compensation fund.
- Support for continued prohibition of ownership of hospitals and nursing homes by publicly traded stock corporations;
- Primary health care services for children, excluding contraceptives and abortion counseling, referrals and services.

1998 LEGISLATIVE AGENDA

Ensuring Universal Access to Necessary, Equitable and Ethical Health Care

- Support for continued prohibition of ownership of hospitals and nursing homes by publicly traded stock corporations;
- Primary health care services for children, excluding contraceptives and abortion counseling, referrals and services.

1999 LEGISLATIVE AGENDA

Health Care

- Protection of conscience for health care providers and adequate access to funding of health services;

- Support for continued prohibition of ownership of hospitals and nursing homes by publicly traded stock corporations;
- Primary health care services for children, excluding contraceptives and abortion counseling, referrals and services;
- Expansion of Medicaid coverage for low income working parents.

2000 LEGISLATIVE AGENDA

Ensuring Equitable Access to Quality Ethical Health Care

- Expansion of health coverage for low and moderate income uninsured individuals;
- Expanded access to primary health care services for underserved low income school age children and pregnant women;
- Protection for the conscience of health care providers;
- Support for the use of tobacco settlement funds for health related purposes;
- Protection of coverage for Medicaid recipients, the working poor and special needs populations;
- Opposition to legislation which threatens the Catholic health care mission;
- Support for continued prohibition of ownership of hospitals and nursing homes by publicly traded stock corporations;
- Opposition to the imposition of arbitrary limits and caps on receipt of Medicaid home care services.

2001 LEGISLATIVE AGENDA

Health Care

- Expanded health care access and insurance coverage for low and moderate income individuals and families;
- Protection of conscience for health care providers;
- Opposition to measures which threaten the Catholic health care mission;
- Collaborative efforts to address health staffing shortages;
- Adequate funding of and access to health services for Medicaid recipients, the working poor, the frail elderly and special needs populations;
- The continued prohibition of ownership of hospitals and nursing homes by publicly traded stock corporations.

2002 LEGISLATIVE AGENDA

Health Care

- Expanded health care access and insurance coverage for low and moderate income individuals and families;
- Protection for the conscience of health care providers;
- Opposition to measures which threaten the Catholic health care mission;
- Collaborative efforts to address health staffing shortages;

- Adequate funding of health services for Medicaid recipients, the working poor, urban poor, and rural poor, the frail elderly and special needs populations;
- The continued prohibition of ownership of local hospitals and nursing homes by publicly traded stock corporations;
- An increase in the Medicaid reimbursement rate for dental services

2003 LEGISLATIVE AGENDA

Access to Health Care

- Expanded health care access and insurance coverage for low and moderate income individuals and families;
- Adequate funding for Medicaid recipients, the working poor, urban poor, rural poor, the frail elderly and special needs populations;
- An increase in the Medicaid rate and simplified reimbursement procedures for dental services;
- Palliative care and appropriate pain medication for the terminally ill;
- Collaborative efforts to address health staffing shortages;
- The continued prohibition of ownership of hospitals and nursing homes by publicly traded stock corporations.

Protection of the Church's Health Care Mission

- The principle of religious freedom in the provision of health care services;
- Opposition to measures which threaten the Catholic health care mission.

2004 LEGISLATIVE AGENDA

Ensure Access to Health Care

- Simplify the enrollment and re-certification processes for Medicaid, Child Health Plus and Family Health Plus;
- Increase the Medicaid rate and simplify reimbursement procedures for dental and behavioral health services;
- Establish collaborative efforts to address health staffing shortages through enhanced salaries and benefits such as day care, transportation, health insurance and career protection;
- Expand home health care and increase appropriate payments for home health care workers.

Protect the Church's Health Care Mission

- Support the principle of religious freedom in the provision of health care service;
- Oppose measures which threaten the Catholic health care mission.

b. Other Legislative Advocacy

Beyond its contributions to the annual Catholic Conference Legislative Agenda, the Council adopted internal priorities and engaged in other advocacy activities.

i.) 1995 Council Public Policy Priorities

At its February 1, 1995 Executive Committee meeting, the Council adopted the following health related priorities:

1.) Creation of an impaired infant compensation fund;
2.) Preservation of NYPHRM V funds with special consideration to distressed hospital and uncompensated care funds;
3.) Reform of nursing home reimbursement;
4.) Maintain prohibition on ownership of health care institutions by publicly traded corporations;
5.) Opposition to state financed Medicaid abortions;
6.) Adequate funding for public health programs which affect vulnerable populations: WIC, PCAP, AIDS;
7.) Opposition to assisted suicide legislation;
8.) Preservation and streamlining of required regulations related to capital projects.

ii.) Hospice Council

On June 21, 1995, the Catholic Conference wrote to state legislators expressing support for S3950 (Tully) creating a State Hospice Council.

iii.) 1998 Legislative Agenda

At its October 6, 1997 Annual Conference, the Council adopted the following 1998 Legislative Agenda:

1.) Care of the Poor
    a.) Restore Medicaid cuts
    b.) Medicaid managed care implementation
    c.) Federal provisions
    d.) Undocumented
2.) Care of the Elderly
    a.) Federal budget
    b.) Broaden conscience clause
    c.) Influence Medicare managed care guidelines
    d.) Longer term Medicare reform
3.) Access to Health Care
    a.) Children's coverage
    b.) Access to Catholic health care
    c.) Managed care accountability
    d.) Undocumented
4.) Catholic Network Development
    a.) Elimination of 8.18 percent surcharge

b.) Regulatory reform
c.) Fidelis expansion

5.) Maintenance of Not-for-Profit Health Care
a.) Oppose publicly traded entities
b.) Advocate for proper structure and funding of Empire BC/BS Foundation

6.) Ethical Issues
a.) Care of dying
b.) Surrogate decision-making
c.) Prohibit human cloning
d.) Bar partial birth abortion
e.) Eliminate Medicaid funding for abortion
f.) Conscience clause

iv.) 2001 Legislative Issues

Through the December 4, 2001 Leaders' Conference Call, the Council recommended continuing opposition to certain mandated insurance coverages without conscience clause protection, and decided to recommend withdrawing opposition to whistle blowing legislation because it had been amended satisfactorily.

v.) Home Care Legislation

Through the Leaders' Conference Call on March 5, 2002, the Council recommended support of a coalition letter for increased funding for home care services.

vi.) Palliative Care Bills –Labor Shortage

Through the Leaders' Conference Call on June 4, 2002, the Council made recommendation on various legislative proposals about staffing shortages and palliative care.

vii.) Enrollment Simplification

Through the Leaders' Conference Call held on February 10, 2004, the Council approved the position paper on simplification of enrollment for Medicaid, Family Health Plus and Child Health Plus as the health care targeted objective for the 2004 Catholic Conference Public Policy Forum.

viii.) Various 2004 Legislative Initiatives

Through the Leaders' Conference Call held on June 7, 2004, the Council addressed these legislative issues:

1.) Expressed concern about the language of various pain management bills;
2.) Expressed opposition to proposals to limit real estate property tax exemption for not-for-profits.

D. Influence on Public Policy

1. Introduction

Ever improving medical technology, continuing efforts to constrain costs, and aggressive efforts of opponents of the Church in the public policy arena over life issues challenged the Catholic Conference and Health Care Council in many areas during the Pataki administration. These issues are discussed here roughly in the chronological order in which they emerged.

2. Surrogate Decision Making

There is no piece of legislation over which there has been debate and discussion for a longer period of time than Surrogate Decision Making legislation. Recall that this legislation had been developed by the Governor's Task Force on Life and the Law late in 1994 to help rationalize and standardize the process by which very difficult end-of-life decisions for individuals could be addressed.

Early on in the debate, the Catholic Conference had recommended a series of amendments. This intervention began a continuing process through which it became clear that this legislation would not be approved in the Senate while the Catholic Conference opposed the bill. Throughout the entire decade covered by this Chapter, there were numerous discussions within the Catholic Conference, between the Catholic Conference and Assembly leadership, and among the Governor, the Task Force on Life and the Law and legislative leaders, without reaching language acceptable to all parties.

As underscored by testimony given by Monsignor Alan Placa before the Senate and Assembly Health Committee on February 7, 1996, the discussion had evolved to a focus on three "threshold issues":

1.) Protection for Patients Without Surrogates

Concerned about the need for protection for isolated, usually elderly persons, the Conference recommended either requirement of a court order or establishment of a statewide ombudsman office for decisions involving the withdrawal or withholding of life sustaining treatment..

2.) Decisions Involving the Withdrawal or Withholding of Nutrition and Hydration

Concerned that this legislation contained no language distinguishing nutrition and hydration from medical treatments, the Conference recommended that such decisions should be guided by a presumption in favor of continued provision of food and water, and could be discontinued in cases where the patient did not express his/her wishes prior to incapacity, only when the provision of nutrition or hydration itself was an excessive burden to the patient.

3.) Decisions Involving Abortion, Sterilization and Treatments of Pregnant Patient to the Detriment of the Unborn Child

Concerned that these types of decisions were inherently different than other types of medical treatment decisions (involving another human being whose life and health must be taken into account), the Conference recommended utilization of a higher decision-making standard in such cases.

These concerns were reiterated in testimony before the Attorney General's Commission on Quality Care at the End of Life, the Senate Aging Committee and the Senate Health Committee by Richard Barnes and Kathleen Gallagher on February 10, 1998.

One positive step was made in late 2001, when the Task Force on Life and the Law offered new language on nutrition and hydration. During this time period, Dr. Karl Adler, Secretary to Cardinal Egan for health affairs, was becoming involved also in discussion on the other two outstanding areas of concern.

While this debate was on-going, there was also introduced in the Legislature the "Health Care Decisions Act for Persons with Mental Retardation", a very similar bill for a much narrower population. Again, the same issues were at stake. Working with bill sponsors, the Catholic Conference was able to secure language in the bill stating that the bill was not intended to permit or promote suicide, assisted suicide or euthanasia, and also to secure changes to make acceptable the bill's provisions with regard to nutrition and hydration. Even though the bill was passed, because it was silent on the issue of pregnant patients, the Conference issued a "Memorandum of Concern" believing that it preserved the Bishops' option for asking for reconsideration during further discussion of the broader bill.

At this writing, it appears that a new Senate version of the bill, sponsored by Senator James Seward, has evolved to a point where the Conference can remove opposition to the bill. The Assembly version, however, does not contain all of the protections in the Senate bill and further includes domestic partners in the list of priority surrogates empowered to make health care decisions, so the Conference remains opposed to the bill in the lower house.

3. Medicaid Managed Care

Limited Medicaid Managed Care legislation had been passed in 1991. A major priority of the Pataki administration was a much broader approach to managed care. This focus created significant challenges and opportunities for the Catholic Conference.

On March 17, 1995, New York State submitted an 1115 waiver request to the Health Care Financing Administration to implement a Statewide Medicaid Managed Care program.

Right from the outset, this application presented a challenge to the Catholic Church through Fidelis because the application stated that:

"Health plans will be required to provide family planning services to their members".

Through a "Position Memorandum" on the waiver, the Catholic Conference articulated three potential solutions which could be incorporated into managed care enabling legislation:

1.) "Family planning services will be provided to members on an out-of-plan basis, or in-plan at the option of the Health Plan";
2.) Continued recognition of partial capitation rates;
3.) Full capitation with family planning services excluded from those services required to be provided in-plan.

These recommendations were conveyed to Mike Finnegan in the Governor's office. Continuing the dialogue, the Executive Committee heard a presentation at its April 5, 1995 meeting on Managed Care from the Department of Health and recommended the establishment of regional workshops on Ethical Directives and managed care.

Given the major implications of this initiative, the Catholic Conference then determined in late April to establish an internal Medicaid Managed Care Task Force. Its time limited (six weeks) responsibilities were "to provide recommendations to diocesan Bishops regarding alternatives and options for maintaining Catholic identity and, health care ministry" and "to develop issues, presentors and recommendations for the Board of Bishops meeting June 9, 1995".

In responding to the invitation, Monsignor Placa stated his belief that this was the critical issue facing the Church at the present time. He expressed concern that "because of misunderstanding of the legal situation and because of unclear thinking on the subject, we lost our institutions of higher education in this country." He exhorted the Catholic Conference to act aggressively so that the scenario was not repeated in health care.

Members on the Task Force included:

Archdiocese
Ms. Mary Healey-Sedutto, Archdiocese
Mr. Gary Horan, Our Lady of Mercy Hospital
Monsignor William Smith, St. Joseph's Seminary

Albany
Dr. James McCormack, Catholic Charities
Sister Maureen Joyce, Catholic Charities

Brooklyn
Ms. Mildred Shanley, Catholic Medical Center
Mr. Tom Hall, Catholic Medical Center
Sister Margaret John Kelly, St. John's University
Mr. Tom DeStefano, Catholic Charities

Buffalo
Sister Annunciata Kelleher, Sisters of Mercy Health System

Rochester
Sister Marie Castagnaro, St. Joseph's Hospital, Elmira

Rockville Centre
Monsignor Alan Placa, Diocese
Ms. Sondra Mahoney, Diocese
Mr. Daniel McGowan, Catholic Charities

This committee developed a program for the June 9, 1995 Bishops' meeting which was to prove pivotal in the Role of Catholic health care in New York State.

Dr. Catherine Marino, Executive Vice-President of Medical Affairs at the Catholic Medical Center of Brooklyn/Queens gave a presentation on "Collaborative Models and the role of Insurance".

Monsignor Alan Placa, Diocesan Coordinator for Health Affairs in the Diocese of Rockville Centre gave a presentation on "Catholic Perspective and the Role of Bishops".

Mr. Dan McGowan, Director of Health Services for Catholic Charities of Rockville Centre gave a presentation on "Catholic Charities: Issues of Concern".

As will be seen in the next section, these presentations became the impetus for the creation of Fidelis Care of New York. The June 24, 1995 letter from Cardinal O'Connor to Monsignor Placa and a copy of the presentation he gave can be considered the formal beginning of Fidelis. They are attached as Appendix V.

Meanwhile, the development of the state's approach to Medicaid managed care was continuing. The Catholic Conference was well represented on the Medicaid Managed Care Subcommittees of the Department of Health as follows:

Alcohol and Substance Abuse Issues
Father Arthur Johnson
St. Joseph's Rehabilitation Center
Tupper Lake
Bad Debt and Charity/Capital
Mr. Daniel Rinaldi
Catholic Medical Center
Family Health Issues
Ms. Susan Tully
Catholic Conference
Quality Information
Dr. Alan Guerci
St. Frances Hospital
Graduate Medical Education
Dr. Lambert King
St. Vincent's, Manhattan and
Mr. Vincent Raab
Catholic Medical Center
Capacity Building
Mr. Joseph Pofit
Mercycare Corporation
Albany

Mental Health/Special Needs Plan
Dr. John McIntyre
St. Mary's Hospital, Rochester
and
Dr. Barry Perlman
St. Joseph's Hospital, Yonkers

People with Developmental Disabilities
Mr. Carlo DeRege
Catholic Charities
Brooklyn

AIDS Special Needs
Dr. Victoria Sharp
St. Clare's Hospital
Manhattan

Two important developments occurred in the summer and fall of 1995:

First, advocacy with the administration on the Family Planning issue was successful. On June 6, 1995 Dr. Barbara DeBuono Health Commissioner wrote to John Kerry indicating "As in the past, the state will allow family planning services to be available both within managed care organizations and on a fee-for-service basis outside of managed care planning." She further indicated that when family planning services are not part of the plan benefit package, the plan must:

1.) Inform participants that family planning services are excluded from the plan but are available;
2.) Refer enrollees to providers who do offer these services, an obligation which can be met by providing enrollees with a list of such providers.

In a November 21, 1995 memorandum to John Kerry, Joe Buttigieg and Richard McDevitt reported that the RFP issued by the state on Medicaid Managed Care was acceptable in its treatment of the Family Planning issue, although there were some concerns about school-based clinics.

Second, internally the Catholic Conference was organizing itself to create a statewide Catholic health insurance organization. This entity would be the first of its kind-an inter-Diocesan insurance endeavor-in the United States. The evolution of Fidelis is described in the next section.

Catholic Conference advocacy with the state for a managed care program in which the Catholic Church could participate continued through a presentation made by Bishop Sullivan at the Annual Meeting of the Bishops with the Governor on February 22, 1996 in which he raised the following points:

1.) The Catholic Church brings values of compassion, personal concern and stewardship of resources to health care ministry.
2.) In its health and human services activities, the Church serves one in every five Medicaid recipients in the state;
3.) The prospect of managed care for-profit domination of health care would not serve the public interest;

4.) The Catholic tradition of low cost, high quality service provision should be recognized and encouraged.

Following up on a meeting of the Department of Health Managed Care Subcommittee on Reproductive Health Services held on April 30, 1996, the Catholic Conference scheduled a meeting with Clare Malone of the DOH Office of Managed Care to discuss reproductive services criteria for network plan providers.

In June 1996, the struggle about family planning requirements for providers came to a head as the Legislature moved to adopt Medicaid managed care enabling legislation. Up until then, the administration had maintained that new legislation was not necessary, but legislative leaders disagreed and it became clear that legislation would have to be passed to provide continuing operating authority.

As determined by the Public Policy Committee, the Catholic Conference position on proposed legislation was:

1.) In any managed care bill, there needs to be language that allows partial capitation and access to family planning services outside the plan that can be directly billed to the state;
2.) Permanitize Medicaid Managed care prepaid health service plans (17 current approved PHSP's in the state);
3.) Permit the development of providers' integrated delivery networks;
4.) Allow the automatic assignment of clients to Medicaid Managed Care Plans;
5.) Approve the direct marketing of Medicaid managed care plans to recipients;
6.) Exempt OMRDD recipients from mandatory "special needs" plans.

In response to continuing Catholic Conference concern on the matter of family planning, Department of Health General Counsel Henry Greenberg wrote to John Kerry on July 9, 1996, expressing the Department's opinion that legislation under discussion would not impair or diminish the Department's ability to implement the policy communicated the previous year to the Catholic Conference.

Still, further concern was expressed by the Conference to Governor Pataki on July 11th around this issue in relation to legislation that the Governor's office put forward on July 10th.

Meetings then ensued with Mike Finnegan from the Governor's office on July 12th, and with Jim Clyne from the Assembly that same day. Negotiations concluded with agreement to adopt language drafted by Richard Barnes including bill amendments, legislative intent letters and regulatory language. This agreement would prove to have great historic significance because the language adopted paved the way for the good work of Fidelis.

By memo of July 16, 1996, Richard McDevitt reported their outcomes included in the final bill passed on July 13th.

1.) The ability to opt out and refer indirectly for morally objectionable services;
2.) Partial capitation is available for rural health participants, providers and plans;

The state administration also promised to submit the following regulatory language:

"No religiously affiliated provider participating as a managed care provider shall be required to directly participate or directly refer for the provision of family planning services, abortion, and sterilization."

Additionally, all parties agreed to work with the Conference on reimbursement procedures for objectionable services and future creation of statutory language for religious providers. And, indeed both legislative leaders sent subsequent letters for inclusion in the bill jacket in support of Catholic providers. When Governor Pataki signed legislation on October 3, 1999, this hurdle was again cleared for the time being.

4. Opposition to Publicly Traded Corporation Health Care Facility Ownership

A second issue which was consistently on the Catholic Conference priority agenda throughout this time period was continuing opposition to establishment of health care facilities owned by publicly traded corporations. As indicated in the previous Chapter, this opposition was based on concerns relating to quality of care, accessibility and cost efficiency.

In May 1996, opposition was expressed to S1307.

On May 28, 1997, Martha Pofit indicated this proposed legislation had again died in committee.

Once again on January 27, 1998, the Catholic Conference expressed opposition to S1100, which would have allowed publicly traded corporations to establish residential health care facilities in the state.

Together with HANYS, the Catholic Conference had been instrumental in maintaining the primary role of not-for-profit health care providers in the state.

5. Fidelis

As indicated previously, the impetus for creating Fidelis was the June 9, 1995 Bishops' meeting. Following on further discussion of this approach at the State Bishops' meeting held on September 22, 1995, with leadership provided by Cardinal O'Connor, discussions proceeded throughout the fall of 1995 on how such a statewide entity would be organized. Agreement on an approach was reached in early January 1996, with Monsignor Placa playing the key role in this birthing process. This Chapter traces the evolution of Fidelis from its beginning in January 1996, until January 1997, when the Bishops formally approved the creation of the organization. The next Chapter will detail the remarkable success story of Fidelis from January 1997 until the present.

On January 6, 1996, Cardinal O'Connor wrote to the Bishops of state indicating:

"Yesterday, the Archdiocese of New York together with the Diocese of Brooklyn, resolved all significant outstanding issues relative to proceeding forward, with a single plan application to the state of New York. This plan was accomplished to a large degree

with the assistance of the Diocese of Rockville Centre, in particular through the good offices of Monsignor Alan Placa."

The letter, which then outlined in broad-brush strokes the proposed organizational structure of the endeavor is Appendix VI.

The timing of this decision permitted submission of an application to meet the RFP deadline of January 16, 1996.

The Cardinal and his staff then developed a white paper providing the background and rationale for establishing the New York State Catholic Health Plan, Inc. The document is Appendix VII.

Following submission of the application, the Catholic Conference organized in late January and February a series of meetings and Department of Health officials and state legislative leaders in support of the application that was submitted.

Meanwhile, in mid-February Conference staff reviewed the application submitted by Fidelis and concluded:

1.) The application was made for 17 of the 32 counties open in the RFP;
2.) The application was strong for the City of New York, and Broome, Erie, Monroe, Oneida, Onondaga and Rockland Counties;
3.) There were major deficiencies in the applications for Albany, Genesee, Montgomery Niagara, Rensselear and Schenectady Counties;
4.) There was question about an operational infrastructure outside of New York City.

This memorandum spurred efforts to obtain additional information to support the application.

A preliminary response from the Department of Health on February 27, 1996 rated the application as follows:

In terms of general technical capability:

Member/Provider Enrollment/Services	Acceptable
Clinical	Acceptable
Experience and Management	Deficient
New York City Addendum	Acceptable

In terms of the County-by-County network assessment, these decisions were made:

Deferred	Deficient
Albany	Bronx
Erie	Brooklyn
Genesee	Broome
Niagara	Manhattan
Oneida	Monroe

Onondaga	Queens
Rensselaer	Rockland
Schenectady	Staten Island

The plan was given a week to provide additional information. To assist in this process, Cardinal O'Connor again wrote to his brother Bishops in the state asking their hospitals to move post haste in providing needed data.

As the applications were being revised, the Catholic Conference convened on March 4, 1996 "the Advisory Committee on Medicaid Managed Care". This group was the forerunner of the Fidelis Board.

Members were:

Archdiocese of New York: Dr. Mary Healey-Sedutto, Archdiocese
Albany: Dr. James McCormack, Diocesan Healthcare Coordinator
Brooklyn: Mr. Mark Lane, Catholic Medical Center
Buffalo: Mr. James Corrigan, Sisters of Charity Hospital
Ogdensburg: Mr. John Gray, Diocese
Rochester: Mr. Jack Balinsky, Catholic Charities
Rockville Centre: Monsignor Alan Placa, Secretary for Health Affairs
Syracuse: Sister Eloise Emm, Diocese

Based upon the agreement negotiated by the Cardinal, this group was then expanded as the Fidelis Care Advisory Committee, which first met on May 9, 1996, and included among its members 7 representatives from Brooklyn, 5 from the Archdiocese and one from each of the other Dioceses as follows:

Archdiocese of New York
- Dr. Karl Adler
- Dr. Michael Brescia
- Monsignor Robert Brucato (replaced after one meeting by Father John Coughlin)
- Dr. Mary Healey-Sedutto
- Mr. Gary Horan

Albany
- Dr. James McCormack

Brooklyn
- Mr. William Armstrong (replaced by Enid McCoy, would serve as staff)
- Mr. Thomas DeStefano
- Ms. Patricia Gilmartin
- Dr. Lydia Gorski
- Mr. Mark Lane (replaced by Bishop Sullivan in September 1996 when he was hired as CEO)
- Mr. William McGuire
- Mr. Daniel Rinaldi

Buffalo
- Mr. James Corrigan

Ogdensburg
Mr. John Gray

Rochester
Mr. Jack Balinsky

Rockville Centre
Monsignor Alan Placa

Syracuse
Sister Eloise Emm

The Committee addressed a number of issues at this meeting as follows:

1.) Tom Hall, serving as Interim CEO of Fidelis, reported on the Readiness Review conducted by the State Department of Health on April 24, 1996, in which it was indicated that Fidelis Care was "in substantial compliance" and it was recommended that it be approved to provide care in all counties where its networks were deemed satisfactory. Two networks, Brooklyn and Queens, were found acceptable. The Manhattan network was found deficient by the City which required more providers in northern Manhattan.
2.) Mark Lane, who from his position at Catholic Medical Center had been given responsibility for network development throughout the state, reported on his initial efforts;
3.) The committee reviewed job descriptions for the CEO, and determined also that there was need for one regional administrator for upstate.

The Committee addressed a number of issues at its July 10, 1996 meeting as follows:

1.) There was discussion about the status of managed care legislation under consideration by the Legislature particularly in relation to conscience clause issues;
2.) There was a lengthy update on upstate network development, in which it was reported there were no additional county approvals, but much progress in many counties.
3.) It was reported that Mark Lane and Bill McGuire had communicated to the state Bishops on June 14, 1996 the Challenges of Plan Expansion and had established the need for investment/start-up resources of $300,000/Diocese;
4.) There was a report on the CEO search process.

On September 13, 1996, Bishop Thomas Daily of Brooklyn wrote to the Bishops of the state, that given that the Catholic Medical Center of Brooklyn and Queens was in the interim period the sole owner of Fidelis Care, he was appointing Mark Lane as President and CEO of Fidelis, and that he was appointing Bishop Sullivan to serve as Board Chairperson.

At its September 16, 1996 meeting, the Advisory Committee addressed these issues:

1.) In discussion about plans for building upstate networks, there was initial consideration of the possibility of purchasing the Better Health Care Plan in Buffalo;

2.) It was reported that on August 13, 1996, Fidelis Care New York was approved to participate in the new Plan Enrollment Process in all five boroughs of New York City;
3.) The Committee reviewed revised proposed By-Laws;
4.) It was reported that the new Fidelis corporate and regional headquarters would be located at Queens Tower, 95-25 Queens Boulevard, Rego Park, NY.

At its meeting on December 20, 1996, the primary agenda item was review of the proposed 1997 budget and capital plan. There was much discussion and a request for further information, including three and five year projections, and further conversation prior to the January 27, 1997 members meeting, which would formally establish Fidelis.

In one year, the organization had come a long way.

5. Mergers and Acquisitions

Already in the late 1980's there had begun the process nationally of creating larger health systems, including Catholic health systems, and at the local level mergers and acquisition activity as health care providers responded to changing conditions and market needs.

This reality would have impact on the work of the Catholic Health Care Council over this decade in several ways.

a. Seton Health System

On March 16, 1995, Catholic Conference Executive Director wrote to the Catholic Healthcare Council apprising them of a legal challenge to the merger of a Catholic hospital and non-Catholic hospital in Troy.

In 1994, the Public Health Council and Department of Health had approved a merger of St. Mary's Hospital and Leonard Hospital which brought together the two hospitals under common ownership of Seton, a new corporation owned and operated by the Daughters of Charity of St. Vincent DePaul who were the existing owners of St. Mary's.

Prior to the merger, Leonard Hospital operated primary care clinics in Troy and neighboring communities which provided family planning services. These services did not include abortion services, but did include contraception distribution and direct referrals for the full range of reproductive health services.

In December 1994, the Center for Reproductive Law and Policy, a division of the ACLU, filed a lawsuit (Amelia v Public Health Council) challenging the merger. They claimed that the approval of the merger violated certain legal requirements by allowing the merged facility to discontinue family planning services and the direct referral of patients for such services.

Obviously, this suit raised significant questions about the ability of Catholic hospitals to participate in mergers and also the ability of Catholic entities to participate in managed care arrangements, and began a lengthy litigation process in which the Catholic Conference was heavily involved.

On March 24, 1995, the Court accepted the Catholic Health Care Council as a party-respondent to the Amelia v Public Health Council suit.

On December 19, 1995, Michael Costello, acting as attorney for Seton, drafted a proposed Memorandum of Understanding between Seton Health Systems and the State Department of Health. Based upon a series of meetings with attorneys for all parties continuing past practice, it articulated a process where Seton would provide patients requesting proscribed services with a list of licensed health care providers able to provide the requested or necessary services.

Happily in May 1996, there was agreement to a Memorandum of Understanding that was essentially the same as the draft. In this memorandum Seton agreed to provide "informational or indirect referrals for services not offered." Seton had made this same agreement in the original negotiated merger approval process with the Department of Health

While this issue came to happy conclusion, however, it was but one of many factors which led to a creation of a Task Force on Mergers of the State Hospital Review and Planning Council.

b. State Hospital Review and Planning Council Task Force

In early 1995, the State Hospital Review and Planning Council established a Taskforce on Access to Family Planning Services in Hospital Mergers. Members were: Dr. Thomas Lavell from the Northeast New York HSA, Carol Raphael, from the Visiting Nurse Service of New York City, Jerry Billings, Director of the State Communities Aid Association and Dr. Patricia Numann from SUNY Syracuse Science Center. At its meeting on March 22, 1995, the Committee which had previously researched background materials, reviewed the Seton litigation and also discussed where in the state there might be other mergers which raised similar issues. Resulting from that meeting, the Task Force developed a 3/30/95 draft "Protocols for Assessment of Reproductive Health Services Availability, after a Merger of Religious and non-Religious Hospitals" which contained significant protocols incompatible with Catholic health services provision.

On July 14, 1995, Richard McDevitt met with Department of Health Executive Deputy Commissioner Karen Schimke to express concern about this approach, without positive result. After a more positive meeting on August 17, 1995 with her replacement as Executive Deputy Commissioner, Dennis Whalen, Richard wrote that Mr. Whalen also had concerns about the finalized statement actually approved by the entire State Hospital Review and Planning Council on August 3rd. These concerns were much the same as those of the Catholic Conference. Mr. Whalen indicated that the Department of Health would respond directly to the Task Force, and had no plans to implement the document.

Once again, the Catholic Conference had effectively warded off a major threat.

c. Internal Church Response

These external activities caused Catholic Church and Catholic health leaders to examine more closely internal protocols for decisions about mergers.

On August 15, 1995 Cardinal John O'Connor issued guidelines for Archdiocesan Catholic health care organizations about possible mergers and acquisitions:

1.) Priority should be given to arrangements with other Catholic institutions;
2.) Catholic entities should give support to other Catholic entities confronting significant challenges;
3.) Entities should operate effectively to insure individual and collective well-being;
4.) Any potential arrangement should be assessed in consultation with the Archbishop or his representative;
5.) Approval of the Archbishop is a prior condition of entering an arrangement;
6.) Arrangements with non-Catholic entities should be explored only with the approval of the Archbishop, there is no possibility for an arrangement with a Catholic entity, and the non-Catholic partner is committed to complying with Catholic medical-moral and ethical principles;
7.) Guidelines were given various specific elements of such a possible arrangement;
8.) The Archbishop should be notified of any possible discussions at the earliest possible date.

In June 1997, the Cardinal extended his request for notification to him about possible merger or acquisition activity by any Catholic health care entity within New York State.

In preparation for a Special Presentation to the Public Policy Committee on December 4, 1997, a leadership group of Conference staff, hospital staff and attorneys met to discuss issues relating to mergers or possible mergers including Seton, Benedictine Hospital, Kingston and St. Mary's Hospital, Amsterdam.

This presentation was to lead to a major effort through a Task Force on the Preservation of Catholic Health Care to address a variety of issues, including protocols for considering mergers and acquisitions.

6. Additional Threats to Catholic Health Care

The Seton litigation and activity of the State Hospital Review and Planning Council were important activities in and of themselves, but also reflective of a more generalized growing public policy threat to the existence of Catholic health care in the state. Some observers felt that the creation of Fidelis Care, the successful Seton merger, and other planned mergers represented an aggressive effort by the Catholic Church to change what had been a delicate public policy balance in the state for the previous thirty years pro-life and pro-choice forces. Whatever the reason, there emerged in 1996 and 1997 a much broader series of threats to Catholic health care.

Bills introduced during this time period included:

A9886 and 9887 (Gottfried)

These bills proposed to codify the Family Planning Advocates "Merger Watch" by requiring Department of Health to publish monthly all CON applications, and requiring that the Commissioner not approve any merger application unless affirmatively finding that no services were eliminated or reduced.

A10693 (Gottfried)

This bill proposed to weaken religious sponsors "reserved powers" by requiring specific State Department of Health approval for "passive parent" arrangements involving Catholic networks.

S7510 (Cook)/A9887 (Hockberg)

This bill proposed to prohibit the reduction or elimination of a health care procedure, including reproductive procedures such as abortion and sterilization, in the event of a merger or corporate affiliation, unless the merging entity ensured these procedures were otherwise available in the community.

A9859 (Gottfried)/S.6938 (Goodman)

This bill proposed to require the Department of Health to establish education and referral standards in Medicaid managed care plans if certain services were not covered in the plan.

A9850, A8877, A432-B, S6329

In the 1998 legislative session, introduced for the first time were a set of four bills (A9850, A8877, A432-B, S6329) that would require health insurance policies that provided coverage for prescription drugs to include coverage for the cost of contraceptive drugs and devices (thus would begin a long legislative struggle which is described later in this Chapter).

A4096 (Gottfried)

This bill proposed to require any person or entity which shared in decision-making authority over a hospital, or the assignment or delegation of that authority, to be subject to the approval of the Public Health Council. The impact of passage of the bill would have been to undermine the authority of religious leaders and sponsors over hospital decision-making central to the facility's religious mission and philosophy.

A4098 (Gottfried)

This bill, a successor to A9859 from the previous session, proposed to require Medicaid Managed Care Plus to meet certain standards for "arranging and referring for service not provided directly by the managed care providers."

Happily, of all these threats, the only area where eventually actual passage occurred related to mandated contraceptive coverage.

7. Catholic Conference Responses

a. Introduction

Challenged by these threats, the Catholic Conference determined to respond with a more comprehensive strategy. In September 1997, the Conference distributed to Catholic Health Care institutions and Dioceses a series of "talking points" in support of Catholic Health Care and Fidelis. Then, following on the Special Issues Presentation to the State Public Policy committee on December 4, 1997, the Catholic Conference made the decision to establish a Task Force on Mergers/Acquisitions, which was later renamed at the suggestion of Mark Lane from Fidelis as the Task Force on the Preservation of Catholic Health Care.

Described here are the work of the Task Force, the efforts of the Weiser Group in public relations as follow-up; the establishment of an Advisory Committee on mergers and; the public relations campaign envisioned by Bishop James McHugh of Rockville Centre.

b. The Task Force on Preservation of Catholic Health Care

As a result of the Special Issues Presentation to the Public Policy Committee on December 4, 1997, through the leadership of Ms. Mary Healey-Sedutto and Martha Pofit, this group was first convened on January 8, 1998. From the outset, it was determined that there would be three subcommittees for the effort: focused on public relations, legislative and regulatory issues and internal Catholic Church protocols.

At the first meeting held on January 8, 1998, there was agreement that the expected results would be:

1.) Development of necessary tools for institutions and dioceses when attacked by external groups;
2.) Implementation of legislative and regulatory initiatives supporting Catholic health ministry;
3.) Development of internal policies and principles appropriate to be utilized on a Diocesan and state level.

The Task Force was divided into three subgroups, as follows:

Subgroup A – Public Relations/Community Relations

Mr. Jack Balinsky, Catholic Charities, Rochester
Mr. Jim Cameron, Terrance Cardinal Cooke Health Center, Manhattan
Ms Danielle Cummings, Diocese of Syracuse
Mr. Frank DeRosa, Diocese of Brooklyn
Ms. Tracey Doolittle, Benedictine Hospital, Kingston
Father Patrick Frawley, Fidelis Care
Mr. Dennis McCarthy, Sisters of Charity Hospital, Buffalo

Mr. Brian Mulligan, Catholic Health Network, Archdiocese
Mr. Joseph Pofit, St. Peter's Hospital, Albany
Ms. Mary Healey-Sedutto, Catholic Health Network, Archdiocese
Mr. Charles Smith, St. Jerome Hospital, Batavia
Ms. Joan Waldrop, St. Mary's Hospital, Amsterdam
Mr. Joseph Zwilling, Archdiocese

Subgroup B – Legislative/Regulatory Provisions

Father John Bonnici, Archdiocese
Mr. Christopher Connors, St. Elizabeth Hospital, Utica
Mr. Robert Iseman, Attorney
Mr. Mark Lane, Fidelis
Mr. Peter Liebold, Catholic Health Association
Mr. Brian Mulligan, Catholic Health Care Network, Archdiocese
Ms. Mary Healey-Sedutto, Catholic Health Care Network, Archdiocese
Monsignor William Toohy, Archdiocese
Mr. Daniel Walsh, Good Samaritan Hospital, West Islip

Subgroup C – Province-Wide Policies

Mr. Peter Capobianco, St. Mary's Hospital, Amsterdam
Mr. Michael Cooney, Attorney
Mr. Michael Costello, Attorney
Mr. Thomas Dee, Benedictine Hospital, Kingston
Sister Maureen Joyce, Catholic Charities, Albany
Bishop Henry Mansell, Diocese of Buffalo
Mr. Brian Mulligan, Catholic Health Care Network, Archdiocese
Monsignor Alan Placa, Diocese of Rockville Centre
Mr. George Rice, Attorney
Ms. Mary Healey-Sedutto, Catholic Health Care Network, Archdiocese
Ms. Mildred Shanley, Catholic Medical Center, Brooklyn
Mr. Joseph Stoeckel, Attorney
Bishop Joseph Sullivan, Diocese of Brooklyn
Monsignor William Toohy, Archdiocese
Mr. Daniel Walsh, Good Samaritan Hospital, West Islip
Ms. Eileen White, Archdiocese

The Task Force met again in Albany of March 9, 1998. Issues addressed included:

1.) It was agreed that the name of the group would be changed to "New York State Catholic Conference Task Force on the Preservation of Catholic Health Care";
2.) There was discussion about various issues in relation to a Catholic Health Care Public Relations campaign;
3.) With regard to Legislative/Regulatory Protections, these issues were addressed:
    a.) Reserved powers issue
    b.) Medicare conscience protection for New York;
    c.) Broad-based conscience protection (Cardinal O'Connor's meeting with Governor Pataki);

d.) Protections for Fidelis;
e.) Assembly legislative package (Martha Pofit);

4.) Province Wide Policies
a.) Rockville Centre policy – Monsignor Placa
b.) Appointment of advisory body on moral theology
c.) Draft of basic principles

In April and May, the three subcommittees met, moving toward a final presentation to the Bishops at their June meeting.

The Task Force held its final meeting on May 19, 1998, and approved the recommendations to be presented to the Bishops in June. The final report, drafted by Richard Barnes, was submitted to the Bishops at their June 12, 1998 Board meeting.

Subgroup A recommended that:

1.) The Weiser Group be hired as the public relations consultant;
2.) Sufficient resources be allocated to put a public relations plan into action;
3.) The firm begin its work on July 1, 1998 for a thirteen-month period;
4.) The program be considered a long-term continuing project necessary for the very survival of Catholic health care;
5.) The Catholic Conference continue the comprehensive compilation of the "Catholic Health Care Data Book;
6.) The Catholic Conference collaborate with the Catholic Health Association in the development of public relations and communications strategies to promote Catholic health care.

The report of Subgroup B focused on the following issues:

1.) Federal issues;
a.) Potential Antitrust challenge
b.) Medicare Managed Care
2.) New York State issues – reserved powers;
3.) Threats to mergers-legislative proposals (A9886, A9887)
4.) Department of Health review process;
a.) DOH guidelines
b.) Potential list of merger applicants
c.) NYSCC survey of applicants
5.) Protection of Fidelis – threats from legislative proposals;
a.) Insurance mandates for family planning (A9977, A432, A9850, S6476)
b.) Family planning in Medicaid and Prenatal Care Assistance Program (A10395, A10396, A10397)
c.) Standards and referral (A9859, S6938)

The report of Subgroup C addressed the following issues:

1.) Proposed set of Diocesan Common Principles governing hospital mergers/joint ventures;
2.) Establish an advisory body available to the Bishops for advice and counsel as merger situations arise;

3.) Convene a summit of Diocesan leaders, religious orders and health systems to facilitate a common vision.

With these recommendations to the Bishops, the Task Force concluded its work.

c. Weiser Group Activities

On September 25, 1998, following on the Bishops endorsement of the proposal to engage the Weiser Group as a consultant to the Health Care Council on public relations, Council Chairman Dan Walsh wrote to member institutions asking their financial support for this effort. He indicated that the first installment of dues for this effort was due October 15, 1998, and the second installment due April 15, 1999.

From the start, there was reluctance of Catholic Health Care entities to contribute to this project. On both the January 5, 1999 and February 2, 1999 Health Care Officers' Conference Call, concern was expressed that Catholic health institutions had not responded to the request for assessment payments to the project.

Finally, with enough funds collected, John Kerry was able to write Bob McGrath from the Weiser Group indicating that the Catholic Conference was ready to enter into agreement with the Weiser Group for a project that would last until June 30, 2000 at a cost of $125,000, scaled-back from the program previously envisioned.

The Catholic Conference established an Advisory Committee to work with the Weiser Group. Its members were:

Mr. Jack Balinsky, Catholic Charities, Rochester
Ms. Jan Caster, St. Joseph's Hospital, Syracuse
Mr. Stephen McClellan, Catholic Medical Center, Brooklyn
Mr. Brian Mulligan, CHC, Archdiocese
Ms. Donna O'Brien, Catholic Health System of Long Island
Mr. William O'Reilly, St. Joseph's Nursing Home, Ogdensburg
Mr. Dennis McCarthy, Sisters of Charity Hospital, Buffalo
Ms. Joan Waldrop, St. Mary's Hospital, Amsterdam
Mr. Mark Ackerman, St. Vincent's Hospital, Manhattan

The Weiser Group presented three proposed strategic communications goals:

1.) Differentiate Catholic health care
2.) Educate about Catholic health care
3.) Respond to proposed legislation and other public policy actions

It proposed the undertaking of these action steps:

1.) Developing a mission statement-branding
2.) Developing press materials
3.) Providing media kit training
4.) Developing a media outreach campaign

Following this conference call, Bob McGrath wrote to the Advisory Committee indicating his belief that the most effective approach would be communicating Catholic health care values in their entirety, rather than trying to differentiate Catholic health care from other health care.

Through its April 12, 1999 conference call, the Advisory Committee reviewed a draft positioning statement entitled "Catholic Health Care in New York: Providing for the Whole Person and the Whole Community". Feedback on the statement was solicited in May from Mission/Media/Marketing Officers in Catholic health care institutions.

The Weiser Group then organized a series of media training sessions to train spokespersons from Catholic health facilities in all eight Dioceses to ensure that common message points were being used to effectively communicate the value of Catholic health care to the whole community.

The first such session was held at the Archdiocesan Instructional Teleconference Center in Yonkers on May 25, 1999. The second session was held on June 15, 1999 at the Albany Diocesan Pastoral Center for representatives from Catholic health care facilities in the Diocese of Albany. The third session was held at Lemoyne College in Syracuse on June 22, 1999 for representatives from health care facilities in the Dioceses of Rochester, Syracuse and Ogdensburg. The fourth session, for representatives of Catholic health care facilities from that Diocese was held at the Catholic Center in Buffalo on June 23, 1999. The fifth session was scheduled to be held in Rockville Centre on June 30, 1999 for representatives from Catholic health care institutions in the Dioceses of Brooklyn and Rockville Centre. This session was cancelled due to the refocusing of the project described below.

The agenda for these sessions included the following components:

1.) Understanding the news media and what they consider news;
2.) Using the Catholic Health Care Positioning Statement to get the message out;
3.) Discussion of ethical and religious directives;
4.) Taking advantage of the interview opportunity.

Following some negative reactions to those sessions, Conference leadership agreed on June 29, 1999 to refocus the project. The major product would be a "press kit", which would provide a strong, unified "message" that could be used productively to build community support and good will for Catholic health care. It was agreed that continuing media training, however useful, was not feasible given the tight budget.

Through its October 5, 1999 conference call, the Officers reviewed a draft of the media kit.

The media kit went through several iterations and was finally ready for distribution in June 2000. Multiple copies were sent to each Diocese and health care institution. This effectively brought to completion the media effort through the Weiser Group.

d. Advisory Panel on Hospital Joint Ventures

Following on the work of Group C of the Task Force on the Preservation of Catholic Health Care, the Catholic Conference worked to establish in early 1999 a Permanent Advisory Panel on Hospital Joint Ventures and Bioethics.

At the June 4, 1999 meeting, the Board of Bishops approved establishment of an Advisory Committee on Health Care Affiliations with the following members:

Bishop Henry Mansell, Buffalo, Chair
Monsignor Alan Placa, Catholic Health Services of Long Island
Monsignor William Smith, St. Joseph's Seminary, Archdiocese
Father Patrick Frawley, Fidelis
Father Gregory Faulhaber, Christ the King
Sister Marie Castagnaro, St. Joseph's Hospital, Elmira
Mr. Dennis Manning, Catholic Charities, Syracuse
Mr. Michael Costello, Attorney, Albany

The Committee held its first meeting by conference call on October 12, 1999. Agenda items included:

1.) Discussion about the genesis of the Committee;
2.) Review of protocols on affiliations from the Archdiocese of New York, the Diocese of Rockville Centre and the Archdioceses of Chicago and Philadelphia.
3.) Adoption of a work plan through which the Committee would develop principles governing hospital mergers/joint ventures which would be available on a statewide basis.

On March 16, 2000, Richard Barnes sent Bishop Mansell a draft protocol for review.

The Committee next met in Buffalo on May 18, 2000 and discussed:

1.) Information-sharing on protocols
2.) Role of Conference staff
3.) Next steps

Through a conference call held on June 13, 2000, the Advisory Committee on Health Care Affiliations proposed a resolution for consideration by the Board of Bishops at their June 23, 2000 meeting.

The Advisory Committee recommended that "whenever any affiliation is contemplated or proposed which requires the Diocesan Bishops' approval or nihil obstat or would result in any change which would affect the mission or religious identity of the Catholic health care or human services provider, including but not limited to the governance structure or ownership, the following practices and procedures should be followed":

1.) Each Diocesan Bishop, before issuing his approval or nihil obstat should, at the earliest possible juncture, notify the "Advisory Committee on Health Care

Affiliations" of the proposed or pending arrangement and should seek the advice and counsel of the Advisory Committee;

2.) Each Diocesan Bishop and Diocesan legal counsel should cooperate fully with the Advisory Committee and should provide the Advisory Committee with such information and documentation as requested by the Advisory Committee to meet its charge of assisting and providing counsel to the Diocesan Bishops;

3.) Each Diocesan Bishop should await the advice, counsel and recommendation of the Advisory Committee before issuing his approval or nihil obstat. The Advisory Committee shall provide its advice and counsel in a timely manner so as not to delay the pending transaction;

4.) Each Diocesan Bishop should give serious weight and consideration to the advice, counsel and recommendations of the Advisory Committee on his decision-making process; and

5.) Communication received by and advice given by the Advisory Committee on Health Care Affiliations shall be deemed confidential communications to the Bishops in support of their canonical and pastoral responsibilities.

The reaction of the Bishops to this proposal reflected the ongoing tension felt by Bishops in wanting to present a uniform approach across the state, but recognizing the canonical responsibility and authority of each Bishop in his own Diocese. While the Bishops found this work helpful, there was no instance in which the Advisory Committee had been used at the time this document was written.

e. Communications Plan for Catholic Health Care

Another follow-up activity to the work of the Task Force on Preservation of Catholic Health Care was the adoption of a "Communications Plan for Catholic Health Care".

This effort was energized by Bishop James McHugh who had recently been appointed as Diocesan Bishop in Rockville Centre.

While appreciating the ongoing efforts of the Weiser Group which resulted in production of the media kits, Bishop McHugh felt that there needed to be an aggressive, Diocesan driven effort to promote Catholic Health Care in Catholic parishes, Catholic schools and local neighborhoods and communities.

This matter was first addressed by the Bishops of the State when Dr. Mary Healey - Sedutto and Dr. Karl Adler made a presentation on health issues to the Bishops at their meeting on February 25, 1999.

After preliminary work had been completed, this proposed initiative was discussed by the Council Executive Committee on April 27, 2000 and endorsed.

The proposed plan was approved by the Bishops at their June 23, 2000 meeting. The plan is attached as Appendix VIII.

The initiative was launched through a conference call on June 30, 2000. Involved in the call were Bishops McHugh, Moynihan, Hubbard and Mansell, Diocesan Public Information/Communications Directors, Diocesan Catholic Health Care Representatives, and Catholic Conference Staff.

From the conference call, there seemed to be consensus on these matters:

1.) The plan actually involved several messages, which needed to be individualized and tailored to their intended audience;
2.) Education of priests and parishioners was essential;
3.) Catholic health care facilities and institutions could be of great assistance by sharing with Dioceses the communications and public relations strategies they had already undertaken;
4.) The role of the Conference should be primarily as a resource;
5.) Conference call participants were urged to meet with key Diocesan leaders to fashion local plans;
6.) A follow-up meeting would be scheduled for the end of the summer.

Discussion of this "Action Plan" at the Officers and Diocesan Health Care Coordinators Conference Call held on August 1, 2000, focused on the need to tie the positive values of Catholic health care to the call for public advocacy outlined in the plan.

Unfortunately, because of Bishop McHugh's illness and subsequent death, this plan was not carried out in its entirety. It did help to spur greater attention and coordination to public relations efforts relating to health care. The Executive Committee discussed these developments at their conference call held on January 16, 2001.

8 Continuing Threats to Catholic Health Care 2000-2004

Unfortunately, as the Conference was developing these responses, yet additional threats emerged to the provision of Catholic health care. Two important developments early in the new century related to emergency contraception for rape victims, and mandates on coverage.

a. Emergency Contraception for Rape Victims

This issue emerged on January 26, 2000 when the Albany Times Union reported on a "study" conducted by the New York branch of the National Abortion and Reproductive Rights Action League (NARAL-NY) of hospital policies covering the provision of emergency contraception to rape victims. The article cited NARAL findings that "54 percent of state hospitals either did not offer emergency contraceptive pills or were not clear on the hospital's policy." The article went on to say that only eight of the states 38 Roman Catholic-run hospitals provided the emergency contraceptive pill.

The first Catholic Conference action in response was to request that Dioceses obtain information from institutions in their Diocese about their policies with regard to the provision of emergency contraception to rape victims.

In the same time frame, Assemblywoman Susan John introduced A9359 requiring every facility "to make emergency contraception available at the hospital."

Through the Officers' Conference Call held on March 7, 2000, the Council discussed a proposed model policy for provision of emergency contraception to rape victims, which was presented to engender discussion without endorsing any particular language or approach.

During discussion, Monsignor Placa reported that the hospitals in Rockville Centre applied the so-called "Peoria Protocol" which laid out specific steps to ascertain whether ovulation and therefore the potential for contraception had occurred. There was agreement that there needed to be developed a "common vocabulary" of terms which could be used to re-canvas the hospitals with more refined questions.

On March 29, 2000, Ron Guglielmo reported on the results of the survey of Catholic Hospitals, indicating that:

- 10 have no policy or do not provide those services;
- 6 have a policy under development or review;
- 23 provide with written policy (18) or provide without written policy (5)

Conference staff recommended that Ordinaries in Dioceses make sure that the Ethical and Religious Directives were widely disseminated in health care institutions and fully understood by staff.

Through the April 5, 2000 Leaders' Conference Call, the Council discussed recommending to the Bishops the Adoption of Province-wide Guidelines for the establishment of policies for the provision of emergency treatment to victims of sexual assaults.

At the same time, on March 30, 2000, the Department of Health indicated that efforts were underway to update and reissue the Sexual Offense Evidence Collection Protocol to provide guidelines for improving the treatment of victims of sexual assault and improving forensic evidence collection. The letter stated that "specifically, attention will be given to outlining for providers the current standards of professional practice including options for pregnancy prevention."

At its meeting on April 27, 2000, the Executive Committee decided that the adoption of any protocol for service was best left to individual hospitals in consultation with the institution's medical staff, ethics committee and board, and that the Council would consider recommending guidelines to the hospitals as a purely informational action, sharing protocols as "best practices" without endorsing any one protocol. The Committee reiterated the need to press the Catholic case before government officials and the general need for protection of religious freedom and prohibition of requirements for objectionable procedures.

On May 11, 2000, members of the Executive Committee met with Health Commissioner Dr. Antonia Novello and her staff and presented to her the Catholic perspective on this and related matters.

Addressing once again the issue of proposed guidelines, the Officers agreed on their August 1, 2000 conference call to forward the proposed guidelines to John Kerry for

submission as appropriate to the Bishops. At the same time the Council distributed information together with selected protocols, to the Catholic hospitals in the state.

On September 18, 2000, Conference staff met with Department of Health leadership to offer recommendations on the DOH draft "Guide to the Acute Care of the Adult Patient Reporting Sexual Assault." Conference staff urged the Department to consider language that would protect the health care needs of female sexual assault victims while maintaining the right of providers to assert their moral convictions and religious beliefs in such fundamental maters of conscience. In addition, the Catholic Conference staff expressed a general concern about the Department's unprecedented intrusion into the realm of specifying a clinical protocol. Following this meeting and internal discussions with ethicists, the Conference submitted a formal written response to these proposed guidelines on January 10, 2001 articulating the same general approach and making four specific suggestions for changes.

Because the Department had not yet issued finalized Guidelines by April 2001, legislation was again introduced, which the Conference again opposed.

Given the continuing concern about this situation, the Bishops adopted at their June 22, 2001 meeting the proposed Province-wide guidelines to assure that all Catholic hospitals in New York State had clear, consistent policies to guide their emergency room staff on morally acceptable application of post-coital treatment to rape victims that was truly contraceptive in nature.

In September, the Department of Health issued a revised draft guide which addressed many of the Conference concerns. There was still, however, lack of clarity on the timing and extent of responsibility of a provider to arrange for provision by others of morally objectionable services.

Once again, because of concern about the lack of finalized guidelines, the Legislature introduced bills on this subject in the 2002 session. The Assembly re--passed A2214, (John) on January 28, 2002 and Senator Spano introduced S2347, which again occasioned the Catholic conference call to oppose this legislation.

However, as a result of once again of effective advocacy by the Catholic Conference, the legislation that was passed in June as Chapter 625 of the Laws of 2003 (same as the Spano Bill) had amendments that made it acceptable to Catholic Conference.

b. <u>Mandated Coverage</u>

In similar fashion, the threats of mandated coverage were major agenda items addressed during this time period. Unfortunately, the Catholic Conference was not as successful in the public policy arena in relation to these initiatives.

The two major pieces of legislation at issue were proposals to mandate inclusion of infertility treatment and contraceptive coverage in health insurance packages.

While these bills had been introduced in previous sessions, active consideration of them began in the 2000 legislative session.

A 1844 (John)/S2996-B (Bonacic) proposed requirement that health insurance policies that provided prescription drug coverage also include coverage of contraceptive drugs and devices.

Despite efforts of Bishop McHugh to meet with Senator LaValle on S3131-B (Lavalle) and A7303 (Silver) mandating infertility treatment coverage, this legislation was passed by the Assembly on February 7, 2000 by a vote of 113-34 and by the Senate on February 8, 2000 by a vote of 31-21. It still remained though to work out differences of conscience protection between these two bills.

The Catholic Conference convened by conference call on February 2000 an ad hoc group of Bishops, health care leaders and Diocesan attorneys to discuss conscience protection legislation.

In their March 1999 meeting with Governor Pataki, the Bishops had won a commitment from the Governor to propose conscience protection legislation on behalf of the Conference. The Governor's proposed program bill, however, was quite limited in that it merely codified existing regulatory practice by adding a provision in the Public Health Law stating that hospitals operated by religious organizations would not be required to perform abortions and sterilizations and amending the Civil Rights Law to add sterilization to the existing protection for practitioners with regard to abortion. The Conference on the other hand, was seeking broader conscience protection, which would apply to all practitioners and institutions, to a broad array of objectionable procedures, and a wide range of public and private activity.

Given the pressure on the Legislature to come to agreement on religious exemption provisions in the infertility treatment coverage bill and the Governor's reluctance to propose a general conscience protection bill, and despite the introduction of S2186 (Maltese), A9402 (Seminerio) legislation to provide broad conscience protections for individuals and institutions, the ad hoc group determined at its follow-up March 10, 2000 conference call to focus on efforts to secure religious exemption in the infertility treatment bill, and developed a nine part action plan toward this end. The Council officers endorsed this strategy at their meeting on April 5, 2000. On June 6, 2000, Ron Guglielmo sent yet another legislative alert as the session neared an end. Another interesting development near the end of the session was the introduction in the Senate of S8118, which would make contraceptive coverage available to employees, but not mandated. This legislation would in essence afford conscience protection to Catholic employees, but not insurers. Fidelis would be exempt from this legislation because it did not apply to Medicaid, but passage of the legislation would in essence prevent Fidelis from developing commercial plans in the future.

The struggle with these issues continued in the 2001 session. On January 23, 2001, the Senate passed bills (S.3, Bruno and S.1265, Lavalle) providing for mandated contraceptive and infertility treatment coverage, respectively with adequate conscience protections, but on January 29, 2001, the Assembly passed its own bills A2002 John and A2006 Glick without conscience protection.

In remarks prepared for the Senate Roundtable on Health and Wellness on January 19, 2001, Ron Guglielmo again asserted the need for conscience protection in relation to these two pieces of legislation. On February 9, 2001, the Conference organized a

conference call of Council Chairs and Diocesan Public Policy Education Network Coordinators to stimulate grassroots advocacy on conscience protection. The February 6, 2001 Leaders' Conference Call was also focused entirely on this agenda item.

On February 13, 2001, a Joint Conference Committee, with five Senate appointees and five Assembly appointees first met. This Joint Conference Committee was one of the rare times such a vehicle had been used to resolve differences between the two houses and was given a mandate to reach agreement by March 9, 2001.

Immediately, the Catholic Conference issued a Legislative Alert urging targeted advocacy toward the ten-committee members. On their March 6, 2001 conference call, the Health Care Leaders spoke of the need for a more positive approach to the Conference's statements concerning the conscience protection issue. Mark Lane from Fidelis had its ad agency prepare a draft statement to go to the Bishops for their consideration of statewide publication, and there was agreement to try to engage leaders of other faith communities as signatories to the statement. During this time period, publication of the fact that some Catholic entities had contraceptive coverage provided through union health plans did not help the Catholic position. But, the Joint Conference Committee could not reach agreement and it appeared that neither bill would be passed in the 2001 legislative session.

In early June 2001, as the legislative session was drawing to a close, the Senate majority developed compromise language with regard to the bill to mandate coverage for infertility treatment which:

1.) Continued appropriate conscience protection;
2.) Would create an insurance "pool' mechanism for employees or insured's of exempt entities to receive coverage for infertility treatments;
3.) Would mandate coverage for infant formula for exempt insurers as a mechanism to eliminate the insurers economic advantage in not providing infertility coverage.

Following a conference call on June 12, 2001 with a small group of advisors, Conference staff communicated to Senate leadership three concerns about the language and on June 15, 2001 reviewed a revised Senate proposal, without committing support.

On June 17, 2001, the Senate introduced two new bills S5626 Bruno, relating to mandated contraceptive concerns and S5627 Lavalle for mandated infertility treatments. Both bills included provision to extend exemptions to religious employers and insurers from having to provide such coverage and to extend optional group-rated coverage to individuals employers or insured by exempt religious entities. There were, however, significant differences in the components of the two bills.

Unfortunately, the Assembly flatly rejected the revised Senate bills, and maintained its insistence on striking or severely limiting conscience protection provisions in any bills addressing these mandates, and once again the bills were not passed.

Activity began almost immediately on these bills in the 2002 legislative session. Concerned that the Senate might waiver in its continuing commitment to adequate conscience protection, at its meeting on January 17, 2002, the State Public Policy committee asked Chairperson Bishop Howard Hubbard to write to the Bishops of the state to contact Senators from their Diocese in light of current legislative situation.

Such efforts were not to be successful.

With concern about the upcoming election, and with hope of saving two seats, the Senate did indeed in the 2002 session move away from its commitment to conscience clause protection. The houses came to agreement first on (S6257B, A9759) providing for mandated coverage of infertility treatment. In the end, this legislation did not pertain to morally objectionable practices so there was no need for conscience protection. Later in the session, the Houses reached agreement on A2006, Glick, S6265 Bruno, which provided for mandated contraceptive coverage, with very limited conscience protection. In order to achieve exemption, an organization had to meet tests relative to mission, persons served, persons employed and funding. The practical consequence was that such exemption could be enjoyed by Dioceses, parishes and schools connected to parishes, but not entities like Catholic Charities or Catholic health care providers.

On December 30, 2002, "confronted with no other means of defending our religious freedom against a governmental assault, plaintiffs representing a broad array of Catholic and Protestant entities, took the necessary steps of initiating legal action against the state of New York challenging the constitutionality of the Women's Health and Wellness Act, Chapter 554 of the Laws of 2002. The lead plaintiff was Catholic Charities of the Diocese of Albany. Michael Costello of Albany served as the lead attorney.

The plaintiffs lost in the decision rendered by the Supreme Court on November 25, 2003, and at this writing were awaiting decision from the Appellate Court, with intention to continue to pursue this legal remedy as far as necessary.

9. Other Public Policy Matters

During this decade, the Council and Conference addressed a number of other public policy issues, as follows:

a. Newborn Length of Stay

On April 15, 1996, the Conference achieved a legislative priority when Governor Pataki signed legislation to limit managed care restrictions on hospital maternity length of stay policies.

b. Assisted Suicide

Cardinal John O'Connor on behalf of the Bishops of the state issued a statement decrying the April 2, 1996 Second U.S. Circuit Court of Appeals decision overturning the Quill v Vacco decision banning assisted suicide.

c. Determination of Death

Continuing on previous discussions in prior years, Dennis Whalen, Director of the Office of Health Systems Management of the Department of Health wrote to Catholic Conference staff on April 17, 1996, requesting that the Catholic Conference review proposed guidelines for Determination of Death. After review of these guidelines by the Health Care Council Executive Committee at its June 20, 1996 meeting, the Catholic Conference communicated to the Department of Health that the proposed guidelines were acceptable.

d. Empire Blue Cross Restructuring

Through the leadership of staff person Martha Pofit, the Council and Conference became involved in a series of activities regarding the proposed restructuring of Empire Blue Cross.

In October and November 1997, meetings were arranged with staff from the Attorney General's Office and Governor's Office to help the Catholic Conference develop a position on the proposed conversion. To prepare for this meeting, there was a conference call involving Council Officers and Special Advisors on the conversion to confirm assumptions and raise questions that might be addressed. In December 1997 and January 1998, further discussions were held with representatives of HANYS and the Albany Medical Center and then Elizabeth McCaul, Acting Superintendent of the Department of Insurance.

Based upon these sessions, the Catholic Conference adopted the following position with regard to the conversion.

1.) Conversion should not occur unless, and until, the Charitable Foundation was adequately valued and appropriately administered;
2.) Alternate financing approaches to the singular stock-based model should receive serious and thoughtful on-going consideration;
3.) The mission and board composition of the Foundation should be sufficiently broad-based to meet societal needs and be responsive to constituencies which shared the Foundation's mission.

e. Family Health Plus

Access to health insurance in the state, a continuing Conference priority, had been enhanced with the establishment of the Child Health Plus program. The proposal to establish a Family Health Plus program in 1999 posed a dilemma for the Catholic Conference because it included provision of objectionable services. In December 1999, the Bishops took a position of opposition to establishment of this program, unless it was established without objectionable services. In the spring of 2001, there arose an effort to revisit this position, as well as the extension of Child Health Plus and expansion of Medicaid to legal immigrants. A special committee of the Public Policy Committee, Chaired by Bishop Mansell was asked to address these questions and sought input from the Council. The Council recommended support of all these initiatives, while noting concern about the objectionable services, a position adopted by the Public Policy Committee.

f. Nathan Littauer Litigation

Although the Health Care Council was not directly involved, it is important to note developments relating to the merger of St. Mary's Hospital and Nathan Littauer Hospital in Amsterdam. The State Attorney General, Eliot Spitzer filed suit asserting his authority to be part of the decision-making process. On March 9, 2001, Judge Bert from the Supreme Court in Fulton County issued a summary judgment against the Attorney General. This ruling was upheld by the Appellate Division on all grounds on December 20, 2001.

g. Emergency Contraception-Pharmacy

The conference opposed new legislation (A888 Paulis, S3339, Hoffman), that would authorize the dispensing of "emergency contraception" by a pharmacist under a physician's not patient specific standing order.

h. Varia

In 2003 and 2004, the Council addressed various legislative issues including palliative care, home care, hospice care and assisted living.

Chapter Six

Fidelis Care New York

1997 – 2004

A. Introduction

One of the most remarkable moments in the history of Catholic health care in New York State, indeed in the country, came to pass at the Marian Shrine in West Haverstraw, New York on January 27, 1997, when the eight Diocesan Bishops of New York State voted to formally establish Fidelis Care New York. The legal mechanism for this act was the transfer of ownership of Fidelis Care from Catholic Medical Center to the eight Bishops jointly, as members or "owners" of the corporation.

The events leading up to this momentous achievement are detailed in the previous Chapter.

Bishops present in West Haverstraw were:

Cardinal John O'Connor, Archdiocese of New York
Bishop Howard Hubbard, Albany
Bishop Thomas Daily, Brooklyn
Bishop Henry Mansell, Buffalo
Bishop Paul Loverde, Ogdensburg
Bishop Matthew Clark, Rochester
Bishop John McGann, Rockville Centre
Bishop James Moynihan, Syracuse

They were joined by Diocesan experts they had chosen to participate in the session.

After introductory remarks from Cardinal O'Connor indicating that the Bishops of the state "were now ready to establish the health care corporation and to move this effort significantly ahead," Bishop Joseph Sullivan gave his perspective on this decision. He indicated his belief that such a joint Diocesan effort was unique not only in the United States, but in the world. He indicated that provision of Medicaid Managed Care insurance would be the first initiative, but that hopefully there would be others. He concluded his remarks by stating:

"Having an insurance company that is a friendly partner to our Catholic providers puts us in a much better position as we move in the future to assure that we are able to provide the best quality care at the best price."

Mark Lane, President and CEO outlined six factors which made the establishment of Fidelis critical to the continuing provision of Catholic health care in New York State:

1.) Current excess of providers of Medicaid Managed Care;
2.) The very competitive field of Medicaid Managed Care;
3.) The over-all effort by government to reduce taxes and therefore provision of health care services;

4.) The growing presence of for-profit entities in the provision of health care;
5.) The limited supply of capital and necessity of using our resources efficiently;
6.) The ability of the Church through Fidelis to continue to be involved in provision of health care consistent with Catholic Ethical and Religious Directives.

He indicated that there would be five measures through which the success of Fidelis could be measured:

1.) financial outcomes
2.) number of persons served
3.) influence on government
4.) quality of service
5.) integration of Catholic health care, behavioral health and human services activities

Then, Monsignor Alan Placa and Mary Healey-Sedutto gave brief presentations outlining the specific actions to be undertaken establishing the corporation through this meeting and creating a Board of Directors which would first meet formally on February 4th.

Following these initial presentations, questions and discussion focused on concerns about quality, complexity, capital and competitiveness.

The establishing motion read:

"Therefore, with the approval of all eight Bishops, the Bishops authorize the expansion of Fidelis Care from Catholic Medical Center to a statewide entity with the approval of By-Laws as presented, with the amendment with regard to the power of the Members in adopting budgets, and with the understanding that each Diocese will participate even if they cannot meet initial financial requirements, recognizing that they will make every effort to do so and will be full fledged members in the interim."

Thus was launched what has been a remarkable journey over the last eight years.

Throughout this time period, the continuing support of the Bishops, especially in raising initial capital and approving strategic directions, has been critical to the success of Fidelis.

The contributions of others are detailed throughout this Chapter.

The next section details individuals who provided over-all leadership, served on the Board, were leadership staff and helped as outside consultants.

The activities of Fidelis are then chronicled with regard to:

EVOLUTION OF MISSION
NETWORK DEVELOPMENT AND ENROLLMENT
QUALITY MANGEMMENT
PROGRAM DEVELOPMENT

B. Leadership, Membership, Staff, Outside Experts

1. Leadership

While many individuals contributed to the growth and success of Fidelis, three Board members must be singled out for their contributions.

First is Bishop Joseph Sullivan who was Auxiliary Bishop of Brooklyn and had been chosen by Bishop Daily as Chairperson of the Advisory Board when Fidelis was owned by Catholic Medical Center of Brooklyn/Queens. He had long been involved in Catholic health and human services activities at the local, state and national level. Throughout this time period, Bishop Sullivan served as Chairperson of the Board. He brought to this task a commitment, expertise and credibility with the Bishops that were invaluable to the growth of Fidelis.

As previously indicated, Monsignor Alan Placa from Rockville Centre played a critical role in 1995 and 1996, as "midwife" to the birth of Fidelis, first in June 1995 challenging the Bishops to become involved in managed care insurance and then helping to facilitate an agreement between the Brooklyn Diocese and Archdiocese about the vehicle to be used to create the statewide entity. Also an attorney, Monsignor Placa had been involved in Catholic Charities in Rockville Centre and for much of this time period served as Diocesan Coordinator of Health Affairs. In this latter role, he was instrumental in the creation of Catholic Health Services of Long Island. He also was to play a major role in the restructuring of Fidelis which was instrumental to its continuing evolution.

Tom Kelly was welcomed as a new Board member in June 1997. He was President and CEO of the Mercy Health System in St. Louis, a managed care insurer, and had had much previous experience in New York. He would play a central role in the evolution of the organization, particularly in the area of Behavioral Health Services, over the next seven years.

2. Board Membership

a. Initial Period 1997-2000

In its inception in early 1997, the Board composition reflected the agreement reached among the Bishops the preceding year: there were seven representatives from Brooklyn, five from the Archdiocese of New York and one from each of the other six Dioceses.

As of the February 4, 1997 meeting, Board officers and members were:

Officers

Officers elected by the members were:

Chairperson: Bishop Joseph Sullivan
Vice-Chairperson: Ms. Mary Healey-Sedutto
Treasurer: Mr. James Corrigan
Secretary: Dr. James McCormack
President and CEO: Mark Lane

Founding Members were:

Archdiocese of New York
Dr. Karl Adler
Dr. Michael Brescia
Father John Coughlin
Ms. Mary Healey-Sedutto, Ph.D.
Mr. Gary Horan

Albany
Dr. James McCormack

Brooklyn
Mr. Thomas DeStefano
Ms. Patricia Gilmartin
Mr. Mark Lane
Ms. Enid McCoy
Mr. William McGuire
Mr. Maurice Reid
Bishop Joseph Sullivan

Buffalo: Mr. James Corrigan
Ogdensburg: Mr. John Gray
Rochester: Mr. Jack Balinsky
Rockville Centre: Monsignor Alan Placa
Syracuse: Mr. Joe Slavik

Changes that occurred in Board membership during this period were:

- As of the June 12, 1997 meeting, the Board welcomed Mr. Tom Kelly as a Brooklyn representative.
- At the March 16, 1998 meeting, it was indicated that Bishop Daily had appointed John R. Kennedy to the Board. He had recently retired after 45 years as President and CEO of the Federal Bond Paper Company in New Jersey and at the time was Chairman of the Board of Trustees of Georgetown University.
- At the June 25, 1998 Board meeting, it was reported Ms. Elise Warrington had been elected by the Bishops as an enrollee/enrollee advocate member.
- At the September 15, 1998 Board meeting, it was indicated that Ms. Danis Joyce Gehl, suggested by Bishop Mansell, had been recommended for election as an enrollee/enrollee advocate. She would make a significant contribution to Fidelis as Chairperson of the Quality Performance Committee.
- At the April 22, 1999 Board meeting, Bishop Sullivan reported that Ms. Mary Healy-Sedutto had resigned from the Board, and that Cardinal O'Connor had appointed Mr. Patrick Aberle as her successor as Vice-Chair and member of the Board. Mr. Aberle was President and CEO of the newly formed Archdiocesan Integrated Delivery Network.

b. Restructured Board – June 2000-2004

On March 3, 2000, the Bishops approved a By-Laws change which provided for restructuring the Board so that it would include 21 members, with 8 elected at-large, including no more than four hospital/hospital system employees. The significance of this decision is further explained in the next section of this Chapter.

At the June 29, 2000 meeting, it was reported that the Bishops had elected the following officers and new members:

Officers

Chairman: Bishop Joseph Sullivan
Vice-chairman: Thomas Kelly
Treasurer: James Corrigan
Secretary: James McCormack

At-Large Members

David Campbell
Dr. Mark Donovan
Edward Sweeney
Dr. Monica Sweeney

Members remaining on the Board included:

Archdiocese: Father John Coughlin
Albany: James McCormack
Brooklyn: Patricia Gilmartin
Buffalo: James Corrigan
Ogdensburg: John Gray
Rochester: Jack Balinsky
Rockville Centre: Monsignor Alan Placa
Syracuse: Joe Slavik

At-Large

Gary Horan
Tom DeStefano
Bishop Sullivan
Enid McCoy

President and CEO: Mark Lane

Catholic Conference Director: John Kerry

Changes in Board membership which ensued during this time period included:

- At the June 19, 2001 Board meeting, it was reported that Gary Horan had submitted his resignation as an at-large member because he had accepted a new

position out-of-state. It was further reported that Bishop Mansell had appointed Dale St. Arnold as his representative from the Buffalo Diocese, replacing Jim Corrigan, who had remained as the Buffalo representative even though he had taken a position in Florida. It was therefore agreed that the Board would recommend to the members that Jim Corrigan be elected to fill the at-large spot vacated by Gary Horan.

- At the October 3, 2001 meeting, Mr. William O'Reilly, administrator of St. Joseph's Nursing Home in Ogdensburg, was welcomed as the new representative from that Diocese. At this meeting, it was indicated that the new Catholic Conference Executive Director, Richard Barnes, had become a Board member.
- At the June 27, 2002 meeting, it was reported that Dale St. Arnold had submitted his resignation because he had accepted an out-of-state job.
- At the December 20, 2002 meeting, it was reported that John Kennedy had resigned from the Board because of his full-time relocation to Florida. His business expertise had helped shape in a positive fashion the perspective of the Board
- At the April 24, 2003 meeting, it was reported that Bishop Mansell had appointed as his representative Mr. Joseph McDonald, the President and CEO of the Catholic Health System of Western New York. The Board approved the recommendation of the Nominating Committee to recommend to the Members election of Father Leo O'Donovan, S.J. to the vacated Director position of John Kennedy.
- At the June 18, 2003 meeting, the Board accepted the Nominating Committee report to recommend to the Members election of Monsignor Alan Placa to replace Mark Donovan as an at-large member, and the election of Sister Patricia Burkard as an enrollee advocate. In addition, the Board accepted the resignation of Danis Joyce Gehl due to her desire to pursue her doctoral dissertation.
- At the September 24, 2003 meeting, the Board welcomed Mr. Kevin Murphy as the new representative from the Diocese of Rockville Centre.
- At the December 18, 2003 meeting, it was reported that William O'Reilly, the Ogdensburg Diocesan representative, had resigned from the Board. It was also noted that Bishop Mansell had been appointed Archbishop of Hartford. Bishop Sullivan acknowledged Bishop Mansell's support of Fidelis throughout the years.
- At the April 29, 2004 meeting, it was reported that David J. Campbell had submitted a letter of resignation.
- At the June 23, 2004 meeting, the board accepted the recommendation of the Nominating Committee to recommend to the Members the appointment of John A. Werwaiss for the vacated Director-at-large position.
- At the September 20, 2004 meeting, John Werwaiss and Andrew Peterson, the new Ogdensburg representative, were welcomed.
- At the December 16, 2004 meeting, it was reported that the Board of Bishops had made a determination that the Catholic Conference Executive Director should not serve on the Board of Fidelis, and accordingly, Richard Barnes had submitted his resignation.

3. <u>Staff</u>

Mark Lane had been appointed as President and CEO of Fidelis by Bishop Daily in the summer of 1996. Originally from upstate, and a graduate of Alfred University, Mark had

worked at St. Peter's in Albany before going to work at Catholic Medical Center in Brooklyn. Mark also obtained a Masters Degree in Health and Health Care Administration and a Masters Degree in Business Administration Major in Finance from Columbia University. Just before his appointment to Fidelis, he had been appointed Executive Vice President and Chief Operating Officer of Catholic Medical Center, but was enticed to leave to take on this enormous, new challenge. Over these years, it was his leadership, vision, commitment and ability to pull together a cohesive, effective Board and staff team that were primarily responsible for the success of Fidelis.

From moment one, Mark was ably assisted by a priest of the Diocese of Brooklyn, Father Pat Frawley, who was transferred from his work in the Tribunal to this assignment, Father Pat's uncle, Pat Frawley, who had headed the Department of Health and Hospitals for the Archdiocese, as described in Chapter Two. Pat brought to his position enormous administrative skill and dedication to detail which made him an invaluable member of the team.

Other leadership staff who contributed so much to Fidelis during this time included:

Finance: Howard Balsam, James Sinkoff, Matthew Walsh, Dina Sorokin, Vincent Achillare and Ronald Weingartner.

Legal: Mildred Shanley, Sean Nataro, Pamela McNair and Regina Trainor.

Medical: Dr. Joseph Nataro, Dr. Michael Wagner, Dr. James Tan and Dr. Marc Michelson.

Program and Planning: Mary Ellen Connington, David Thomas and James Burnosky.

4. Outside Experts

Over this eight year period, Fidelis utilized the services of outside experts and consultants for a variety of purposes.

Two stand out as deserving mention.

In the fall of 1996, Fidelis hired the Medingetrix consulting plan to help put together the first Fidelis five-year business plan. Pat Barry provided invaluable assistance in this effort, and also advised Fidelis with regard to acquisition of Better Health Plan. Pat Gammel, as she was then known, became the Fidelis CFO in December 2001 and served in this capacity until her untimely death in summer 2002.

In the spring of 1997, the law firm of McDermott, Will and Emery was hired as General Counsel for Fidelis. Throughout this time period, Mr. Andrew Roth served as the principal managing partner and made enormous contributions to Fidelis.

C. Evolution of Mission

1. Initial Work 1997-1998

During his presentation to the Bishops about Medicaid Managed Care on June 9, 1995, Monsignor Placa had asserted:

"If the Sisters of the Poor were to immigrate to this country today, and step onto the shore in New York City, and wish to carry out the Gospel call to healing, they would start an insurance company."

This statement vividly dramatized the concept that the mission of Fidelis was as a new form of Catholic health care ministry to the poor.

As with many new organizations, this vision was not shared by all. Coming to a united vision was complicated by the fact that health care providers throughout the state had capitalized Fidelis, and that many of the Diocesan representatives on the Board were providers. Many of these representatives felt that the primary mission of Fidelis was to serve the Catholic health care provider community.

The story of the evolution of the mission of Fidelis is an important one, and one in which Monsignor Placa again played a critical role.

A first formal articulation of the conflicting views of mission occurred at the first official Board meeting held on February 4, 1997, when concern was expressed about the relationship of Fidelis and MDNY, a Catholic health care entity on Long Island. After a series of discussions organized by Monsignor Placa, it was reported at the April 15, 1997 meeting that Fidelis should have the ability to develop multiple product lines, including but not limited to Medicaid, long term care, worker's compensation, special needs populations and Medicare.

The next important development in the evolution of the Fidelis mission came when the Ad Hoc Task Force on Behavioral Health (Dr. Karl Adler, Tom Kelly and Jack Balinsky) appointed after the August 19, 1997 meeting, reported at the October 14, 1997 Board meeting that, at the request of Bishop Sullivan, they had identified four underlying issues which they felt the Board should address.

- Whether Fidelis should seek to serve only populations affiliated with Catholic entities or the entire population regardless of affiliation with providers.
- Whether Fidelis should consistently apply performance standards to all providers, or should accommodate the needs of Catholic providers.
- Whether Catholic providers should give preference to Fidelis in partnering arrangements.
- Whether the Board of Fidelis should be broadened beyond the existing predominantly provider base.

This discussion really began the Fidelis strategic planning endeavor and set the stage for a Board Strategic Planning Retreat.

At the December 18, 1997 meeting, what had become the Task Force on Board Policy Issues gave a report outlining their recommendations of four guiding principles for strategic planning:

- Develop a process to address Fidelis' composition of network providers through developing Regional Advisory Committees.
- Utilize, wherever possible, services from founding members of Fidelis, as long as they were competitive with other vendors on price and quality.
- Fidelis should be the preferred management services organization (MSO) for the sponsoring and Catholic affiliated providers.
- Board membership should be broadened to bring a greater diversity of expertise.

The importance of addressing these issues was underscored in the aftermath of the acquisition of Better Health Plan described below. At the March 6, 1998 Board meeting, concern was expressed by representatives of the Archdiocese that with the acquisition of Better Health Plan there had been added to the Fidelis network nine network participants who were not Catholic and that this might have a negative impact on Catholic providers.

With facilitation from the firm of Jennings Ryan and Kolb, the Board held a strategic Planning Retreat on May 15, 1998. At the June 15, 1998 meeting, the Board discussed the results of this retreat. It was agreed that progress had been made, but that many issues still needed to be resolved. It was agreed that a Task Force chaired by Monsignor Placa, and including Dr. Healey-Sedutto, Mr. Kennedy, Dr. McCormack and Mr. Corrigan, would work to facilitate the steps that were identified by the Board at the retreat as necessary to ultimately resolve these issues and reach a consensus.

At the December 17, 1998 meeting, it was affirmed that the primary task of this group was addressing the conflicting visions of Fidelis among the members, the Board management and providers. It was indicated that the Task Force had concluded that despite differing options on some aspects of the role of Fidelis, there was emerging consensus that Fidelis represented a new and vital vehicle for Catholic health care ministry.

At this meeting, the Board reviewed four specific recommendations made by the Task Force, relating to:

- Composition of the Board
- Developing a consensus on mission
- Return of capital to subvention holders
- Fidelis' strategic role within the Catholic health care ministry

An important step in the process to clarify the mission and structure of Fidelis was a second Board Strategic Planning Retreat, held on February 23, 1999.

At the session there was strong agreement with this mission statement:

"The Board of Directors must build consensus that the mission of Fidelis is a new form of ministry designed to serve the poor and local communities."

There was strong agreement, although not unanimous support about the following business strategies:

- Develop market presence in additional counties for Medicaid and Child Health Plus
- Create and implement strategies for increased enrollment of Medicaid and Child Health Plus program members in Catholic provider networks
- Develop incentives and risk sharing contracts with Catholic provider networks
- Increase member satisfaction and member retention
- Increase provider satisfaction
- Develop business planning process for coverage of special needs populations
- Position Fidelis to be competitive as programs emerge for the uninsured
- Evaluate the feasibility of Fidelis developing a Medicare risk product

In addition, the Board evidenced a favorable reaction to a suggestion made by Cardinal O'Connor at the Members meeting held on September 25, 1998 that there be equal representation of the Diocese on the Fidelis Board. With some fine-tuning yet to come, the Board was in strong support of recommending to the Members a change in Board composition so that it would include:

- Designation of one Director per Bishop (currently, the Bishop of Brooklyn appointed seven members and the Archbishop of New York five members)
- Individuals to be recommended through the Boards' Nominating Committee based on the following criteria:

    * Financial expertise
    * Insurance and/or HMO experience
    * Legal expertise
    * Physician representation
    * Hospital representation, limited to three hospital/system CEO's
- Enrollee/Advocate
- Ex-Officio Directors (Fidelis CEO, Executive Director of New York State Catholic Conference)

There was also strong affirmation of the plan to begin returning investor capital commencing in 2002.

At the April 22, 1999 meeting, the Board approved the Restated Planning Document with minor revisions suggested from the February 23, 1999 meeting. This document was unanimously approved by the Bishops at their meeting on June 4, 1999. the document is attached as Appendix IX. With this step, an important phase in the evolution of Fidelis was concluded. At the June 24, 1999 meeting, Bishop Sullivan complimented the Board on its significant progress. With this very positive Board meeting held in Rochester, many observers thought that Fidelis had come of age.

2. <u>Strategic Planning - 2001</u>

Further activity with regard to the evolution of Fidelis occurred in 2001.

At its April 21, 2001 meeting, the Board heard a summary presentation on the outcome of a Board Planning Retreat held on March 1, 2001.

It was reported that the Board had identified several activities it wished to undertake in support of Fidelis including:

- Enhance the Board's role as advocate relative to selective public policy issues
- Establish mission oriented communication approach with the Bishops
- Identify means to capture information from consumers relating to trends, barriers, etc.
- Attend and participate in Board meetings
- Think as a Board Member, not a constituent

The Board also agreed that growth was essential to the future of Fidelis and identified several strategies for achieving this goal, including:

- New product development (Medicare, Family Health Plus, HIV AIDS Special Needs Plan)
- Acquisition of other plans
- Improved retention of existing membership
- Creation of appropriate partnerships with providers and agencies
- Expansion into new geographic areas within New York State

As follow-up to the retreat, the Board created two task forces. The first would focus on defining the Board of Directors' roles and responsibilities. The second would focus on establishing an effective working relationship with the New York State Catholic Conference.

At the October 3, 2001 Board meeting, it was reported that the Task Force on the Board's Role and Responsibilities had met on October 1, 2001. It was agreed that there was need for the Board to move from operational oversight to strategic oversight. It was agreed that the Task Force would draft a document that would refine Fidelis' strategic vision and clearly articulate the connection between the plan's organizational strategy and the broader mission of the Church.

This document was presented at the December 20, 2001 meeting. The report recognized that the Board of Directors initially viewed themselves as investors in Fidelis, but now viewed themselves as entrepreneurs. Further, the Task Force believed that the Board of Directors no longer needed to be as concerned with the structure of the corporation, rather the Board could focus on developing this new aspect of the Church's mission which was to ensure access to quality health care for the poor and medically underserved. Monsignor Placa was once again applauded for the key role he had played in fostering this new phase in the evolution of Fidelis.

3. Strategic Planning 2003

At the April 24, 2003 meeting, Bishop Sullivan indicated that a consensus from a review of evaluations by members was that the Board should spend less time hearing reports and more time focusing on strategic planning. Accordingly, a good portion of time was given over at the meeting to a presentation from the Fidelis Planning Department commencing

this strategic planning emphasis. In this presentation, it was indicated that there were perhaps only 750,000 additional potential Medicaid Managed Care enrollees in the state, and that given existing market share, Fidelis might expect 75,000 more enrollees. It was clear that the number of existing providers would be reduced and that Fidelis was initiating a process to look at the possible acquisition of other managed care companies.

At the September 24, 2003 meeting, the Board heard a presentation from Monsignor Placa about the work of the Board Task Force created in June to consider strategic initiatives for the expansion of the mission and ministry of Fidelis. The Task Force had concluded that there was immediate need for a for profit subsidiary of Fidelis in order to pursue business initiatives, such as Partners in Community Care, without jeopardizing Fidelis tax-exempt status through the receipt of unrelated business income. There were many other long-term opportunities which could also be pursued through this vehicle. At the December 18, 2003 meeting, the Board approved a recommendation to the members for the establishment of such a subsidiary corporation. The members approved this action in early 2004.

4. 2004 Strategic Planning Priorities

At the December 16, 2004 meeting, the Board heard a presentation on accomplishments in 2004 related to eight strategic priorities adopted at the beginning of the year.

a. Furtherance of Fidelis Mission

2004 Results

- The plan self-insured its employee pharmacy benefit
- The plan created Salus Administrative Services, a for-profit subsidiary
- The Healthy Kids Fund subsidized $168,000 in co-premiums for low-income children
- The plan provided grants in excess of $1.5 million pursuant to the Diocesan Grant Fund

2005 Initiatives

- Research creation of a new Fidelis Hope insurance product
- Continuation of grant programs
- Continuation of Healthy Kids Fund

b. The Delivery of Quality Health Care

2004 Results

- Positive results for the 2004 Quality Assurance Reporting Requirement
- Increase in provider payments for Quality Incentive Program (QIP)

2005 Initiatives

- Enhancement of disease management initiatives

- Continue efforts to educate providers regarding QIP
- Align health care goals of members and providers

c. Growth of Fidelis' Business

2004 Results

- Fidelis enrollment increased during 2004 and voluntary disenrollments were below targeted benchmarks
- Fidelis expanded into additional counties
- Fidelis enhanced its provider network

2005 Initiatives

- Continue strategies for membership growth in all lines of business

d. Strengthening Provider Relations

2004 Results

- Provider satisfaction with Fidelis continues to improve as evidenced by the Gallup Provider Satisfaction Survey
- Enhancement of the provider network with the addition of the following providers:

  - Medisys
  - Memorial Sloan Kettering
  - United Health Services
  - Mary Imogene Bassett Health Care
  - Long Island Health Network
  - Strong Health System
  - Greater Rochester IPA

- Expansion of WebMd initiatives resulting in increase in the percentage of claims submitted electronically

2005 Initiatives

- Continue enhancement of the provider network
- Expand initiatives related to partnerships with Catholic institutions

e. Improving Customer Services

2004 Results

- Fidelis continued to be an efficient and administratively well run plan
- Simplified billing and payment processes for Child Health Plus members

2005 Initiatives

- Strengthen internal processes related to the flow of information

f. New Business and Diversification

2004 Results

- Introduced Fidelis Medicare Advantage in Oneida and Herkimer counties

2005 Initiatives

- Acquire Good Samaritan Hospital's membership interest in Partners in Community Care
- Expand the Medicare Advantage program to additional counties
- Explore feasibility of developing a PACE program
- Explore the development of a Fidelis Hope product
- Explore diversification through the development of third party administrative services

g. Internal Operational Excellence

2004 Results

- Successful implementation of a new information technology system
- Completed space expansion
- Expanded internal employee training programs
- Continued to develop Fidelis' Corporate Compliance Program

2005 Initiatives

- Develop various incentive and performance management programs
- Develop departmental employee training programs

h. Affirmation of Fidelis' Reputation

2004 Results

- Participation in 2004 Cover the Uninsured Week
- Developed a comprehensive communication plan

2005 Initiatives

- Continue to enhance communication
- Expand Fidelis' Website
- Expand Fidelis' partnerships particularly with Catholic institutions

5. Conclusion

In eight years, Fidelis had come a long way in understanding and charging out its mission to ensure access to quality medical care for the poor and medically underinsured.

D. Network Development and Enrollment

1. Overview

The following chart demonstrates dramatically the rapid growth of Fidelis in this eight-year period.

Year	Provider	Counties	Medicaid Members	Child Health Plus Members	Family Health Plus Members
1997	10,916	15	60,645	6,423	
1998	13,251	16	61,982	14,135	
1999	13,519	22	64,466	21,595	
2000	19,938	34	74,179	29,365	
2001	21,789	34	90,842	33,485	115
2002	21,415	33	136,866	28,565	11,462
2003	21,030	33	167,122	22,672	24,592
2004	28,420	34	179,229	23,268	34,515

2. Medicaid Managed Care

a. Introduction

In the previous Chapter it was reported that Fidelis had gained approval to provide services in Brooklyn and Queens in the summer of 1996, and that by the end of 1996, Fidelis was operational in the five boroughs of New York City. This section details milestones in the growth of Fidelis in the Medicaid program, and the next two sections detail growth in Child Health Plus program and Family Health Plus program respectively.

b. Better Health Plan - 1997

At its April 15, 1997 meeting the Board approved hiring Medimetrix to do a Phase I due diligence/valuation assessment study about the possible acquisition of Better Health Plus, a Medicaid Managed Care provider primarily serving the Buffalo and Albany areas.

At its June 12, 1997 meeting, following on several presentations reporting on due diligence activities, and lengthy discussion, the Board approved a resolution recommending to the members the acquisition of Better Health Plan, a managed care company with approximately 40,000 members enrolled throughout the state, an

experienced managed care staff, and the highly regarded Diamond information system, which represented an upgrade to the existing Fidelis system.

With the completion of the acquisition of Better Health Plan, as of October 1997, Fidelis was approved for operation in the following counties:

Bronx	Onondaga
Cortland	Oswego
Erie	Queens
Kings	Richmond
Nassau	Rockland
New York	Suffolk
Niagara	Westchester
Oneida	

This acquisition was the first example of what was to be the experience of Fidelis that it was easier to "buy" a network than to "build" a network.

c. Building the Network 1997-2000

Following the acquisition of Better Health Plan, Fidelis went about the slow and tedious process of recruiting additional members in counties where Fidelis was operational and building networks and gaining approval to operate in additional counties.

Highlights of this work are reported here.

At the August 19, 1997 meeting, the Board reviewed a memo from Father Frawley to Mark Lane discussing problems of involuntary disenrollment, over which Fidelis had no control, and voluntary disenrollments caused largely by problems with Healthscope. The involuntary disenrollment problem, caused largely by individuals losing their Medicaid eligibility for a variety of reasons, would plague Fidelis for years to come. With the termination of the contract with Healthscope as of May 19, 1997, and with the assumption by Fidelis of direct control over marketing, Father Frawley proposed several new marketing approaches, including an initiative to connect to Fidelis patients served by Catholic institutions. (It was also reported at this meeting, that dental services were added as a covered service as of July 1, 1997.)

At the October 14, 1997 meeting, it was reported that it had become clear that community-based generic marketing would not enable Fidelis to meet its enrollment targets. Priority would be given to the one-time opportunity when mandatory enrollment was enacted. Emphasis would be given to relationship with county officials.

At this October meeting, much time was devoted at the board meeting to the status of integration of the Better Health Plan organization into Fidelis. It was indicated that with the acquisition of Better Health Plan, Fidelis now had three regional offices:

- The Western New York Regional office in Amherst, serving Buffalo and Rochester Dioceses.

- The Northeast Regional office in Albany, serving the Ogdensburg, Syracuse, Albany Dioceses and the northern counties in the Archdiocese, with a satellite office in Syracuse.
- The Rego Park office serving the New York Metropolitan area.

At the March 6, 1998 meeting, Father Frawley indicated that the new Fidelis marketing campaign would emphasize the Fidelis mission to distinguish it from other plans.

At the April 23, 1998 Board meeting, there was again lengthy discussion about enrollment and marketing. Concern was expressed that despite new enrollments of 3000 per month, enrollment was static because of an average of 2300 involuntary and 700 voluntary disenrollments per month. In light of this situation, it was agreed that Fidelis should take three approaches.

- Targeting marketing efforts individually with emphasis on a "partnership program" between Fidelis and local providers to enroll current Medicaid fee-for-service clients.
- Continuing to pursue gaining approval in additional counties upstate.
- Gearing up for the conversion to the mandatory modality both downstate and upstate.

At the September 15, 1998 meeting, the focus was on New York City. Again, it was recognized that the implementation of the mandatory enrollment requirement was a critical opportunity for Fidelis. It was reported that mandatory enrollment was scheduled to begin in New York City on a four-phase approach over two years. Concern was expressed about legislation introduced into the New York City Council that would prohibit "auto assignment" to Fidelis because it did not directly provide family planning services, but it was reported that the Mayor had indicated he would veto such legislation. (At the December 18, 1997 meeting, the Board had approved a policy on provision of family planning services acceptable to the State Department of Health, and consistent with the state and federal regulations, provisions required of all Medicaid Managed Care Plans, and existing Memoranda of Understanding between the State Department of Health and other Catholic affiliated health care institutions. Nonetheless, the issue of family planning would surface again and again over the years).

It was reported at the April 22, 1999 meeting that with the approval for operations in Albany, Rensselaer and Orleans Counties, Fidelis was operational in 18 Counties.

At the June 24, 1999 meeting, it was reported that Fidelis had received approval to begin operations in four new counties: Broome, Cattaraugus, Columbia and Greene.

At the December 16, 1999 meeting, it was reported that New York City had begun to implement mandatory enrollment in September, and that 15 Counties throughout the state were requiring mandatory enrollment. To take advantage of these opportunities, Fidelis planned to significantly increase marketing staff.

d. Partners Health Plans Acquisition - 2000

At the April 27, 2000 meeting, Bishop Sullivan reported that on January 25, 2000, the Executive Committee had met to review an analysis of the Partners Health Plans acquisition. The Executive Committee approved the pursuit of the acquisition, and an Asset Purchase agreement between Fidelis and Partners was executed on January 28, 2000.

It was reported that the State Department of Health transferred Partners Membership to Fidelis' Member roster on April 4, 2000. The State Department of Health approved the acquisition, including the Asset Purchase Agreement on April 10, 2000. This approval letter amended Fidelis' service area to include 11 new Counties. Fidelis was approved to enroll Medicaid Members in Chautauqua, Herkimer and Saratoga counties. Fidelis also received approval to enroll Child Health Plus Members in the following counties: Chautauqua, Clinton, Dutchess, Essex, Franklin, Hamilton, Herkimer, Saratoga, Ulster, Warren and Washington.

Through this acquisition, Fidelis Membership was expected to increase by approximately 6000 Medicaid enrollees and 2100 Child Health Plus enrollees. In addition, Fidelis acquired contracts with about 3700 new physicians and 25 new hospitals.

With the acquisition of the Partners program, enrollment levels were above those projected in the operating budget.

e. Continuing Network Development – 2000-2004

At the December 21, 2000 meeting, it was reported that enrollment projected for 2001 was somewhat lower than the projection given in the five-year business plan.

Three significant factors affecting these projections were:

- Delay of implementation of mandatory enrollment in New York City and other Counties.
- The continuing problem of involuntary disenrollments caused in significant part by welfare reform initiatives, which was still in the range of 4 percent per month.
- The changeover to more complex enrollment in the Child Health Plus program, which will be described in the next section.

At the October 23, 2001 meeting, these matters were reported:

- That because of the initiation of mandatory enrollment in Nassau, Suffolk and Rockland counties, membership had grown by 4000
- That continuing involuntary disenrollments of 3.8 percent and the slowness of implementation of mandatory enrollment in New York city had negative impact on enrollment, although Phase II was scheduled to begin in New York City in October

- Finally the Board gave contingent approval to acquiring 400 Medicaid enrollees from the Community Physician Primary Care group in Erie County, a program capitated only for primary care purposes.

At the April 5, 2002 meeting, it was reported that, at two public hearings regarding implementation of phases 4 and 5 of mandatory enrollment in New York City, representatives of the National Abortion and Reproductive Rights Action League had testified inaccurately that Fidelis members were denied access to family planning services. The Board appointed an Ad Hoc Committee comprised of Danis Gehl, Patricia Gilmartin and Father Coughlin to develop recommendations about a response.

At the end of April 2002, enrollment in the Medicaid program was 106,509 as compared to a budget projection of 89,555, enrollment in the Child Health Plus Program was 32,608 as compared to a budget projection of 38,231, and enrollment in Family Health Plus was 2210 as compared to a budget projection of 1,243.

The major factor driving the increased enrollment in the Medicaid program was the implementation of mandatory enrollment in New York City and five other counties: Cattaraugus, Chautauqua, Oneida, Nassau and Suffolk. Through mandatory enrollment, Fidelis had received a significant share of auto-assignments because of its high quality ratings. The mandatory requirement also had resulted in fewer involuntary disenrollments.

On the other hand, it was noted that those enrolled by auto-assignment tended to be less motivated and to have more health problems. Already, there had been apparent lessening of meeting quality measures such as initial contact, health risk assessment completion, etc. It was suggested that Fidelis needed to work with the State Department of Health to establish new quality rating mechanisms for this target population. It was also reported that Fidelis would work with Brooklyn Catholic Charities on a pilot project about joint ways to reach out to this population.

Two important matters were discussed at the September 25, 2002 meeting:

- It was reported that overall enrollment had reached 160,000 members, with enrollment growth over the three previous months described as “outstanding”. A major reason was the implementation, especially in New York City, of the mandatory enrollment requirement.
- Monsignor Placa raised the question of whether Fidelis was retaining auto-assigned members. In follow-up to the response that these members were being retained, Monsignor Placa indicted that this reality confirmed that the quality and service being provided by Fidelis as a Catholic sponsored health plan operating in accord with the Ethical and Religious Directives, was satisfactory even to members who did not actually seek to enroll in Fidelis.

At each of the meetings held in 2004, it was reported that the growth of enrollment was slowing due to increasing market saturation.

f. Conclusion

Over the eight years recorded here, Fidelis had done a remarkable job in enrollment growth and county expansion. Clearly, a major positive factor had been the mandatory enrollment requirement. As reported elsewhere, the high quality performance of Fidelis resulted in Fidelis getting a significant share of "auto-assignments". Nonetheless, as reported previously, with growing market saturation, there was increasing need to pursue opportunities for acquiring other plans. At the end of 2004, Fidelis was involved in discussions about just such an opportunity. If completed in 2005, it would be a fitting completion to the decade that had elapsed since the pivotal meeting of the Bishops in June 1995.

3. Child Health Plus

At its first formal Board meeting, held on February 4, 1997, the board reviewed possible participation in the newly created Child Health Plus program. Assurance was given that such participation would not compromise the adherence of Fidelis to Catholic Ethical and Religious Directives, particularly with regard to Family Planning Services.

At the June 12, 1997 meeting, it was reported that Fidelis had been awarded a contract for Child Health Plus with approval for counties in which it was already operating and with the ability to expand to other counties as networks were developed.

At its August 19, 1997 meeting, the Board reviewed a strategic plan for implementation of the program beginning October 1, 1997.

By the end of 1997, enrollment for the program was already over 6000. With the advent of this program and the acquisition Better Health Program, it was decided to name this program Fidelis Tender Care and the Medicaid Managed Care product Fidelis Better Health

At the September 15, 1998 meeting, the Board heard a lengthy report on this program, which by now had an enrollment of 10,000 persons in the greater metropolitan area, with positive financial results. In the previous three months, the program had been expanded into Nassau, Suffolk and Westchester Counties.

It was reported that legislation recently signed by Governor Pataki posed opportunities and challenges for the program. On one hand, benefits offered and income eligibility were expanded, and co-payments reduced, but on the other hand it was required that any family in the program eligible for Medicaid had to be removed from the program and enrolled in Medicaid. It was estimated this would affect a very large percentage of those enrolled in the Fidelis program.

Despite these challenges, enrollment in the program continued to grow steadily over the next two years. During this time, Fidelis established a Healthy Kids Foundation as a vehicle to help pay co-payments in the Child Health Plus program and to support other initiatives to help improve children's health.

At the September 14, 2000 meeting, the Board heard a report on the facilitated enrollment process. First, there was a comparison of eligibility and benefits for Medicaid and Child

Health Plus. It was reported that the federal government had recently determined to require that all Medicaid eligible CHP Children be recertified in Medicaid. For Fidelis, this meant between 50 percent and 80 percent of the Child Health Plus enrollment. Because of the onerous process of recertification and the stigma felt by some in relation to Medicaid, it was reported that Fidelis new CHP enrollments and recertifications had been reduced by almost 50 percent.

It was indicated that the Fidelis strategy going forward was:

- Building and maintaining positive relationships with lead facilitated enrollment agencies
- Increased advocacy at the state and county levels to ensure that as many children as possible remained in Child Health Plus
- Working closely with providers to ensure recertification of existing Members
- Expanded Fidelis outreach efforts

The full impact of these changes began to be felt in 2002. During 2002 the enrollment would drop from 33,500 to 28,500. Already at the April 25, 2002 meeting, it was reported that enrollment was lower than budgeted because of increases in Medicaid eligibility and the fact that the re-enrollment process was not yet streamlined. At the September 25, 2002 meeting, it was reported that in the previous month 2300 new members had been enrolled, but still overall membership declined. This matter was brought to the attention of State Health Commissioner Dr. Antonia Novello that day when she spoke to the Board. (At this session, she indicated her belief that of the 29 managed care plans in the state that provided insurance to low income individuals, Fidelis was without question the best and was a source of pride to the State Department of Health)

For 2003 and 2004, enrollment in the program was stabilized at about 23,000.

4. Family Health Plus

At the request of Governor Pataki, the Legislature approved at the very end of 1999 creation of a new low-income health insurance program, the Family Health Plus program. As reported in the previous Chapter, the Catholic Conference had had difficulties with this program despite its consistent advocacy for increased access to health care, because of concerns about objectionable services included in the program.

At the September 14, 2000 meeting, the Board heard a report about key elements of the program which was projected to commence on January 1, 2001. It was indicated that "Requests for Applications" would be issued to organizations approved as Medicaid Managed care or Child Health Plus plans, and that Fidelis would apply in those counties in which it was already doing business.

This information was updated at the June 19, 2001 meeting when it was indicated that the state's waiver application for the program had finally been approved by HCFA and that the program would commence on September 1, 2001.

At the October 3, 2001 meeting, it was indicated that Fidelis had been approved as a Family Health Plus provider in 32 counties.

In what would become a pattern, it was reported at the September 25, 2002 meeting that there were already 6500 enrollees in the program, but that there were 4500 applications filed with local Departments of Social Services awaiting processing, with these applicants in the meantime having no health insurance. It was explained that a major reason for the delay was counties not having sufficient resources to process applications.

As of August 28, 2003, Fidelis was awaiting 3068 Family Health Plus eligibility determinations. Half of the applications had been submitted prior to June 1, 2003.

Nonetheless, for 2002, 2003, 2004, enrollment continued to grow by almost 1000 persons per month, and at the end of 2004, was over 34,000.

E. Quality Management

1. Introduction

A significant milestone in the evolution of Fidelis Quality Management efforts came in June 1999 with the creation of the Quality Performance Committee as a coordinated mechanism for overseeing quality issues and the appointment of Davis Joyce Gehl from Buffalo as its Chairperson. Results in the early years were impacted by difficulties with Healthscope/United, who had been providing TPA services to Fidelis when it was a part of Catholic Medical Center, but whose contract was terminated in early 1997, complications caused by the integration of Fidelis and Better Health management systems, and finally issues surrounding integration of behavioral health services into the internal management of Fidelis. With these matters resolved, there was throughout the remainder of this time period significant and steady improvement in quality of service provision. Reported here as indicators of quality management are QARR results, results of customer and provider satisfaction surveys, and a description of the Quality Incentive Program.

2. QARR Results

As indicated above, a major factor influencing 1996 QARR results was the difficulty with Healthscope/United. Specific areas needing improvement included HIV education, mammography and cervical cancer screening.

A major factor influencing these results, particularly relating to percentages of Board Certified Physicians, was the necessity to use two different management information systems, that of Fidelis and that of Better Health Plan, prior to the final integration of administrative services.

At the December 17, 1998 meeting, the Board reviewed the 1997 QARR report. Results showed that Fidelis performed well in those areas where Fidelis had specific disease management programs such as Baby Care and Asthma. Fidelis performed less well in areas where formal programs were lacking.

Although not required to do so, Fidelis presented a plan of correction to the State Department of Health reflecting the Fidelis commitment to improving performance. The plan included Fidelis participation in the "QARR Push" program, including restructuring of information systems, as well as member and provider outreach and education programs.

It was agreed that the focus for improvement would be in:

- Well Child Visits, 3-6 Years
- Adolescent Visits
- Tobacco Screening for Adolescents
- Alcohol and Substance Abuse Screening
- Lead Screening, Pediatric
- Breast Cancer Screening, Mammography
- Glycohemoglobin Screening

It was review of these results and the more general positive evolution of internal administration that led the Board to create the Quality Performance Committee. At this meeting, staff also initiated the Consolidated Program Performance Report.

Two main concerns which came to light through the 1998 QARR results were concern about the integrity of data following the IDT system conversion and concern regarding inadequate record gathering performed by vendors. Fidelis determined to have an independent auditor do a QARR review for the time period July 1, 1998 to June 30, 1999. The Board also reviewed a report on the Plan of Corrective Action, which included such approaches as the Quality Incentive Program, employment by Fidelis of its own medical record review nurses, on-going medical record review, Baby Care Incentive program, and outreach to members who needed monitoring.

At the April 27, 2000 meeting, the Board received a positive report that:

- The half-year QARR successfully reported the five measures requested by the State Department of Health.
- On March 17, 2000, Fidelis was notified that the state had accepted the Plan of Correction.
- The Ernst and Young Audit indicated that Fidelis had a strong ability to collect, store, and retrieve data.

This improvement continued with results reported from the 1999 full year QARR. There were no categories where there were significant negative findings.

At the June 19, 2001 meeting, the Board again heard an overview of the QARR process and 2000 results. These results were divided into five domains, with highlights as follows:

- Access to/Availability of Care: improvement was shown in all areas
- Health Plan Stability: there was improvement in all categories except "Mental Health Practitioner", where as previously reported, there were many changes in 2000

- Health Plan Descriptive Information: Fidelis continued to demonstrate growth in enrollment and Board Certification and Residency Completion rates improved
- Effectiveness of Care: in all categories Fidelis demonstrated dramatic improvement over the previous year
- Use of Services: although a majority of utilization statistics remained stable, there was an increase in ambulatory encounters and a decrease in inpatient utilization

It was reported at the October 3, 2001 meeting that the positive 2000 QARR results were already having an impact on auto-assignments as plans with higher quality ratings were given preference in the auto-assignment process.

At the June 27, 2002 meeting, it was reported that the plan's QARR measures were audited by Island Peer Review Organization (IPRO) and it had been determined that Fidelis had demonstrated a commitment to quality incomes and that all measures were "reportable" (acceptable). At the subsequent meeting, the Board received the final Audit Report prepared by IPRO, in which it was shown that there were eight measures in which Fidelis had scored above the statewide average, with all remaining measures at the statewide average. It was at this meeting that State Health Commissioner, Dr. Antonia Novello spoke to positively at Fidelis and announced that, based upon achieving quality thresholds in member satisfaction and quality of care, Fidelis would be receiving a .5 percent increase in its premium rate.

At the June 18, 2003 meeting, the Board reviewed 2002 QARR results. Once again, all measures were "reportable". The 2002 QARR results reflected the stabilization of Fidelis' outcome data and validated the effectiveness of quality enrollment activities that had been undertaken. Whereas in the prior two years, these results had demonstrated "meteoric" improvement, the 2002 results reflected the maturation of quality initiatives. There was discussion, however, about the impact of increasing numbers of auto-assignments on quality results, as it was noted these members in general tended to be less motivated about seeking care.

At the September 24, 2003 meeting, the Board reviewed the Quality Performance Matrix released by the State Department of Health. There were 22 measures of comparison for 2002 QARR results with regard to the statewide average. Of these, Fidelis had eight measures above the statewide average, ten measures at statewide average and four measures below statewide average. Of these four, three related to Comprehensive Diabetes Care. It was reported that Fidelis was studying ways to improve scores on these measures. Dr. Adler noted that the medical community in general recognized the necessity of a comprehensive program regarding diabetes education and care, particularly for the medically uninsured.

It was also indicated that Fidelis had received a .5 percent premium increase for quality performance again in 2003.

At the June 23, 2004 meeting, it was reported that 2003 QARR results had exceeded 2002 results in every area. Significant improvement was noted in annual dental visits, mental health practitioner stability, asthma, diabetes and well child visits in both the Medicaid and Child Health Plus programs.

3. Customer and Provider Satisfaction Surveys

Throughout the time period, results of both customer and provider satisfaction surveys showed great satisfaction with Fidelis. This level of satisfaction was also confirmed by the continuous very low rate of voluntary disenrollments. Results of specific surveys undertaken in this time period are reported here.

First efforts to measure member satisfaction were reported at the June 25, 1998 meeting. It was indicated that initiatives undertaken included: a mail survey, focus groups, review of member complaints and one-to-one follow-up with members who had disenrolled.

At the June 24, 1999 meeting, it was reported that the Gallup organization had undertaken a survey of 620 adult members and 451 child members. Results were generally positive, with an over-all rating of 88 percent, but opportunities for improvement existed in pre-enrollment information and in several other areas.

At the June 29, 2000 meeting, it was reported that the results of the members satisfaction survey showed continued high ratings with a composite average of 8.09 on a scale of 10, but that the results of the provider satisfaction survey were not particularly helpful because the rate of return was so low.

At the June 19, 2001 meeting, it was reported that customer satisfaction survey results remained consistent with 2000 results, showing slight improvement in several important categories. It was explained that what emerging was a pattern that reflected a subtle "shifting of the curve" of responses away from the low end to mid range and higher end scores. It was also reported that planning was being undertaken with assistance from the Gallup organization to improve a provider satisfaction survey.

At the December 20, 2001 meeting, the Board heard presentations on both a member satisfaction survey and a provider satisfaction survey. The Board heard a lengthy presentation from Dr. Blizzard of the Gallup Organization on a comparative analysis of member satisfaction surveys undertaken in 1999, 2000 and 2001. He reported that significant improvement had been realized over three years. Overall satisfaction improved significantly from 8.11 in 1999 to 8.34 in 2001. In addition, 85 percent of adult Fidelis members reported that they would recommend Fidelis to family or friends. Dr. Blizzard reported that Fidelis had also made significant improvements in serving the needs of its child members, where overall satisfaction improved from 8.43 in 1999 to 8.70 in 2001.

With regard to the provider satisfaction survey, it was reported that about two-thirds of physicians contacted reported insufficient knowledge to respond to the survey. It was noted that physicians under 35 demonstrated the highest percentage of full engagement.

At the December 18, 2003 meeting, the Board again heard presentations on both provider satisfaction and member satisfaction surveys. Dr. Richard Blizzard from the Gallup Organization presented the provider satisfaction survey. He noted significant improvement in the 2003 survey in several areas including:

- Physician awareness of Fidelis
- Physician opinion of Fidelis

- The degree of engagement of physicians participating in Fidelis' network

The Board then heard a presentation from staff on Fidelis' continuing efforts to improve provider satisfaction including:

- Enhanced training of physician – interacting staff
- Enhanced focus on the drivers of confidence and integrity (e.g. helpfulness of claims and provider relations staff), the Quality Incentive Program and Health and Disease Management Programs
- Evaluating employees based upon the attainment of specific goals related to provider satisfaction
- Initiation of a best practice study based upon the success with Family Practice physicians
- Increased outreach to managed care coordinators

Ms. Roseann Carothers and Mr. David Bahlinger from the Myers Group presented the results of the member satisfaction survey. They indicated that the summary score for the overall health plan was 84.4 percent, a decrease for the previous year score of 85.5 percent, although there was significant improvement in the Medicaid child survey.

Staff presented Fidelis' strategy to improve member satisfaction which included enhanced training for member contact staff, specifically marketing field representatives, member services representatives, lead team representatives and retention team representatives.

4. Quality Incentive Program

Another very effective technique which Fidelis used to enhance quality performance was the establishment of the Quality Incentive Program.

At the September 16, 1999 meeting, after the program had been discussed in concept at the previous Board meeting, it was indicated that an announcement of the Quality Incentive Program had been sent to all primary care providers, with copies to CEO's of Articles 28 facilities and the State Department of Health.

At the April 27, 2000 meeting, the Board heard an update on the program. It was reported that the program was already showing success as measured by the increase in the number of encounter submissions pertaining to quality measures. The Board was reminded that Fidelis had enhanced the program by initiating the Baby Care Incentive Program for 2000.

At the June 19, 2001 meeting, it was reported that Fidelis had paid out $3.6 million in quality incentives for services rendered in 2000. It was noted that the Fidelis 2000 budget made available $7.5 million for the Quality Incentive Program.

At the June 27, 2002 meeting, it was reported that of the $10 million opportunity, providers had taken advantage of $7.3 million in 2001.

At the September 24, 2003 meeting, the Board was reminded of the four components of the Quality Incentive Program.

- Effectiveness of Care
- Health Risk assessment
- Baby Care Incentive Program
- Dental Care Incentive Program

It was reported that total payments made pursuant to the program in 2002 exceeded $9.3 million, but that Catholic providers alone could have earned over $10 million more.

At the September 20, 2004 meeting, it was reported that Fidelis had provided over $14.4 million in payments for 2003, and that efforts continued to enhance the program, especially in relation to Catholic providers.

5. Conclusion

Again in this area, Fidelis had made enormous strides in a very short time period. The successful implementation of the FACETS information system on July 1, 2004 augured well for the continued ability of Fidelis to maintain and improve its quality performance.

F. Program Development

1. Introduction

Within the framework of its mission to provide access to quality health care for the poor and medically underserved, Fidelis explored over this eight-year period a wide variety of program opportunities. Described here in roughly chronological order are the five most important of these initiatives.

2. HIV/AIDS SNP

When Medicaid Managed Care enabling legislation was enacted in 1996, provision was made for development of Special Needs Plans (SNP's) relating to Behavioral Health and HIV/AIDS. From its earliest inception, Fidelis determined to pursue participation in. This quest was to prove to be among the most frustrating of all Fidelis endeavors. There were lengthy delays in development of the Request for Proposals by the State Department of Health. When the official document was finally released in spring 1999, it was over 880 pages long, as was the Fidelis' application. When approval was finally received, after many more delays, Fidelis finally began operation of the program in spring 2003. From the inception of service delivery, there were great difficulties for Fidelis, but also for the other seven providers around the state who had received SNP approval. There was little incentive for providers to participate because fee-for-service opportunities continued to exist and rates for this approach were generally higher than contracting for service through a managed care approach. Hence, participation in all plans was much lower than projected. In addition, Fidelis had another challenge in that the hoped for partnership to operate this program between Fidelis and St. Vincent Catholic Medical Centers never materialized. Census in the time period never reached ten. At the end of 2004, Fidelis was exploring its options in relation to this program.

3. Behavioral Health

The advent of managed care to the behavioral health field created among service providers much creativity and exploration of possible options for service delivery. Fidelis was very much at the center of this activity among Catholic providers.

While a part of Catholic Medical Center, Fidelis had purchased behavioral health services from an organization known as CHCS (later known as Options). When Fidelis acquired Better Health Plan, it inherited Integra as a service provider in those networks.

Already at the June 12, 1997 meeting, it was affirmed that it was crucial to have a statewide network and that the Catholic Charities Directors had agreed to cooperate in developing such a statewide Catholic network, recognizing that Fidelis would maintain its existing contractual relationship with CHCS in the interim.

To facilitate exploration of the possibilities for a statewide network, Fidelis appointed after the August 19, 1997 Board meeting an Ad Hoc Behavioral Health Task Force comprised of Dr. Karl Adler, Jack Balinsky, Jim Corrigan, Tom DeStefano, Gary Horan, Tom Kelly and Bill McGuire. As a first order of business, the Task Force sent a questionnaire to all Catholic providers in the state, inquiring about their existing services and future interest.

At a meeting of the Task Force held immediately after the Board meeting on December 18, 1997, there was agreement on the following action steps:

- Identify small groups
- Initiate a sixty day work period with work plan and timelines
- Set a goal of becoming operational in one year
- Attend to regulatory issues.

At the March 6, 1998 Board meeting, it was reported that the planning process for creating a statewide Catholic Behavioral Health Services network continued. Involved in the discussion were Fidelis, the State Council of Catholic Charities Directors and three Regional Behavioral Health Networks (Network Behavioral Health, Archdiocese; Capital Behavioral Health, Albany; and Western New York Catholic Behavioral Health, Buffalo). It was reported that KPMG had been engaged as a consultant for the process.

At the April 23, 1998 meeting, it was reported that the Task Force had reached a consensus that the model under which they would proceed would be to create a new company, structured as a management services organization owned jointly by the five entities involved in the planning process. The Task Force had determined to seek proposals from both Integra and Options to develop this management services organization.

At the June 25, 1998 meeting, it was reported that the planning process had been interrupted by the reversal of position of Network Behavioral Health who had taken the position that they could put together a Statewide Behavioral Health Services Network by themselves. It was also reported that, in the wake of this development, the State Council

of Catholic Charities Directors had opted out of participation as an equity owner of a statewide organization.

At the September 15, 1998 meeting, it was reported that because Network Behavioral Health had not yet been able to reach agreement with either Options or Integra on a partnership arrangement, Fidelis would extend both the Options and Integra contracts for two years with a ninety-day termination provision.

At the December 17, 1998 meeting, it was reported that the Board Task Force had met with representatives from Network Behavioral Health and developed a timetable and work plan to implement a statewide behavioral health system through NBH.

At the June 29, 2000 Board meeting, it was reported that since network Behavioral Health had gone out of business, Fidelis was beginning to proceed to "in-source" these services, first for those areas served by Value/Options.

At the October 3, 2001 meeting, it was reported that in-sourcing of this service had gone reasonably well. Expenses were somewhat reduced from what they would have been. Tom Kelly was thanked for the major role he had played over the previous four years in helping bring Fidelis to this point in providing quality behavioral health services.

4. Voucher Insurance Program

During this time period, Fidelis explored a number of initiatives to provide coverage to uninsured persons including:

- Robert Wood Johnson initiative
- Entrance into the small employer and direct pay insurance market
- Support of facilitated enrollment efforts
- Voucher Insurance Plan
- Fidelis Hope (post September 11th)

Of these possibilities, the program which took root was the Voucher Insurance Program.

At the June 25, 1998 meeting, it was reported that in May Fidelis had submitted a proposal to the New York State Department of Insurance to serve as the Administrator for the Voucher Insurance Program (VIP), an eighteen-month demonstration program targeting uninsured adults in Rensselaer and Westchester Counties.

At the September 15, 1998 meeting, it was reported that Fidelis was not accepted as the lowest responsible bidder to serve as administrator for this program and was preparing a bid to serve as insurer.

At the April 22, 1999 meeting, it was reported that Fidelis had received approval of its premium rates for these two counties.

This demonstration program provided an opportunity to serve about 200 individuals before it came to an end in early 2001.

5. Medicare Plus Choice

At the request of Sister Marie Castagnaro, President and CEO of St. Joseph's Hospital in Elmira, Fidelis first considered participation in the Medicare Plus Choice program at the September 15, 1998 meeting. The Board approved at the meeting the expenditure of $75,000 to engage a consultant to develop a feasibility study.

Immediately after the Board Planning Retreat held on February 23, 1999, Jim Burnosky from Medimetrix gave an overview presentation on Medicare risk programs.

At the June 24, 1999 meeting, it was reported that demographic and market penetration analysis had been done in four upstate markets: Albany, Binghamton, Buffalo and Syracuse, with the understanding that the next step would be financial analysis.

At the September 16, 1999 meeting, there was a report on the programmatic and financial feasibility study which focused on the Albany, Binghamton, Buffalo and Syracuse regions.

The conclusion was that a Medicare product was financially viable in the target regions if Fidelis could substantially reduce health care services utilization by:

- Attraction of younger Members
- Reduction of length of stay
- Reduction of inpatient admissions

It was agreed that Fidelis would create regional provider groups and they would report back at the December meeting.

There was Board consensus that Fidelis should become involved in such a program if risk was shared with providers.

At the April 27, 2000 meeting, it was indicated that feasibility study efforts were continuing, and that New York City would be added as a possible target area.

At the September 14, 2000 meeting, it was reported that because plan withdrawals nationwide from the Medicare Plus Choice program had reached historic highs, Fidelis had determined to delay development of an application

At the June 29, 2001 meeting, because changes in the program had made it more attractive, and because the absence of other providers in the Utica area would make Fidelis eligible for an enhanced premium, the Board approved proceeded developing an application for the Medicare Plus Choice program in the Utica area.

After much intervening planning, Fidelis filed this application in June 2003 for Oneida and Herkimer Counties.

The program was initiated in 2004 and by the end of the year had about 100 enrollees.

Thus was fulfilled a prediction by Monsignor Placa in his June 9, 1995 presentation to the Bishops that participation of the Church in Medicaid Managed Care would ultimately lead to participation in Medicare Managed Care.

6. Partners in Community Care

In spring 1999, Fidelis entered a partnership with Good Samaritan Hospital in the Hudson Valley to develop a demonstration project for provision of managed long-term care services for about 400 recipients. Fidelis would play a role as the MSO, while owning half the joint venture. While the program ran smoothly at first, significant financial difficulties developed in the latter half of 2003. While improvements were made in early 2004, at the end of 2004 agreement had been reached that Fidelis would purchase the 50 percent share owned by Good Samaritan Hospital and run the program on its own.

G. Conclusion

At the end of 2004, Fidelis had approximately 250,000 members and was among the five largest managed care companies in the state. This was a remarkable achievement in the eyes of those present at the formal creation of Fidelis on January 1997. Further, to the surprise of some and the delight of the Bishops and providers, Fidelis had been able to repay by the end of 2002 the $16 million initial capital investment from Dioceses, health care providers and Catholic Charities.

Nonetheless, with growing market saturation and increased financial pressures on government, Fidelis was in a situation where it was ever more important to seek acquisition possibilities and other lines of business. Fortunately, with support from the Bishops, leadership from the Board, first-rate management, and a strong financial and internal management situation, Fidelis was in an excellent position to do so.

Conclusion

In 1924, no leader involved in Catholic health care could have envisioned that eighty years later one of the major involvements of the Church in health care would be through creation of an insurance company. In those eighty years, the world had changed dramatically. Advances in medical science, much increased government oversight, much expanded community-based services and the changing face of competition all had enormous impact on the delivery of health care.

Yet, throughout all this change, the constant was the continuing commitment of the Catholic Church to the healing ministry of Jesus and the mission of providing access to quality health care especially for the poor and medically underinsured. This commitment was carried out in parishes, institutions and communities across the state.

At the same time as delivering direct services, Catholic leaders were enormously influential in shaping health care public policy in New York State, their continued advocacy based upon the Gospel message and the principles of Catholic Social Teaching.

Appendix I

NEW YORK STATE CATHOLIC CONFERENCE

11 NORTH PEARL STREET, ALBANY, NEW YORK 12207 • TELEPHONE (518) 434-6195

MEMORANDUM

TO: State Catholic Committee

FROM: James A. Cashen

RE: Statement on Catholic Hospitals

For your information I enclose a copy of a proposed Statement on Catholic Hospitals prepared and approved by the Health and Hospital Advisory Committee of the State Catholic Conference. It is proposed that this statement be sent to the Bishops of the State with the enclosed covering letter.

This matter will be on the agenda of the State Catholic Committee meeting on Thursday.

The enclosed report on Catholic health care in New York State is presented on behalf of the Catholic health providers by the Health and Hospital Advisory Committee of the New York State Catholic Conference.

Through the Administrative Board of the New York State Catholic Conference, we wish to respectfully submit to the Ordinaries of the Dioceses of New York State the need to reassess the attitudes and the involvement of the Church in the provision of Health care services to the people in their respective dioceses. Our task is by far not an easy one as it touches upon a history and tradition of religious institutions and must be responsive to current pressure from government and communities to alter or curtail long standing health care delivery. It is our belief that a failure on the part of the Church to address the critical issues facing the Catholic health care institutions might well result in their demise.

In New York State there are 45 Catholic hospitals in the eight dioceses treating 1.6 million patients annually with a total operating expenditure averaging approximately one billion dollars annually.

Catholic hospitals are important. The hospital is an essential community facility representing a major and important investment of labor, capital and other resources for the provision of critical services to the public. All Catholic health facilities support this function.

Catholic health facilities in the United States are the largest group of institutions in the world operating under a similar philosophy. Their philosophy holds that the dignity of human life is sacred, that patients are to be treated as total persons and not just disease entities.

Jesus' ministry of healing has been the motivating inspiration behind the Church's involvement in the health care apostolate. This inspiration has resulted in unique facilities providing care which is patterned after the values, loyalties, commitments, and attitudes of Christ.

Those who administer, advise, or own Catholic hospitals have an inescapable mandate to abide by the values of the Church and Christianity - values that are merely preferable in secular institutions.

Today, Catholic health providers are faced with numerous constraints, some of which are more difficult to observe because of the beliefs we hold. The escalation and complexity of regulations imposed by local, state and national bodies have special implications for Catholic institutions. The facilities obey these mandates in order to continue to serve all who come to them for help, while at the same time recognizing their obligation to the higher authority of the Church.

In order to survive in this environment, we must plan to meet the needs of health institutions, and support them in their quest for political and economic survival. We recognize that this report emphasizes the institutional delivery of health care provided under Catholic sponsorship, and we also are cognizant of the limitations we have in discussing such broad areas as health affairs. This paper does not fail to recognize the Church's activities and concerns in health care generally, but due to the immediacy of concern on health care issues relating to hospitals and nursing homes, we must therefore limit its scope to the following significant areas:

1. Identifying health care as a major priority for the institutional Church.

2. Developing sound short and long-term planning programs including such activities as communicating the Diocesan Commitment to parishes, schools, hospitals and nursing homes.

3. Becoming aware of the involvement of governmental agencies, e.g., Health Systems Agency (HSA), Community Planning Boards, State Planning Boards and Councils.

4. Developing a strong political and social base especially in advocacy activities, by developing working relationships with local legislators, community groups and health organizations.

5. Educating the public about the importance and uniqueness of Catholic health care.

6. Establishing strong and consistent communications network among the institutions, their sponsoring groups, diocesan representatives to health care, the Ordinary and the people of the diocese.

7. Demonstrating a leadership role.

8. Reassessing the provision of Diocesan resources, personnel and funding in the area of health care services and administration.

9. Determining the health needs of the people and effecting programs where feasible to meet those needs.

Today, individuals are empowered by law to pursue their own interests, even when these are in direct conflict with the more basic rights of others. In addition, public entities are losing the right to form their own institutional consciences, making it vital that the existence of Catholic facilities continue. Only through support of our institutions on all levels can we preserve the important role they serve.

THE IMPORTANCE OF THE CATHOLIC HEALTH CARE APOSTOLATE

INTRODUCTION

Catholic health facilities in the United States are the largest single group of institutions in the world operating under a similar philosophy. The Catholic Hospital System of more than 700 hospitals having over 161,000 beds almost 50 million annual patient days is an important component of the entire health care industry and the Catholic Church in the United States (note Appendix A).

In New York State alone, the Catholic hospitals cared for 1.5 million patients in 1975, provided employment for approximately 37,000 persons and touched the lives of their patients, patients' families and visitors, employees, physicians and volunteers.

The Catholic hospitals in many of our states' largest urban settings account for upwards of 20% of the total inpatient care and reach percentages in excess of 75% in numerous suburban and rural settings. The purpose for establishing the Catholic hospitals in New York State over the past two centuries has been consistent with the Church's mission to serve the physical and spiritual needs of the people. Our Christian purpose in supporting such an apostolate is being severely tested. The need for a Catholic commitment to health care has been challenged, and as a result we are seeing the beginnings of an erosion of the Catholic sponsored system.

THEOLOGICAL BASIS OF HEALTH APOSTOLATE

The impetus for institutional care of the poor and the sick can be found as early as the first ecumenical council in the early fourth century (325). With the virtue of love and the example of the Good Samaritan so explicitly set forth in the Gospels, it was natural for the Church to become the major provider of care for the leper, the blind, the crippled, the mentally ill, and the destitute. The modern hospital itself arose in the Middle Ages

under the sponsorship of religious orders attempting to meet the individual and social needs of the sick.

Our mission as Catholics is to live as Christ did, and to do His good work. The examples of Christ as healer are numerous in the Scriptures. Jesus Himself was convinced of His Father's purpose that all men be made whole and be saved. (John 3:16; 10:10) "As Jesus went along, he saw a man who had been blind from birth. His Disciples asked Him, 'Rabbi, who sinned, this man or his parents, for him to have been born blind?' neither he nor his parents sinned, Jesus answered: He was born blind so that the works of God might be displayed to him." (John 9:1-3). The Sermon on the Mount revealed that Jesus' earthly ministry was closely bound up with the frail and feeble of body and soul. In His ministry, Jesus responded to individuals as an essentail unity of body and soul. Because of the integral view of man, Jesus was able to see the influence of body and mind upon each other. He was always concerned to heal the sick: "and sufferers from every kind of illness, racked with pain, possessed by devils, epileptic, or paralyzed, were all brought to Him, and He cured them." (Mt. 4:24).

When John the Baptist heard about the works Christ was performing, he sent his Disciples to ask "Are you He who is to come, or do we look for another?" Jesus replied, "Go back and report to John what you hear and see: the blind recover their sight, cripples walk, lepers are cured, the deaf hear, dead men are raised to life, and the poor have the Good News preached to them. Blessed is the man who finds no stumbling block in me." (Matt. 11:4-6). Luke, the physician, describes the Healer Christ many times in his gospels: The Christ who "laid His hand upon each and cured them" (Luke 4:40). The Christ who saw a man full of leprosy ... and stretching forth His hand, he touched him saying "be thou made clean" (Luke 5:12-13). The Christ who "Laid His hands

on a woman horribly bent over, "and instantly she was made straight and glorified God" (Luke 12:11-13).

It was Jesus' own command: "Whatever town you enter, and they receive you ... cure the sick who are there" (Luke 10:1 809). "So they went out and preached, bidding men repent; they cast out many devils; and many who were sick they anointed with oil, and healed them." (Mark 6:7-13).

We should live by Christ's Word, which was "Do the will of my Father, and He shall give you abundance that the poor and sick can be relieved of their wants. When a man has had a great deal given to him in trust, even more will be expected of him." (Luke 12:48).

Thus: Prayerful reflections on the Gospel reveal a Christ whose ministry reached out to the poor and sick. Jesus' ministry of healing has been the motivating inspiration behind the Church's involvement in the health care apostolate. His healing ministry was a medium through which He communicated His love and compassion for the individual's suffering and through which He alleviated pain and restored wholeness. His profound concern was with the person who was called to share in the fullness of life. Physical rehabilitation was not enough. His healing was a call to change, to conversion, to reordering one's priorities, and to discovery of God.[1]

Jesus left more than His examples and sermons to care for the sick. He provided, in the anointing of the sick, a sacramental ministration to complement the other sacraments, His own gift of grace to those who are suffering.

THE ROLE OF THE CATHOLIC HOSPITAL

The philosophy of the Catholic hospital is to emphasize the value system of life, the dignity of the person, humaneness, consideration of others, and

protection of patients' rights. In the implementation of this philosophy, a true Catholic philosophy emerges through which each patient is regarded as an individual created in the likeness of God. It is this Christian concept of respect for the person, therefore, that should emphasize the patient as the center of all the activities of the hospital and is treated totally. It is this ingredient, intangible at time, that attracts patients, qualified directors of services, private practitioners and other staff.

As such an influential segment of American society, our health care facilities have the opportunity to bring Christ to millions of people and to provide a viable alternative to some of the detrimental practices of health care which are accepted as normal and ordinary practice.

The major goals of a Catholic hospital are pastoral ministry to the sick and the health serving community, providing every patient with excellent care, preparing highly trained and dedicated people to teach and assist in the care of the sick and, finally, to conduct research that will contribute to the control and conquest of disease. The relentless effort to achieve these goals takes place in a climate of concern and compassion for the whole person.

The role of the hospital in the community is a central and important one. Simply defined, the hospital is an essential community facility representing a major and important investment of labor, capital, and other resources for the provision of critical services to the public. In addition to its relationship with the Church, canon law considers the incorporation of ahospital as a device to protect and promote Church properties and to facilitate their administration. The Diocese, however, is charged to administer these properties according to the teaching of the Church and the norms of canon law. The trustess of such institutions are bound to insure that civil law, to the extent possible, insures this reality. The mere fact that a moral person in the Church, such as a

religious community, parish or hospital is incorporated under the laws of a state does not mean that this moral person loses its existence as a juridic personality under canon law and becomes totally subject to the state. In fact, it becomes subject to the laws of both the Church and the state. It acquires a double legal personality.

The state, in recognizing the rights of religion over the ownership and control of Church property has given religion the benefit of two great legal principles. First, the free exercise clause of the first amendment to the Constitution of the Unites States, which, in effect, gives to the Church a qualified right to own and administer Church property in accord with her law and for her purposes. Secondly, the Church, similar to any institution in our land, has the right to use all those legal and civil instrumentalities of law to protect herself in her day-to-day existence.

UNIQUENESS OF CATHOLIC HEALTH FACILITIES

Today, Catholic hospitals still reflect the values of the Gospels and the examples of the early hospitals, by upholding at all times the sacredness of life. They simply do it on a larger scale. In recent years, the continued existence of Catholic hospitals and nursing homes have been subject to questioning and examination. Many in the Church has asked "What difference is there between Catholic institutions and secular facilities? Why don't we let others operate the hospitals and nursing homes and devote our efforts to service in areas no one else wants to become involved in?" Our reply must be that the institutional health apostolate is people organized around a common goal, the apostolate of care on an organized basis. Through the efforts of the apostolate, the influence of the Gospel penetrates the care and services of the sick.

Catholic institutions allow us to live community, not just preach it. They provide a permanent, public, official, and formally professed witness to the works of Christ and the sanctity of all life. The Catholic hospital is "an oasis in a materialistically oriented world. Its personnel, medical, paramedical, and ancillary should manifest the motivations, values, loyalties, commitments, and attitudes of Christ. This concept is compatible with both ecumenism and with pluralistic staffs and patients, since all Christian faiths agree on the goals and behaviour of Christ, even though they may differ on His precise nature."[2]

ISSUES FACING CATHOLIC HEALTH CARE PROVIDERS

As Catholics providing health services, our prime concern is not profit, but care for people. Because of our fundamental beliefs, financial costs and revenues are never the only bases for our decisions. We also take into consideration the social, catholic benefits our our choices. In the present health care system, we are faced with numerous constraints, some of which are more difficult to observe because of the beliefs we hold. The escalation and complexity of regulations imposed by local, state and national bodies have special implications for Catholic institutions. The facilities obey those mandates in order to continue to serve all whom come to them for help, while at the same time, recognizing their obligation to the authority of the Church.

ECONOMIC AND POLITICAL SURVIVAL: THE NEED FOR COORDINATED EFFORT

Conflicts arising from state imposed conditions which may jeopardize our practice of faith and values are being experienced daily in many of our Catholic hospitals. A current concern illustrating this is the threatened existence of obstetrical services in Catholic hospitals due to regionalization of health care.

A state agency can call for the termination of obstetrical services based on the need for such a service to the population served by the hospital. This has occurred several times in New York alone.

In addition to government regulations, important problems facing all health facilities are the cost of health care, and the management of a very large system of payments for care. Relationship with governmental agencies must remain workable and balanced. Yet, without a strong planning approach on both the diocesan and state-wide basis, we could well find ourselves weakened and prey to criticism and imposed closure. Public Law 93-641 expressed the priorities determined by Congress for the future: "The development of multi-institutional arrangements for the sharing of support services necessary to all health institutions." Most health providers approve this concept. Many dioceses have also endorsed it and implemented their support in the form of shared computer health services, insurance programs, laundry facilities, etc.

This cooperation with regulatory agencies has been accompanied with demonstrations of the importance of our values for quality health care. Such coordination of effort has been heralded by health planners and legislators as the best way to care for patients. In particular, the increased communication and cooperation by our facilities under the auspices of the New York State Catholic Conference has been held up as an example of what can be done given concern and commitment to improve the quality of service of the health apostolate. We must systematically approach the questions of spiralling costs, new technological advancements and the cost of personnel fully aware of our commitment to a quality service and of the parameters under which we function. We must plan to meet the needs of health institutions we sponsor, before our planning is imposed entirely from outside our control. We have seen a leveling

in our system and in recent years a shrinkage of the number of Catholic institutions providing care. The reasons for the closure of Catholic institutions can vary, but in many cases in recent history, an inability to continue an active commitment or political naivete have been the cause. Our failure to continue to expand and innovatively maintain our institutions as Catholic will inevitably result in the disintegration of the viable alternative health delivery system we have created. We must work to maintain Catholic sponshorship of hospitals and health facilities if we are to have a significant presence in the health care field and prevent a reoccurrence of what happened in England and Canada. It is in these countries that we see a once prosperous number of Catholic hospitals dwindle in a short time to only a few, with that few struggling against almost impossible political pressure for survival. It is time for all components of the Catholic health care system to meet and plan together and eliminate the fragmentation which has plagued us in the past.

Our concern for economic and political survival can only be overshadowed by our concern for the survival of our morality and the provision of an alternative to a lack of moral values in today's society. Moral principles have been forgotten by many in our society. Our children, being taught in schools to respect the law, realize that the law itself does not always respect human life. For supported by the law, men and women have the power to destroy human life for no greater reason than their own convenience. Today, when the right to life has already been undermined by a disastrous Supreme Court decision at one end of the spectrum, and is being severely challenged at the other, by threatened restriction on the delivery of maternity services, there is little reason to believe that God's gift of life, at any stage, will long be cherished and protected as it should.

As the cost of medical care continues to soar, as individuals are empowered by law to pursue their own interests even when they are in direct conflict with the more basic rights of others, and as public facilities lose the right to form their own institutional conscience, the need for an institutional commitment to a higher law becomes even more critical. Institutional commitment is prophecy, and Christian witness in its truest and best sense. The health industry is most intimately concerned with these issues.

It is the responsibility of the Bishop, as ultimate leader of the Diocese, to fight against further degradation of life. A serious erosion has taken place in our society -- a fundamental depreciation in the perception and understanding of God's Commandments. America desperately needs a new sense of moral direction and an appreciation of the moral dimensions of the new scientific and technological age in which we find ourselves. Our health institutions provide an opportunity in our society where people can be certain that life is valued, where providers can learn respect for life, where, if we work together, we can counteract the erosion that has taken place.

ALTERNATIVE METHODS OF SPONSORING CATHOLIC HOSPITALS

The Catholic Hospital Association has been involved in a study of alternative methods of sponsoring Catholic hospitals. Dr. Paul Donnelly, Vice President of the Catholic Hospital Association, reported in a conference held in November 1976 on Alternatives for Catholic sponsorship of health care that approximately 100 Catholic health care facilities had lost their Catholic identity in the last five years either through merger, transfer to a civic community or sale of the facility or through other transactions. Sister Mary Maurita, former Catholic Hospital Association President notes that the decline

in the number of health care facilities since Vatican II heightens two needs: (1) for cooperation and commitment of the corporation and commitment of the Catholic hierachy, religious congregations and health facilities; (2) for enlarging the role of the laity as full partners in the health care facilities. The success of multi-hospital systems had hed the CHA's Project 1980 Committee to conclude that the single hospital would no longer be able to exist or go it alone as an isolated entity in delivery health care.

We need to review our commitment to the poor, and assure them of a determination on our part to protect their interest and assure for the provision of quality care. Our hospitals and homes were all founded to reach out to the poor or those society preferred to ignore. Our picture of deliverance of care may well change in the future if we are to abide by and emulate the work of the pioneer religious and lay persons who established the Catholic facilities. The Cross on our buildings should be the symbol, not only of the Catholicity but also of the commitment to dare to be a strength in a weakened world.

The sponsorship of Catholic facilities requires study in terms of the ability or willingness of religious congregations to continue to sponsor health care apostolates. The unfortunate decline in religious vocations has severely affected the Catholic hospitals. The visibility of sisters in direct patient care has been curtailed and the ability of religious sponsors is limited as operating costs increase. Thus, education and trust in the laity will be more essential now than ever before.

Responsible leadership will provide much needed direction for Catholic health care institutions as they plan for the future. It is in this leadership

role that the Ordinary, his representatives, and sponsoring religious entities must continue to provide health care delivery in a Catholic setting. This can only be achieved with a public commitment by the Ordinary to health care as a viable and definite Mission of the Church. Although the Catholic Health Care Delivery System cries for a strong and already highlighted their perceptions of the health care apostolate. (Note Appendix B).

The Catholic hospital exemplifies faith in life and confidence in what free men, working through free institutions, can accomplish. This faith is particularly necessary during these times when voluntarism at all levels seems to be under very serous attack by governmental regulatory agencies. If Catholic hospitals are to continue to survive the impact of this attack, they must speak from a position of strength. In this era, to attempt to stand alone may result in failure and an injustice to the Church and the patients we serve. If Catholic institutions work together with the assistance and leadership of the Ordinary, they can maintain a strong and staunch position in the health care system and continue their tradition of personal service to the sick.

The key to returning religious sense to technology and science, the way to restore a spiritual significance to man's work, is to make technology the intermediary between God and the human mind. In achieving this goal, we insure quality patient care and assume a leadership role for others to follow.

Now is the time to look at the present and future concerns of our institutions and health apostolate and take action to meet them. Unity of purpose will demonstrate to other facilities, government, and consumers that we have the strength, the flexibility, and commitment and the concern for our fellow man to be an absolutely necessary component of society.

FOOTNOTES:

(1) Rev. Joseph M. Sullivan, "Why Create a System of Catholic Health Care Facilities," Hospital Progress 56:81, September, 1976

(2) Rev. Trafford P. Maher, (The Viability of the Catholic Hospital The Mission of Healing (St. Louis: The Catholic Hospital Association 1975)

Appendix II

Approved April 25, 1980
Amended January 22, 1982

NEW YORK STATE

COUNCIL OF CATHOLIC HOSPITALS

C O N S T I T U T I O N

PREAMBLE

The Board of Bishops of the New York State Catholic Conference hereby establishes the New York State Council of Catholic Hospitals as an activity of the Conference. This Council will serve all affiliated Catholic hospitals in the eight Dioceses of New York State.

ARTICLE I - NAME

The name of this organization shall be the New York State Council of Catholic Hospitals.

ARTICLE II - PURPOSES

To unite the Catholic hospitals in New York State in an Association that will bring together their strengths.

(1) To witness as a group to the healing ministry of Jesus.

(2) To emphasize respect, reverence, and caring for the sick, aged, disabled, and dying as well as for life at its beginning.

(3) To focus on issues of particular concern to Catholic hospitals, not duplicating the work of other hospital associations and even joining in those efforts when it would benefit all hospitals.

(4) To assist in appropriate planning of long-range goals and policies for health care in Catholic hospitals in New York State and in that connection serve as a resource agency in compiling significant statistical data.

(5) To provide advice and recommendations to the Bishops' State Public Policy Committee regarding legislation affecting health care in Catholic hospitals.

(6) To provide liaison with the New York State Health Department.

(7) To support the recognition of "religious need" as an element of public need and the establishment and operation of Catholic health facilities.

(8) To provide information about our institutions to the people, including the parish, in order to obtain better understanding and support from the Catholic community as well as other interested persons and to emphasize to these publics the State Health Department policies as they impact on our Catholic hospitals.

(9) To provide a forum for the communication and exchange of ideas affecting health in New York State.

(10) To encourage and sponsor research, and provide liaison relative to experiments which impact on health management; education; and medical and ethical issues.

ARTICLE III - MEMBERSHIP

The membership of the Council shall consist of sixteen (16) persons, of which eight (8) will be chief executive officers elected by the chief executive officers of the affiliated Catholic hospitals in their respective dioceses and also one (1) person appointed by each Ordinary of the respective dioceses in the state.

Vacancies on the Council shall be filled in the following manner: In the event of the vacancy of a seat held by elected member, the appointed member from the diocese in which the vacancy exists shall conduct an election among the chief executive officers of the affiliated Catholic hospitals in that diocese. In the event of the vacancy of a seat held by an appointed member, the Executive Secretary shall request, in writing, that the Ordinary of the diocese in which the vacancy exists appoint a replacement.

ARTICLE IV - AFFILIATED CATHOLIC HOSPITALS

All Catholic hospitals in New York State who wish to participate in the work of the Council shall be considered as affiliated hospitals and shall contribute to the partial financing of the Council according to a formula based on the respective number of acute care beds.

[illegible] the the formula is limited [illegible] per cent

ARTICLE V - OFFICERS AND ELECTIONS

Section 1: The officers of the Council shall be a President and Vice-President whose respective duties are described in the bylaws.

Section 2: Officers of the Council shall be elected at the last meeting of the Council in the July-June year of the Conference activities; officers shall assume office at the close of said meeting; officers shall be elected for a term of two years and may not serve again in the same office until a lapse of two years.

ARTICLE VI - MEETINGS

Section 1: The Council shall meet not less than four times a year to conduct the affairs of the Council and to advise the Conference staff on appropriate activities to promote the purposes of the Council.

Section 2: The Council shall convene all of the Catholic hospitals in New York State annually in order to receive direction in its activities, to share current information, and to formulate policy recommendations for the Board of Bishops for the New York State Catholic Conference.

Section 3: The dates, times, and places of all meetings of the Council shall be determined by the officers of the Council after appropriate consultation as may be necessary with other Council members.

ARTICLE VII - AMENDMENTS

Section 1: An amendment to the Constitution may be introduced at any regular meeting of the Council, and it shall be presented in writing with sufficient copies for all members of the Council whether present or not.

Section 2: Discussion of any proposed amendment may take place no sooner than the second regular meeting after its proposal. Prior to that meeting the Executive Secretary of the Council shall mail to all members ballots to be submitted at the meeting when requested by the President or to be returned by mail, postmarked no later than midnight seven full days before the meeting.

Section 3: Voting on any proposed amendment may take place no sooner than the second regular meeting after its proposal.

Section 4: Amendments, when approved by a two-thirds vote of the total membership (eleven members), shall become part of this Constitution after approval by the Board of Bishops of the New York State Catholic Conference; such amendments shall become effective immediately following the approval of the Board of Bishops unless the approved amendment itself should specify otherwise.

BYLAWS

BYLAW I - QUALIFICATIONS OF OFFICERS

Section 1: Any member of the Council may be elected to office as long as he/she has been a member for at least two full years preceding such election.

Section 2: Candidates for election must be notified beforehand and must consent to stand.

BYLAW II - ELECTION PROCEDURES

Section 1: As stated in Article V of this Constitution, the election of officers will take place at the final annual meeting of the Council; nominations, therefore, should be entertained at the preceding Council meeting. Any member may submit a nomination either orally or by mail prior to that meeting at which nominations are to be made. It will be the responsibility of the Executive Secretary to notify each nominee, obtain his/her consent, and in accordance with his/her response either include or omit his/her name from the ballot.

Section 2: Nominations may not be made at the meeting at which the voting is to take place, nominations will be considered closed with the conclusion of the meeting preceding the meeting of election.

Section 3: Election will be by written ballot previously prepared by the Executive Secretary and distributed by mail to each member of the Council at least thirty days prior to the election meeting.

Section 4: Election to the office will be on the basis of a majority of ballots cast.

Section 5: Ballots will be counted by the Executive Secretary and verified by the outgoing officers. Results will be announced by the presiding officer of the final annual meeting.

BYLAW III - DUTIES OF THE OFFICERS

Section 1: The President of the Council shall

(a) Preside at all meetings of the Council.

(b) Convene all meetings of the Council, by selection of place, date, and time in accordance with the wishes of the members as manifested by consultation of the officers.

(c) Appoint all committees and chairmen thereof and serve as an ex officio member of all committees of the Council.

(d) Serve as the Council's representative with the New York State Public Policy Committee and shall be responsible for the submission of all Council reports and recommendations.

(e) Direct and work with the Executive Secretary in carrying on the business of the Council.

(f) Serve with the Vice-President and one other member of the Council, appointed by the President, as a Finance Committee with regard to the determination of the financial contributions of the Catholic hospitals to the work of the Council.

Section 2: The Vice President of the Council shall:

(a) In the absence of the President preside at all meetings.

(b) Assume the office of President in the event that the President becomes incapacitated, resigns, or becomes ineligible for membership by reason of a change in the qualifying position.

(c) Fill those responsibilities assigned him by the President.

(d) Serve with the President and one other member of the Council as a Finance Committee to oversee the contributions of the Catholic hospitals.

Section 3: It shall be the responsibility of the President to appoint a Vice-President for the completion of the term if that office becomes vacant.

BYLAW IV - VOTING

Section 1: In all matters each member of the Council will be eligible to vote individually.

Section 2: Except for mailed ballots used with the elections, a member must be present to vote; no proxy voting procedure will be permitted.

BYLAW V - COMMITTEES AND ORGANIZATIONS

Section 1: Standing Committees may be estabished by the Council according to the following norms:

(a) Establishment of any standing committee requires a two-thirds vote of a total membership obtained at any meeting of the Council.

(b) Members and number for each such committee shall be determined by the President on the basis of Council consensus.

(c) The chairman of each such committee, appointed by the President, shall be responsible for convening necessary meetings of the Committee, submitting oral and written reports to the Council, and maintaining proper Committee records.

(d) The purpose and scope of each such committee shall be defined in the Minutes of the Council meeting at which it is established.

(e) Continuance of each standing committee must be reviewed two years after its establishment and shall be voted upon by the members present at the meeting at which continuance is considered.

(f) Members of such committees shall be appointed by a two-year term, renewable by appointment of the President, initial members, however, may be cycled for terms of one and two years to avoid possible total turnover of members at a given time.

Section 2: Ad Hoc Committees may be established by the Council according to the following norms:

(a) The establishment of any ad hoc committee shall be determined by the President on the basis of Council consensus.

(b) The chairman of each committee, appointed by the President, shall be responsible for convening necessary meetings of the committee, submitting oral and written reports to the Council, and maintaining proper committee records.

(c) The purpose and scope of such committee shall be defined in the Minutes of the Council meeting at which it is established.

(d) The committee shall be dissolved with the accomplishment of its specific purpose.

(e) Terms of the committee members shall be the same as the term of the committee itself.

Section 3: The Finance Committee, specified in Bylaw III, shall be considered an ad hoc committee.

Section 4: No committee shall act in the name of the Council or bind the Council to any decision, commitment, or undertaking.

Section 5: Membership on the Council's standing and ad hoc committees shall be restricted to members of the Council.

Section 6: According to need and other circumstances the Council may also establish Advisory Committees for the purpose of rendering some specific assistance to the Council, these shall be set up according to the following norms:

(a) Members need not be members of the Council.

(b) The chairman should be a member of the Council, appointed by the Council President.

(c) Appointment of members, length of term, meetings, reports, and all other details shall be the responsibility of the chairman of the committee.

BYLAW VI - COUNCIL RELATIONSHIPS

Section 1: Established by the Board of Bishops of the New York State Catholic Conference, the Council is a constituent organization of the New York State Catholic Conference, subject to the policies of the Conference with the right and responsibility to contribute to the development thereof.

Section 2: The President of the Council shall serve as the ex officio delegate member on the Public Policy Committee.

Section 3: The Council shall maintain membership in such organizations as the Council selects and decides upon by vote, which are in accord with the nature and purposes of the Council.

Section 4: The Council shall be represented by the Executive Secretary in such professional associations and organizations where membership will benefit directly or indirectly the purposes of the Council.

BYLAW VII - EXECUTIVE SECRETARY

Section 1: The staff of the New York State Catholic Conference will provide to the Council professional staff services; the person so assigned shall serve as the Executive Secretary of the Council.

Section 2: The Executive Secretary will be the administrative officer of the Council.

Section 3: As such, the Executive Secretary's responsibilities will include the following:

(a) Preparatory and follow-up procedures for all meetings of the Council, including all necessary Minutes and other such records.

(b) Liaison with departments of New York State, professional associations and organizations, and any other group at which Council representation would be in the best interest of the Catholic hospitals apostolate and the Council itself.

(c) Unless structured specifically in a different fashion, general administration of activities and projects are undertaken by the Council.

(d) Development of the Council as a channel of communication, information center; public relations and public information source; agency for the promotion of research, professional activities and standards, and the religious nature of the Catholic hospital apostolate.

(e) Exploration of undertakings and activities which are consonant with the objectives of the Council.

Section 4: The selection, hiring, and assignment of the Executive Secretary, as well as the term and other details of his employment, shall be the responsibility of the Executive Director of the New York State Catholic Conference in consultation and with the approval of the Council membership.

Section 4: The Executive Secretary will function under the immediate direction of the President of the Council, recognizing that he serves as a part of the professional staff of the New York State Catholic Conference.

Section 5: The responsibility of the Executive Secretary will not include voting privileges in the Council, commitment of the Council to any activity or undertaking unless previously approved specifically or by general policy, or any responsibility or authority specifically withheld from the office of Executive Secretary by the Council or by the Executive Director of the State Catholic Conference.

BYLAW VIII - LEGAL COUNSEL

Section 1: The Legal Counsel of the New York State Catholic Conference will be ex officio the legal counsel for the Council.

Section 2: The legal counsel shall be invited to all meetings of the Council and shall be in receipt of all Council communications and memorandums.

BYLAW IX - COUNCIL FINANCES

Section 1: Financing the activities of the Council shall be the responsibility of the New York State Catholic Conference whose budget shall make provision for services to the Council of Catholic Hospitals as it does for similarly affiliated Councils.

Section 2: The Council shall agree each year to obtain from the affiliated Catholic hospitals in New York State a total contribution toward part of the costs of the Council's operations; contribution by affiliated hospitals shall be derived from a formula based upon acute care beds.

Section 3: The Executive Director of the New York State Catholic Conference shall present to the Council each year a financial report on the expenditure of contributions from the affiliated Catholic hospitals.

BYLAW X - RESPONSIBILITIES OF MEMBERSHIP

Section 1: All Council members shall be responsible for attendance at all meetings of the Council except when sufficient cause requires absence.

Section 2: With the prior approval of the Council President, a member may be permitted to send a substitute to a Council meeting.

BYLAW XI - QUORUM

A quorum of all meetings of the Council shall consist of nine members.

BYLAW XII - AMENDMENTS

These Bylaws may be amended by a two-thirds vote of the members present and voting at any regular meeting, provided that notice of the proposed amendment has been submitted in writing no later than the previous meeting of the Council and distributed by the Executive Secretary in notice of the meeting in which it is to be discussed and voted upon.

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PROPOSED STATEMENT ON PASTORAL CARE **Appendix III**

Approved by the NYS Council of Catholic Hospitals
April 7, 1981

STATEMENT

If Christian ministry is to be Christ-like, there can be no doubt that care for the sick is a part of it. A great portion of the Gospels is devoted to accounts of how Christ healed the physically and mentally ill. His love for the sick seems to have been the clearest evidence to others of His mission from the Father and of the life giving truth of his preaching. "Go and tell John what you have seen: The blind see, the deaf hear, the lame walk...and the dead return to life." Math. 11:5. Again, "I was hungry and you gave me to eat, thirsty and you gave me to drink, sick and you came to visit me..." Math. 25:35-40.

In these passages we see that the hallmark of the fulfillment of human life is the concerned intervention that makes God's creative and redeeming love a reality. You cannot love God whom you cannot see if you do not love your neighbor whom you can see. Throughout the centuries the Church has been serving in hospitals and health care facilities because of its concern and love. Since in the course of history, science and religious development have become separate and have gone their own ways, pastoral care can be the mending, the bringing together of these services to create integration and a holistic approach to the care of the sick.

In pastoral care, the Church witnesses in a manner most closely identified with the Gospel message in healing, evangelization and comforting. We recognize and believe that a system of comprehensive health care should provide care for the spiritual needs of the infirm as well as for their physical and emotional needs. We recognize that pastoral care is an essential element of the Church's role in ministry to sick persons and we reaffirm the need for the Church to constantly improve and expand its pastoral care programs in conjunction with its total mission.

Statement of Theology and Objectives

Since the pastoral care of the sick and the dependent is an essential and specialized ministry within the Church, it is recommended that every

diocese within New York State establish a pastoral office of health care ministry. The responsibility of this office will be to develop guidelines with the help of our Catholic health care facilities, to provide holistic and quality health care and to select those individuals as pastoral care personnel whose sensitivity and concern reflect the presence and the compassion of Jesus Christ.

The Pastoral Care department should be a pivotal point within our hospitals and nursing homes and must positively impact on every area of the institution and upon the community it serves.

Every Catholic health care facility should develop a written statement of its theology of pastoral care which proclaims the healing ministry of Jesus Christ by respecting and fostering the inherent dignity of every person. Pastoral care personnel in working together as a team should formulate clear and measurable goals and objectives for their program along with the overall principles for which the program exists, namely the ministry of pastoral care for all patients, their families, and the staff of the health care facilities.

Integration of pastoral care activities

Besides the priority of prayer and the sacramental ministry within pastoral care departments, it is recommended that these departments also initiate and maintain educational and informational programs for patients, families, and the staff of the health care facilities. These programs should support the importance the health care facility attaches to the overall healing ministry of the Church.

Appointment of pastoral care personnel

Accredited ordained clergy, religious, clergy of other faiths, and qualified laity sufficient to meet the needs of the facility should be appointed. A directive of the Administrative Board of USCC/NCCB states that the local ordinary should be the endorsing agent for all institutional ministries, both ordained chaplains and non-ordained pastoral associates who function in their jurisdiction.

Training of pastoral care personnel

It is of importance that each Catholic health care facility should have a well-trained and accredited pastoral care staff. Because pastoral care departments have responsibility for ministering to the sick and infirm as well as to the staff

of the health care facility, each member of the pastoral care team needs adequate training especially in the area of clerical pastoral education. Certification by the United States Catholic Conference through the National Association of Catholic Chaplains or the College of Hospital Chaplains or a similar accrediting agency, helps to ensure that pastoral care personnel possess an acceptable theological foundation and encourages a continued deepening of their faith commitment.

Pastoral Care personnel supports

For all those who dedicate their lives in the pastoral care of the sick and dependent, it is advisable that psychological supports be developed for them.

Pastoral care personnel should also have sufficient opportunities for spiritual growth in their lives. To ensure the quality of pastoral care, continuing education and informational programs are necessary especially in theology, spirituality, psychology, counselling and other fields related to pastoral ministry.

Accountability of pastoral care personnel

In the establishment of the department of pastoral care, a written plan of organization and operation should be developed. A well-organized pastoral care program helps to ensure the primary goal of providing pastoral care for patients, their families and staff of the health care facility. A Catholic health care facility's organization chart should include a pastoral care program with lines of communication and responsibility clearly established both within and without the program. Normally, the pastoral care department, through the director, should be accountable to a member of the administration of the facility.

Pastoral care as a total Church commitment

It should be recognized that the pastoral care program should collaborate with the local Church communities in the pastoral care of patients during and after their stay at the health care facility. The focus of pastoral care extends beyond the confines of the health care facility. In-service education of the local clergy, parish visitors and Eucharistic ministers will help them to become more sensitive to their responsibilities toward the sick and the dependent.

NEW YORK STATE
DEPARTMENT OF HEALTH
ROBERT P. WHALEN ...ssioner

Appendix IV

Chang... ...bject...
New York City
January 10, 1978

If Lister Hill and Phillip Burton could only see us now: up to our gluteus maximus in hospitals and nursing homes.

In the 32 years since the passage of the Hill-Burton Act, New York State has received $230 million in federal aid for capital expansion of health care facilities.

Somehow, I don't think that's what Hermann Biggs, the first New York State Health Commissioner, had in mind 64 years ago when he said: "Public health is purchasable. Within natural limitations, any community can determine its own death rate."

Nor do I think health historians have fully appreciated the impact that Hill and Burton had on health and health planning in this country, but their idea that every community which wants one should have its own well-equipped hospital has probably done more to advance the cause of curative medicine--at the expense of traditional concepts of public health--than any other factor.

And, only now are we beginning to face up to the expensive heritage left us; only now have we begun to admit that we have greatly overbuilt the capacity of our institutional health care system. It has taken us fully thirty years to learn what seems to be a rather rudimentary lesson: a people's health cannot be determined by the number of hospitals or hospital beds they have, any more than it can be determined by the nation's supply of doctors.

For, as Eric Cassell has eloquently observed, "The general health of populations is not directly dependent on medical services. Medical care did not get us out of our past (health) troubles, and it will not get us out of our present ones."

If we had more time, I would also quote Howard Cosell.

With this in mind, let us look back to the time when the Hospital Survey and Construction Act of 1946, known as the Hill-Burton Act, became law. New York State, in 1946, had some 400 hospitals with a capacity of over 56,000 beds. The state's population was 14-and-a-half million. Up until that time, hospitals and other health-related institutions were largely a product of voluntary civic effort and private philanthropy. The oldest and often best of these facilities had their origins in the concern of private, well-to-do citizens and religious organizations for care of the sick and infirm.

In 1947, soon after the passage of the Hill-Burton Law, Governor Dewey established the Joint Hospital Survey and Planning Commission to administer the program in New York State. Thus, this state became a pioneer in hospital planning on a regional basis. A state advisory council, with 25 members representative of professional and public interests, was appointed by the Governor.

For planning purposes, the state was divided into seven hospital service regions, centered on teaching medical centers in Buffalo, Rochester, Syracuse, Albany and New York City.

Acting on the philosophy that local participation is the backbone (or as some wag said recently, the Achilles heel) of effective planning, the Hospital Survey and Planning Commission promoted the creation of representative councils in each of the seven service regions. The membership of the Regional Councils was composed of hospital administrators, hospital trustees, the medical profession, the nursing profession, Blue Cross Plans, public and voluntary health and welfare agencies, labor, industry, and the consumer, and pretty much in that order of prominence.

The State and Regional Hospital Planning Councils made the following major contributions to the Hill-Burton hospital construction program in the state:

1. Provided local, broadly representative hospital medical facility planning on a voluntary basis.

2. Carried out inventories of facilities and developed estimates of need for hospitals, nursing homes, rehabilitation centers, and diagnostic and treatment centers.

3. Developed basic planning policies with respect to size of facilities, affiliations, distribution and expansion of hospitals.

4. Reviewed individual applications for Hill-Burton and other federal grants for construction of hospitals and related facilities and transmitted recommendations for approval or disapproval by the state agency.

In 1960, the Joint Hospital Survey and Planning Commission was abolished and a Division of Hospital Review and Planning was created in the State Health Department. The Department and the State Hospital Review and Planning Council were requested to accelerate leadership and assistance in the reorganization of the regional councils, and add to the role of hospital planning, the subject of hospital review. Among the questions asked were:

...Are hospitals being utilized satisfactorily?

...Are too many hospital beds being built?

...Are there gaps in service facilities leading to high cost hospitalization when long-term facilities might be more appropriate?

...What steps may be taken to encourage more ambulatory outpatient care and home care to assist in reducing the ever-mounting costs of capital expansion and operation?

(Do any of these sound familiar?)

As a result of these inquiries and subsequent deliberations, the regional hospital councils were reorganized as nonprofit membership corporations for hospital planning and review activities; operating budgets were developed; funds were secured from various local sources including the hospitals themselves; and full-time personnel were recruited to staff the regional councils.

Activities of the reorganized regional councils contributed in large measure to the voluntary establishment of utilization committees in most of the hospitals. Areawide planning, particularly in the metropolitan and larger urban areas, received greater emphasis. And studies were undertaken pertaining to factors affecting hospital costs, such as the size, location and scope of services of hospitals.

In the early 1960s, there was a continuing dialogue involving the health care industry, health insurers, members of the legislature, and representatives of labor and industry, dealing with the need to adopt some form of partial franchise in order to curtail the unnecessary development of new hospitals or the expansion of existing ones. This led in 1964 to the passage of the Metcalf-McCloskey Act.

This legislation expanded the membership of the State Hospital Review and Planning Council from 25 to 31 members and increased consumer representation. It also authorized the council, in cooperation with the regional councils, to:

1. Advise the State Department of Social Welfare and the Board of Social Welfare on the establishment of new institutions or the construction of, addition to, or substantial modification of a structure by an existing facility.

2. In general, seek to improve the quality, standards, efficiency and economy of health care throughout the state.

The Metcalf-McCloskey legislation established special controls designed to guard against over-construction and duplication of facilities and provided for a decentralized voluntary as well as governmental review of the individual proposals for all medical care facilities with due consideration to the quality of care and the effect upon the health and medical economy.

In 1965, the Governor's Committee on Hospital Costs concluded that the fragmentation of responsibilities for hospital affairs among many agencies of the state was one of the greatest barriers to effective administration of the institutional health care system. The Committee, also known as the Folsom Committee, after its chairman, Marion Folsom, recommended that the State Health Department should become the central state agency for hospital affairs.

Legislation implementing this recommendation added a new Article 28 to the New York State Public Health Law and provided that, effective February 1, 1966, the Department of Health would become responsible for the supervision, inspection, and construction review of over 1,000 hospitals, nursing homes and related medical facilities in the state. It also charged the State Commissioner of Health with

the responsibility for establishing rates for hospitals, nursing homes and other health care facilities which were reasonably related to the cost of providing such services.

With the advent of Article 28, twenty years had passed since the adoption of the Hill-Burton Law. During those two decades, 282 hospital and related medical facility projects had been approved for Hill-Burton or other forms of federal support, in accordance with the recommendations of the respective regional councils. Federal grants to New York for these projects amounted to $127 million. Additional costs of these projects not covered by federal grants brought their total cost to $607 million. The projects involved institutions in 55 of 57 counties upstate and in all of New York City's boroughs. In 20 years, hospital bed capacity had climbed from 56,000 beds to almost 74,000 beds. The state's population had risen from 14-and-a-half million to almost 18 million. On February 1, 1966, there were 391 hospitals certified in the state, together with 692 nursing homes, the latter having a capacity of 42,500 beds.

With all of the planning and review that had gone on during the preceding 20 years, one would think that 1966 was a period of serenity and winding down for the health care industry in New York State. Alas, the advent of Title 18 - Medicare - and Title 19 - Medicaid - of the Social Security Act, brought turmoil instead of peace.

I guess that has always been the lot of the health planner.

Someone recently told me the story of the physician, engineer and planner who were having a heated discussion about God's creation of the world.

"God must have been a doctor," said the physician, "because how else could he have created Eve from Adam's rib?"

"No", said the engineer, "he must have been an engineer. Don't you remember the Book of Genesis, which says that God made the earth, light, sun and the planets, and before that there was only darkness and chaos?"

With that, the planner jumped in: "That only proves my point," he said. "God was a planner. Who else would have been in charge of darkness and chaos?"

Or, as an old-timer from Maine once observed, "It's kind of hard to make predictions. Especially about the future."

I think the best example of that is the opening sentence of an editorial which appeared in Health News, the magazine of the State Health Department, in 1968. The editorial was entitled, "Planning for Better Health," and the first sentence read as follows: "When the 21st century rolls around, New York's population will have grown to 26 million." Moreover, the article went on, this was "the sober projection of experts on population, science and technology." If we could be no more accurate than that in projecting population, how were we to correctly forecast our needs for health care facilities?

With the arrival of Article 28, Medicare and Medicaid, the emphasis on capital development shifted to include nursing homes as well as

hospitals.

Which is not to say, hospital construction and renovation stopped completely; it just slowed down. For example, in 1969, construction contracts were let for 17 hospitals, using a mix of federal Hill-Burton money and state mortgage loans. In 1970, construction was begun on thirteen hospital projects, involving $33 million in state-approved mortgage loans and more than $8 million in federal grants. In the same year, 16 New York City municipal hospitals were undergoing renovation which to that point had cost $23 million. There was a new emphasis on modernization of larger, urban hospitals.

When the Health Department was delegated authority for supervision of nursing homes in 1966, it found the long-term care field poorly organized and without any well-defined or cohesive role to play in the medical care system (if indeed, medical care could be characterized as a system at that time). Nursing homes, in general, were unconnected with hospitals or other kinds of health care facilities. Many had serious physical deficiencies not amenable to correction, and most suffered from serious shortages of professional personnel.

In the face of these shortcomings, the major task facing the Department was to marshal and induce the nursing homes, singly and as a group, into producing better and safer care, and to make them capable of joining the health care continuum. The advent to Medicaid and Medicare, together with the increasing population of persons 65 or over, made the Department's task one of pressing social importance.

A Health Department inventory of nursing home beds revealed that, in terms of 1970 needs, there was an absolute shortage in 1966 of 10,600 beds and that about one-third of existing nursing home beds in the state were in unsuitable, nonfire-resistant structures. Many nursing homes were small proprietary facilities, and these accounted for about 80 percent of the unsuitable structures.

There was now a clear need for a program of state aid to foster construction of needed extended care facilities. The first of these aid programs was enacted by the 1965 Legislature, and it provided funds to underwrite one-third of the cost of constructing publicly sponsored nursing homes and infirmaries. Chapters 813 and 814 of the Laws of 1966 authorized state loans for the construction of non-profit nursing homes. Under Article 28A of the Public Health Law, the Department, with the HFA as banker, provided fiscal incentives for the creation of a network of modern, long-term care facilities in areas of the state where they were most needed. The program, later amended by Article 28B, provided funds in the form of long-term, low-cost mortgage loans for new construction, additions and modernization of nursing homes, hospitals and health-related facilities. Dormitory Authority financing was still available for individual health care projects and the public sector was utilizing the Facilities Development Corporation. Federal Housing Administration and conventional mortgages were freely available to proprietary projects.

Health-re[illegible]acilities came into formal existence on January 1, 1969, when the Department began implementing standards for a new type of institution providing a level of care below that of a skilled nursing home but greater than that afforded by a domiciliary type of facility.

Incidentally, it was not until 1973 that the Legislature amended the Public Health Law to give the Health Department jurisdiction over New York City proprietary nursing homes and hospitals. They had been exempted when Article 28 went into effect in 1966.

Between 1966 and the end of 1974, 368 non-conforming nursing homes were closed in New York State. They contained a total of 12,726 beds.

During this same period, under Article 28A, 87 projects received mortgage loans totalling $558 million. Sixty-three of these projects, involving 9,150 nursing home beds and 3,000 health-related facility beds, had been completed. Between June 1, 1970 and December 31, 1974, the Department received 644 applications involving nursing home and health-related facility construction projects. A total of 315 establishment or construction applications were approved, and they added 36,676 beds in voluntary, non-profit institutions, 26,235 proprietary beds, and 1,407 publicly sponsored beds.

As a result of all-out efforts between 1966 and 1974 -- involving on-site surveys by field staff, closings of unsatisfactory facilities, periodic medical reviews, and a construction program to replace non-conforming nursing homes and satisfy community needs -- there were in the state on January 1, 1975, 603 skilled nursing homes with nearly 70,000 beds. Four-hundred-seven of these homes conformed fully with the various state and federal structural, fire and life safety codes, and met all prescribed operational standards.

Of the remaining 196 homes, 95 were in conforming structures but were in violation of one or more of the state and federal operational code requirements. Another 33 homes were in the process of replacing structurally unsuitable buildings. The Department was actively pursuing litigation to close the remaining 68 homes, although many of these operators were using delaying actions to forestall their closing by the state.

Overall, between 1966 and the end of 1974, the non-profit hospital and nursing home loan programs administered by the Department covered projects with an estimated mortgage loan value of $2.8 billion.

1975 changed all that.

A new Administration arrived in Albany and found itself confronted with a fiscal crisis that threatened the state's very survival. In the miasma of near bankruptcy, there emerged a rethinking and a reordering of the state's health care priorities. The state's health care system was to be examined and tested as never before. For the first time, government began to perceive that health was not simply a matter of endlessly adding to the state's capacity for treating illness, and that dollars spent for this purpose were dollars not available to clean up the environment, feed and house the poor, and increase immunization protection of children. New and unprecedented regulatory powers were

vested in the State Health Commissioner, among them the authority to decertify excess beds in hospitals and nursing homes.

To cope with enormously costly new medical technology, a centralized certificate of need program was established. In a move certain to bear on hospitals' capital spending, the state began to move toward a uniform reimbursement policy for all patients, not just those covered by Medicaid and Blue Cross. Comprehensive health planning became a reality, not mere rhetorical exercise.

During the past three years, these and other factors have brought about the closing of 28 hospitals for a net reduction in hospital capacity of over 2,500 beds. In the same span, 103 substandard or inefficient nursing homes, containing a total of 6,500 beds, have been closed. There are now but four nursing homes in the entire state which fail to conform with state and federal structural standards, and efforts continue to close these last four of what had been 101 non-conforming homes in use when the Carey Administration arrived in Albany.

Withal, the task before us is still greater and more challenging than the one behind us. The state's needs for long-term care facilities have been satisfied, but we still have more hospital beds than we need, perhaps 7,000 unnecessary beds, most of them in New York City. The exorbitant cost of new medical technology is a serious challenge, highlighted by such devices as computerized brain scanners, which will add an estimated $1 billion to the nation's health care costs this year. Unless we firmly address this issue, we will find that reducing bed capacity of hospitals will lead only to more capitalization per bed.

And, the fact remains, after thirty-one years of health planning in New York State, years in which the institutional health care system was almost entirely rebuilt, we have not achieved the efficient, effective health care system we have been striving for. The question is WHY?

Some of the answers are obvious.

First of all, the Hill-Burton program provided funds on the basis of a demand formula, not a need formula. If a community sought to build a new hospital, and was willing to commit itself to raising matching funds, there was little governmental restraint to prevent the building of that hospital. For a period of twenty years, up until the passage of Article 28, construction review and planning was largely a function of the health care industry, and as with the PSROs and utilization review today, peer review was not a particularly effective deterrent to unnecessary building.

A second factor was that federal and state grants and loans required very little equity on the part of the provider. In itself, this was not bad, but it fueled phenomenal growth, not all of it needed, in a relatively short span of time. Mortgaged indebtedness is an eminent reason behind the extremely high institutional health care costs that we are experiencing in this state.

Also, if I may use the retrospectoscope, there is no question that we must move aggressively to close sub-standard institutions and buildings, when new facilities come on line. Until very recently, no one saw the urgency of balancing gains with losses.

I think this is one of the faults or assets of the entire planning process: the unconscious weight given to the prevailing social and political philosophy. In the mid-1960s, the philosophy of state government was one of growth, symbolized by the building of a billion-dollar South Mall. Population projections called for New York to have 26 million people by the end of the century. Therefore, planners foresaw that New York would need many new nursing homes and hospitals to care for this increased population. Sad to say, our population has grown scarcely at all since then, and the Days of Wine and Roses have given way to hard-nosed fiscal austerity.

Another factor that was impossible to foresee was the decline in family cohesiveness during the past two decades. The extended family, covering three generations, has almost totally disappeared. So, when an aged parent became sick or infirm, one no longer cared for him or her at home, one placed them in a nursing home or extended care facility. As a consequence of this, and the influence of Medicare and Medicaid, we have two-and-a-half times as many patients in long-term care facilities today as we did in the middle of the last decade.

Also, let us not forget that there was little provider restraint in the pass-through reimbursement practices and real property bonanzas in the nursing home field associated with Title 18 and Title 19. So, as far as capital improvements were concerned, the philosophy was, Keep up with the Joneses.

Yet, if one looks back on the past thirty years, one is awed by what we <u>have</u> accomplished in terms of quality and safety of the institutional health care system in New York State. No longer does one have to worry about placing a loved one in a wooden fire-trap of a nursing home. We've weeded out the unscrupulous enterpreneurs like Bernard Bergman. And, despite the hue and cry, we <u>are</u> eliminating waste and unneeded capacity in the hospital industry. There is no question that we could have done more, but what state has done as much? None that I know of.

As we move forward with our efforts to shrink the unnecessary capacity of the institutional health care system, there are several concepts I hope we will keep uppermost in mind.

One is that we must continue to strive for improvements in health care quality, and reductions in cost or capacity cannot be at the expense of the excellence we have so carefully nurtured for so many years. I am convinced that reducing excess capacity is the only way to assure the financial well-being of our hospital system.

Secondly, I have serious concerns about the role of private philanthropy in capitalization of the hospital industry. Should we let the rich get richer, particularly when hospitals utilize private money to acquire expensive technology or new capacity that later has to be sustained by public funds? For example, what is the relative importance of building, say, a new medical center on the east side of Manhattan, an area inundated with physicians, when there are no hospitals or physicians where they are most needed in The Bronx or Brooklyn, and when the financially strapped City of New York continues to dump raw sewage into the sea, threatening the lives, safety and livelihood of people who live on the seaboard of Long Island and New Jersey. The role of private philanthropy is a question which I hope we will have time to address at this gathering.

And, finally, anyone who would seek to promote greater efficiency in the institutional health care system without also addressing the state's oversupply of physicians is, in my view, doomed to failure. Much of our most expensive health care results not from consumer demand, but from physicians who determine that demand. We are host to 12 percent of the nation's practicing physicians and 18 percent of the nation's interns and residents, and they serve but eight-and-a-half percent of the nation's population. Over the next decade, we can expect a huge increase in the nation's - and the state's - supply of physicians. How are we to sustain them and, at the same time, the excellence and efficiency of our health care system?

The primary responsibility of government is, after all, not simply to treat sickness, but to promote the people's health. And, when it comes to health, we should keep in mind something Sir Francis Galton once said: There is a considerable difference between a good doctor and a bad one, but hardly any difference between a good doctor and none at all.

Thank you.

Appendix V

Susan

CARDINAL'S OFFICE
1011 FIRST AVENUE
NEW YORK, NY 10022

June 24, 1995

Dear Monsignor Placa,

Many thanks for your further reflections on Medicaid Managed Care. Your presentation on June 9 was great and this amplification helps clarify the issues even more.

I agree wholeheartedly with your assessment regarding the impact of a loss of a Catholic identity in health care. You made the point during your talk on June 9th that it is our apostolate that makes our "system" work. To lose that, in my judgment, is to lose the "system".

I will communicate with John Kerry and the Board of Bishops about your suggestion that some forum be made available in order for us to get at this issue in a unified and coordinated fashion. It is clear that we can afford no delay.

You are a gift to the Church in New York. Thanks for your efforts.

With a promise of prayers and

Fraternally in Christ,

J. Cardinal O'Connor

Archbishop of New York

Rev. Msgr. Alan J. Placa
Vice Chancellor
Secretary to the Bishop for Health Affairs
Diocese of Rockville Centre
50 North Park Avenue
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19 June 1995 Rec. Cardinal's Off. 6/21/95

HIS EMINENCE JOHN CARDINAL O'CONNOR
Archbishop of New York
452 Madison Avenue
New York, New York 10022

Your Eminence:

Please accept my sincere thanks for giving me the opportunity to speak with you at the New York State Catholic Conference's joint meeting of the Board of Bishops and the Public Policy Committee on Friday, June 9th.

I am sending the enclosed additional reflection on the topic *"Medicaid Managed Care: Catholic Issues and the Role of Bishops"* to you and the other Diocesan Bishops of our Province in the hope that you will find it useful in your on-going study of the question. If you think it might be useful for other bishops in your diocese to have this document, please feel free to share it with them.

I hope most earnestly that you and your brother bishops will provide us with a forum — within the Conference structure or otherwise — to continue the work of coordinating the Catholic health care apostolate across our State. I believe that one of the first tasks of such a group should be to advise you on the formulation of guidelines for reviewing proposed "joint ventures" in health care.

Sincerely,

REV. MSGR. ALAN J. PLACA
Vice Chancellor
Secretary to the Bishop for Health Affairs

Enclosure

Medicaid Managed Care:

"Catholic Issues and the Role of Bishops"

◇

Additional Reflections on a Presentation to the
Joint Meeting of the
New York State Catholic Conference
BOARD OF BISHOPS
and the
PUBLIC POLICY COMMITTEE
9 June 1995

19 June 1995

REV. MSGR. ALAN J. PLACA
Vice Chancellor · Secretary to the Bishop for Health Affairs
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Introduction

More than a year ago, in my annual report to Bishop McGann and the other Corporate Members who govern our health care institutions in the Diocese of Rockville Centre, I offered the following reflection:

> SOME YEARS AGO, in response to fiscal and demographic pressures from outside their ivy-covered walls, Catholic colleges and universities—most of them sponsored by Religious Congregations which had strong and long-standing commitments to Catholic higher education— began making small and subtle changes in their corporate organizational structures in order to make themselves eligible for grants of public monies.
>
> Before these changes were begun, most of these institutions were operated by Boards of Trustees whose majorities consisted of Religious appointed by the Provincial Superiors or by the Provincial Councils of Religious Congregations. The initial change seemed like a small thing: all that was needed for the public monies to begin flowing was that the Religious Congregation give up its arithmetical majority on the Board. The Congregations were careful to cede their majority only to the most loyal of their alumni and to the most committed Catholic lay persons they could find. The change, then, seemed merely cosmetic: a simple accommodation to a mere technicality required by the Legislature, but not a substantial change in the nature, mission, and identity of the institution. In fact, the newly constituted Boards of Trustees gave place of honor to the Provincial Superior, and they gave decisive attention to the concerns expressed by the Religious who, though in the arithmetical minority, were the clear leaders of the Boards.
>
> Now, less than a quarter century later, these institutions are no longer described as *Catholic* Colleges, but as "Colleges in the Catholic Tradition." The Major Superior of one Religious Congregation had been in office for more than four years before he was elected to the Board of Trustees of the College his Congregation had founded nearly a hundred years before, and the nature of that Religious Congregation had changed so radically in less than twenty years that there were very few Religious left who had either the interest or the qualifications to serve on the College's Board of Trustees. Today, that College's curriculum has little in it that one could identify as "Catholic," and when a member of the Board of Trustees made public statements against the Church's teachings, the Congregation and the Diocese in which the College is located were powerless to intervene.
>
> The loss of our Colleges and Universities is being felt, painfully, in every area of Church ministry today. Where are the Catholic laymen and laywomen, thoroughly grounded in Catholic doctrine and in the traditions of the Church, to staff our schools? Where are the candidates for the priesthood and for Religious Life who have been educated in our Church's philosophy and theology, brought up in our literary and artistic culture, formed in our liturgical and ascetical traditions? We have paid very dearly for the survival of these institutions, and one must wonder whether the price we have paid was truly higher than the sacrifice which would have been required to maintain control of these precious human, cultural, and spiritual resources.
>
> AS DIRE AS THE FISCAL THREAT to Catholic higher education may have seemed twenty-five years ago, the present situation of Catholic Health Care is even more problematic. By its very nature the provision of modern health care is an enormously expensive undertaking. What is more, the present "managed care" environment poses a serious threat to the independence of Catholic-sponsored health care providers. In the emerging market, those who will not "network" will die. But the paradox is this: those who *do* "network" with non-Catholic-sponsored providers may find that their attempt to "ride the tiger's back" has landed them where most such rides end: in the tiger's stomach!
>
> When *Catholic* colleges become "Colleges in the Catholic Tradition" we lose a valuable asset in one of the many aspects of our mission of handing on the Faith to future generations, and we are faced with today's challenge of accomplishing that same goal in new and imaginative ways. If our health care providers pass out of our control, then we lose the ability to *make real*, with loving and competent hands, what we proclaim *all* men and women of good will must do: to protect, cherish, and respect God's gifts of human dignity and of human life itself. There is no room for error in this most delicate project, no chance to recover from our own missteps. We must "get it right" *the first time*, and we must face *whatever* sacrifice is necessary to "get it right."

While I have no wish to be an *alarmist*, I am aggressively committed to sounding the *alarm* — we are facing a crisis-moment of unprecedented proportions in Catholic health care, and the Church must be willing to marshal its resources in response.

As I tried to suggest in our meeting in New York, this crisis goes to the heart *not only* of the Church's health care ministry *but also* to the very heart of the Church's evangelizing mission. I sincerely believe that researchers and practitioners in the medical sciences are self-consciously attempting to re-define *humanity* and *personhood*.[1] One foundation of this attempt is a belief commonly held in the "scientific community" that empirical science is the only sure foundation of knowledge; that any appeal to theology (to say nothing of divine revelation) is a retreat into a dark age of superstition. This fundamental attack on revelation and on our very epistemology is, in itself, a crisis. This attempt at a re-definition of *humanity* is also rooted in a desire to justify certain contemporary medical practices and to lay the foundation for experimentation and treatment in the future.[2]

It was suggested at our meeting on June 9th that our Diocesan Bishops have to take responsibility for integrating *all* the ministries which constitute "Catholic health care" because "you can't delegate ministry" and because "the lines between different ministries are blurring — health care, social services, education are all one." While I agree absolutely with the conclusion — our Bishops *must* play the central role in coordinating this apostolate — I'm afraid I disagree with the reasoning offered. I believe we must look much more deeply into the issue to find the *ground* for the role which Bishops must play.

In the first place, I believe that bishops *can* delegate ministry. In fact, the very first time the bishops of the Church gathered for a "business meeting" that is *precisely* what they did:

> "At that time, as the number of disciples continued to grow, the Hellenists complained against the Hebrews because their widows were being neglected in the daily distribution. So the Twelve called together the community of the disciples and said, 'It is not right for us to neglect the word of God to serve at table. Brothers, select from among you seven reputable men, filled with the Spirit and wisdom, whom we shall appoint to this task, whereas we shall devote ourselves to prayer and to the ministry of the word.' The proposal was acceptable to the whole community, so they chose Stephen, a man filled with faith and the holy Spirit, also Philip, Prochorus, Nicanor, Timon, Parmenas, and Nicholas of Antioch, a convert to Judaism. They presented these men to the apostles who prayed and laid hands on them."[3]

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[1] As I noted in the materials I distributed at our meeting in New York, the debate over "harvesting fetal tissue" provides chilling examples. One "ethician" dismissed ethical questions about "harvesting" tissue from anencephalic fetuses "because they are not human." Another dismissed the question of the morality of direct, intentional abortions as a source of fetal tissue "because abortion is legal." The typical argument of pro-abortion partisans is that the fetus "is not a person." Each of these positions springs from the assumption that definitions of *humanity* and *personhood* can be arrived at *without reference to* Revelation.

[2] A re-definition of *personhood* and of the *radical liberty* of the human person (re-defined without reference to theological principles or values) is a necessary foundation, for example, of the approach to human suffering implied in Dr. Kevorkian's work.

[3] Acts 6:1-6.

In only three years' involvement in my diocese's health care apostolate I've learned how easy it is to "neglect the Word." The field is so indescribably complex — and each step one takes gives rise to so many new questions, choices, and dangers — that one can easily get "lost in the details," and I often find myself perilously far from my "supply lines." If you will allow me the presumption, *this is the key role Bishops must play* in the health care apostolate: "devote [yourselves] to the ministry of the word" — hammer, relentlessly, at "the Word" which underlies all the business complexities and all the ministries.

Secondly, although it is quite difficult to keep the various ministries *clear* in their purposes and *anchored* to their source, recognizing the *un-blurred* differences among them is the key to the only *real* unity there can be in the apostolate:

> "Now the body is not a single part, but many. If a foot should say, 'Because I am not a hand I do not belong to the body,' it does not for this reason belong any less to the body. ... If the whole body were an eye, where would the hearing be? If the whole body were hearing, where would the sense of smell be? But as it is, God placed the parts, each one of them, in the body as he intended. If they were all one part, where would the body be? But as it is, there are many parts, yet one body."[4]

Although it is certainly an over-simplification, it seems to me that the "role of Bishops" — in health care as in all things — is *precisely* to keep the Church's vision *locked* on the essential unity of the *apostolate* "striving to preserve *the unity which is ours in the Spirit* through the bond of peace: one body and one Spirit, as you were also called to one hope."[5] Who could know better than Diocesan Bishops that the zeal of the many "specialists" with which the Church is blessed leads those specialists to assert that "all ministry is educational ministry," that "all ministry is health care ministry," that "all ministry is social ministry," or that "all ministry is liturgical ministry." But none of these formulations is the *whole* truth. Depending on tastes and prejudices, one or the other of these incantations may have a seductive appeal to us in our search for the "key" that will make health care easier to deal with. But Bishops will have to face squarely, in this most critical area of the Church's apostolate, the challenge which was presented to them by the Fathers of the Second Vatican Council:

> "Various forms of the apostolate should be encouraged, and in the whole diocese, or in given areas of it the coordination and close interconnection of all apostolic works should be fostered under the direction of the bishop. In this way, all undertakings and organizations, whether catechetical, missionary, charitable, social, family, educational, or any other program serving a pastoral goal, will be brought into harmonious action. At the same time the unity of the diocese will be made more evident."[6]

The new *Ethical and Religious Directives for Catholic Health Care Services*[7] re-states the same challenge in this way:

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[4] 1 Corinthians 12:14-15, 17-20.

[5] Ephesians 4:3-4. Emphasis supplied.

[6] Second Vatican Council, "Decree on the Bishops' Pastoral Office in the Church," *Christus Dominus*, 17 (Oct. 28, 1965).

[7] National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Washington, D.C.: United States Catholic Conference Publishing Services, 1995). Cited in this paper as *"Directives."*

The Role of Bishops — Purposes

In the first place,

> " ... Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care."[9]

Therefore, the first concern of Bishops must be to maintain the position from which we can raise *the full range* of ethical questions involved in health care. This means that the Church must be deeply enough involved in medical education, medical research, and the delivery of acute-care services that we can raise ethical and moral questions about developing medical technologies. It also means that the Church must be so thoroughly engaged in the delivery of health care services[10] that we can raise ethical and moral questions about *access* to these services by the poor.

Secondly, the Church must be an active presence in medical research and experimentation so that we can keep our ethical and moral perspective before society *even when* medical science devises ways to withdraw medical procedures and treatments from public discourse by "privatizing" them. This is what has been attempted by "privatizing" the issue of artificial contraception by the introduction of "the birth-control pill." This is what is now being attempted by "privatizing" the issue of abortion by the proposed introduction of the "French abortion pill," RU-486.

While the activity of moral theologians is critical in this *apostolic* enterprise,[11] the Church must also show that it is not merely commenting on these issues "from the sidelines," but that it maintains an active presence in the *scientific research* from which these issues arise and in the *clinical services* which this research makes possible.

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[9] *Directives*, Part One, "The Social Responsibility of Catholic Health Care Services," Introduction, p. 6. In a footnote associated with this passage, the following references are cited:

> Pope John XXIII, Encyclical Letter, "Peace on Earth," *Pacem in Terris* (Washington, D.C.: United States Catholic Conference Publishing Services, 1963), no. 11; *Health and Health Care*, pp. 5, 17-18; *Catechism of the Catholic Church* (Washington, D.C.: United States Catholic Conference Publishing Services, 1994), no. 2211.

[10] From the presentations which we heard on June 9th, it is clear that these services are not limited to hospital services, but include at least: Acute-Care Hospitals, Long-Term Care Facilities, Hospices, Home Health Care, Catholic Charities, Child Care, and Services to "Special Needs Populations."

[11] The activity of moral theologians is another aspect of the *Apostolate* which must be drawn into the Church's overall approach to this question. The Holy See's Sacred Congregation for Catholic Education, commenting on seminary education around the world, recently observed that:

> "[t]he professors of the individual philosophical and theological disciplines must be outstanding not only for their scientific competence but also for their attachment to the Church's Magisterium and for their strong sense of Church."

"Directives on the Formation of Seminarians Concerning Problems Related to Marriage and the Family," June 6, 1995.

The Role of Bishops — Strategies

I suggest *three* immediate strategies to which the Bishops of New York State might commit themselves in order to promote these purposes.

(1) Preferring Partnerships Among Catholic Providers

Where possible, we should have a clear preference for partnerships among Catholic providers:

> "Partnership opportunities for some Catholic health care providers may even threaten the continued existence of other Catholic institutions and services, particularly when partnerships are driven by financial considerations alone. Because of the potential dangers involved in the new partnerships that are emerging, an increased collaboration among Catholic-sponsored health care institutions is essential and should be sought before other forms of partnerships."[12]

Let me emphasize that partnerships with Catholic providers should be preferred *where possible*. Real involvement in medical research, for example, may require that we form *academic affiliations* with institutions of higher learning which are not governed under Catholic auspices. Also, the delivery of "tertiary" and "quaternary" acute-care services — so necessary for the formation of the "delivery networks" required in the managed-care environment — may require *clinical affiliations* with hospitals which are not governed under Catholic auspices. But this leaves much room for deep and meaningful partnerships with Catholic providers.

For example, Bishops should urge that Medicaid Managed Care contracting be undertaken in our State through the instrumentality of Catholic organizations like the Catholic Medical Center of Brooklyn and Queens' *Fidelis* and Our Lady of Mercy's *Universal*. Efforts are under way at this moment to develop practical structures through which Dioceses can form meaningful partnerships with these organizations for delivery of Medicaid Managed Care services. These structures will allow for the formation of equity-sharing partnerships while leaving *canonical sponsorship* and *corporate governance* in the hands of the Diocese (or Religious Congregation) which controls the services.

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[12] *Directives*, Part Six, "Forming New Partnerships with Health Care Organizations and Providers," Introduction, p. 26. The assertion that partnerships entered into by one Catholic provider "may even threaten the continued existence of other Catholic institutions ... " is very important. It invites us to recognize that *someone* must take responsibility to see to it that the competition inherent in the health care "industry" does not pit Catholic-sponsored institutions *against one another*. "Diocesan lines" and "market boundaries" often overlap, and protecting against the danger of "Catholic-against-Catholic" competition will require communication between Diocesan Bishops.

(2) Insuring Our Own Employees

One of the greatest strengths of the Church in health care in New York State is the fact that we are *both* the largest non-governmental providers of health care services *and* one of the largest employers in the State.[13]

While we use commercial insurers, we surrender our power as *purchasers* of health care services to others. If we make our health care facilities the vehicle for insuring the thousands of people the Church employs in parishes, schools, Catholic Charities, hospitals, and our other ministries, we can accomplish several important goals:

- we can realize enormous savings as employers providing health-care coverage to our own employees;
- we can help secure the future of our hospitals and other providers by directing more patients to them;
- we can demonstrate the viability of health care coverage which excludes morally objectionable services;[14] and
- we can make our facilities "necessary and attractive partners" to non-Catholic providers, and so have an opportunity to bear witness to our moral values by refusing to allow provision of morally objectionable services under our partnership arrangements with non-Catholic providers.[15]

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[13] In my presentation on June 9th I indicated that *six* agents are active in the relatively unstable health care environment in our State at the present time: Providers (including *Hospitals* and *Physicians*), *Employers* (who purchase health care services for their employees), *Consumers* (most of whom are employees), *Insurance Companies*, and *Government*. The Church is a *provider*, an *employer*, an advocate for *consumers*, and a *quasi-insurer* (because of our entrance into the risk-bearing "managed-care" market). The Church will be a *partner of Government* in delivery of Medicaid and Medicare managed-care services.

Because of this unique position, I believe we have the opportunity to stabilize the health care environment in our State by making ourselves a *bridge* between competing forces. Stabilizing the environment serves another of the Church's principal goals in health care: to protect consumers — especially the poor and vulnerable — from competing market forces which do not factor *human need* and *human dignity* into their business plans.

[14] "When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person." *Directives*, Part Three, "The Professional-Patient Relationship," Introduction, p. 13.

[15] " ... new partnerships [with non-Catholic providers] can be viewed as opportunities for Catholic health care institutions and services to witness to their religious and ethical commitments and so influence the healing profession." *Directives*, Part Six, "Forming New Partnerships with Health Care Organizations and Providers," Introduction, p. 25.

AGENDA ITEM III(4)(b)

CARDINAL'S OFFICE
1011 FIRST AVENUE
NEW YORK, NY 10022

6 January 1996

His Excellency
Most Reverend Henry J. Mansell
Bishop of Buffalo
795 Main Street
Buffalo, N.Y. 14203

Your Excellency:

Yesterday, the Archdiocese of New York together with the Diocese of Brooklyn, resolved all significant outstanding issues relative to proceeding forward with a single plan application to the State of New York, for a Catholic-sponsored Medicaid Managed Care Plan. This was accomplished to a large degree with the assistance of the Diocese of Rockville Centre, in particular through the good offices of Monsignor Alan Placa.

We are now prepared to meet the January 16, 1996 deadline for the submission of a single application, the corporate name of which will be the *New York State Catholic Health Plan, Inc.*

The governance arrangement will consist of a Member Corporation, the composition of which will be limited to the eight Ordinaries of the eight Catholic dioceses in New York State, and I have agreed upon request to serve as the Chairman. No Ordinary is obligated to join the Member corporation, and may at any time request to withdraw from the Corporation.

There will additionally be an operating Board of Directors associated with the plan, the composition of which will be as a result of an election by the Member Corporation. It is being proposed that for a three year transitional period there be 7 directors appointed by the Bishop of Brooklyn, 5 directors appointed by the Archbishop of New York, and one director each appointed by the remaining diocesan bishops. At the end of this period, directors will be appointed in proportion to the percentage of enrollment in each diocese. I have additionally been requested to serve as the President of the Board.

The future of the Catholic healthcare ministry in New York, indeed the United States, rests upon two pillars; those being adherence to Canon Law and our protection of our Catholic medical-moral principles. We have I feel, achieved an organizational design which will safe-guard the assets and prerogatives of each Ordinary, yet will enable us to move forward in coordination and a singular voice throughout the State. The By-Laws agreed upon yesterday for our Catholic Medicaid Managed Care Health Care Plan, insure protection of both these foundational pillars.

and will additionally enable us to provide access to medical care for those for whom we have always given preferential commitment, namely the Medicaid recipients.

Attached is an organizational flow chart which hopefully will pictorially describe the arrangement which we have designed. Once the draft By-Laws are completed as well as the draft application , we will forward both to you for your review and information. I ask however for the sake of completing the application, that you endorse this communication and return it by Fax transmittal, reflecting your support for this approach. Due to the time requisite of application submission, I ask to receive your endorsement no later than Tuesday, January 9, 1995.

I am sure that you will agree with me in that we are embarking upon a momentous journey in Catholic healthcare, and I hope that you agree with me that such a journey is essential for the preservation of our ministry.

Fraternally in Christ,

John Cardinal O'Connor

Date: 6 Jan 1996

Signature: John Cardinal O'Connor

Bishop of New York

A White Paper

addressing

The NewYork State Catholic Health Plan, Inc. Prepaid Health Services Plan (PHSP) application; its evolution and meaning for the future of Catholic health and human services in the State of New York

Background

The rapidly accelerating penetration of managed care throughout New York State has caused major changes in the delivery of healthcare. As is often the case in highly competitive situations, profit and marginal surpluses from program operations became driving forces, putting greater and greater pressures on those providers with preferential commitment to serve the poor, under-served and uninsured. Not surprisingly therefore, during the last two to three years Catholic healthcare providers found themselves facing new challenges to their healing ministry, which necessitated new organizational and business responses. The spectrum of responses to these challenges, on the part of the many Catholic health and human services agencies, spread throughout New York State's eight Roman Catholic dioceses, is varied and disparate. They range from total non-involvement and resultant crisis to the preservation of a healing ministry, all the way to independent Medicaid managed care plan development, as in the case of the formation of the *Fidelis Care PHSP* in Brooklyn and the *Universal Health Plan PHSP*, a joint venture program in the Bronx.

While the changes in healthcare delivery have affected all programs and peoples, perhaps no program has been so greatly affected as that of Medicaid. In New York State a voluntary Medicaid managed care program began in July of 1991. Current levels of program activity can only be likened to the ground shaking under our feet, so rapid have the changes been. By November of 1995, over 700,000 Medicaid recipients in New York State were enrolled in

Medicaid managed care programs, representing over 25% of the total 2.6 million Medicaid eligibles throughout the State. This enrollment of 700,000 represented an increase of over 300,000 from January 1, 1995, and a 100% increase over the prior year's enrollment. Even the New York State Commissioner of the Department of Health, Dr. Barbara DeBuono, characterized the status of the Medicaid managed care program as "chaos", suggesting that the department "needs to put some order back into the system" (*N.Y. Times, August 23, 1995*). Catholic providers, given their preferential commitment to serving the Medicaid population, have to a large degree felt a disproportional effect from this chaos. Following a series of investigations over the summer of 1995, the State Department of Health moved to intensify the regulations imposed on Medicaid HMOs. These new regulations are aimed at improving the service delivery, accessibility and accountability of the plans, and such a strategy is welcomed by the Catholic providers throughout the State.

As the number of plans participating in the Medicaid managed care program in New York State increased, larger numbers of for-profit plans and insurance companies became major participants in the Medicaid program. Healthcare in general is increasingly transitioning from a charitable human service to an "industry" where anywhere from 15% to 30% of the total dollars are allocated to marketing costs, administrative overhead and profits to the stock holders. The reciprocal of this is that only 70% to 85% of the dollars allocated to healthcare find their way to the actual delivery of medical services. In 1985 there were 5 million people enrolled in for-profit HMOs, with an additional 13.5 million people in not-for-profit HMOs. By 1994 the table had significantly turned, with a shocking 24.5 million enrolled in for-profit plans while only 20.5 million remained in not-for-profit plans. Ironically, the very commercial and for-profit plans which were originally uninterested in serving the poor and Medicaid patient, soon found the Medicaid managed care program to represent their most profitable line of business. There is no accident associated with the fact that 60% of the Medicaid managed care plans in New York are HMOs, as opposed to provider sponsored not-for-profit PHSPs. These HMOs are often earning profits and "subcontracting" with non-profit hospitals, many of which are Catholic hospitals, at a discount for the provision of care to the poor and those enrolled in the Medicaid program, which

the (Catholic) hospitals themselves previously directly provided.

Why a Catholic sponsorship for a Medicaid managed care plan?

The Catholic healthcare ministry, particularly in New York State, has a long and inspired history of attending to the needs of the sick and disadvantaged. This history demonstrates a preferential commitment to the poor and disadvantaged, and is proof of the Church's steadfast service to those groups shunned by most others. Pope John Paul II in his encyclical *Laborem Exercens*, called the Church to a solidarity with the struggling poor. It is therefore no surprise that the Catholic Church has stepped to the forefront in care for the prisoner, for the AIDS victim, the unwed mother, the terminally ill and aged. Were it not for the 42 Catholic-sponsored hospitals and 60 Catholic-sponsored long term Care facilities and 29 Catholic-sponsored home healthcare agencies in New York, the state's healthcare delivery system would collapse, in that Catholic-sponsored healthcare agencies represent 20% of the total healthcare providers in the State of New York. Sponsoring religious institutes and dioceses have long supplemented the delivery of services through the usage of clerical and religious personnel and facilities/resources, keeping the costs of care to a minimum. Catholic healthcare providers in New York; led by the Cardinal Archbishop and the other bishops, are dedicated to preventing Catholic healthcare from becoming an "industry", another for-profit enterprise.

As healthcare providers continue to struggle in an environment shaped by economic concerns and pressures, the diocesan leaders throughout New York came to understand how the mission of the Catholic healthcare ministry and its inherent values could only be protected through collaboration with one another and with additional providers of common value and mission. Decades of competition have harmed Catholic healthcare providers, and the newly intensified competition in Medicaid managed care has become of crisis proportions. As the State of New York unfolded its intentions to move towards a mandatory program of Medicaid managed care, and a competitive bidding process was announced which would reduce the number of currently

licensed provider programs, it became a concern of the Church that there could result a situation where there would be no Catholic-sponsored Medicaid managed care program throughout the entire State of New York. This would leave remaining, for the most part, for-profit HMOs to address the needs of the Medicaid recipients. This is obviously an untenable and intolerable situation, jeopardizing the very existence of the healthcare ministry.

The dilemma of for-profit healthcare providers compromising the delivery of charitable care is not a local issue. On January 10, 1996 the National Coalition on Catholic Health Care Ministry, a broad coalition of Church-associated leadership organizations that participate in meeting the healthcare needs of communities throughout the United States issued a statement which represents the unified belief of its entire membership. They stated that " we believe that healthcare is fundamentally different from most goods and services and is consequently best delivered in a setting where human and community needs are the primary concerns. The primary motivation of publicly-traded, investor-owned providers (hospital chains) is to provide a return to the shareholder. This compromises the Church's position to an unacceptable degree."

It is for these reasons that the eight Ordinaries of the Roman Catholic dioceses throughout New York State, under the leadership of John Cardinal O'Connor, Archbishop of New York and Metropolitan of the Province of New York, moved to collaborate on the development of a State-wide application, seeking authorization to extend the license of the Fidelis Care plan into each of the eight dioceses, under the title of "The New York State Catholic Health Plan, Inc". This proposed plan would offer Catholic and non-Catholic hospitals alike an opportunity to participate in a plan, committed to serving the poor, medically indigent and under-served, at the same time safeguarding the medical, moral and ethical principles of the Catholic healthcare ministry, at the same time complying with both civil and canon law. It is the strong belief of Cardinal O'Connor that "the future of the Catholic healthcare ministry in New York, indeed the United States, rests upon two pillars; those being adherence to our Canon Law and our protection of our Catholic medical-moral principles". By doing so the Church is fulfilling its obligation to give public witness and demonstrate solidarity in its preferential commitment to the poor.

What actually is the New York State Catholic Health Plan, Inc?

In April of 1995 a task force of the New York State Catholic Conference was established to address Medicaid managed care issues, and how they were affecting Catholic hospitals throughout the State. On June 6, 1995 and again on September 22, 1995, the Board of Bishops convened meetings to discuss the findings and recommendations of the task force. It was at the September 22, 1995 meeting that the Bishops from throughout the State passed a resolution calling for the development of a single, state-wide Catholic-sponsored Medicaid managed care program. Conference staff were asked to work with representatives from *Fidelis Care* and *Universal Health* to develop an integrated plan proposal which would be capable of integrating all the willing Catholic healthcare providers throughout the State as well as their non-Catholic affiliates in each of the eight Roman Catholic dioceses.

As a direct result of this work effort, an application was prepared and submitted to the New York State Department of Health on January 17, 1996, seeking authorization to extend the *Fidelis Care* license as described above. While it was originally the intent of the work group to submit an application with dual PHSP licenses, reflective of the integration of both Catholic-sponsored PHSPs, upon advice received from Health Department personnel, it was ultimately decided to submit under the license of a single plan, namely *Fidelis Care*. The intent remains however to programmatically integrate both plans, resulting in the single state-wide entity.

The new state-wide plan will be structured with a member corporation consisting of the eight Ordinaries, the Cardinal Archbishop serving as the Chairman. At the operating board level, representation will come from all the dioceses, other participating health care provider groups and consumers. The provider network will consist of both Catholic and non-Catholic healthcare institutions, agencies and physicians, representing a broad geographic base throughout the state. It is envisioned that implementation of the plan will be a phased-in effort, consistent with the plans

of the state with respect to county participation in the Medicaid managed care program.

Why should the New York State Catholic Health Plan, Inc. application be approved?

The approach reflected in the application is quite sound from an organizational standpoint, allowing for a standardization of operating procedures, an efficiency and economy of scale and an overall adherence to the same high-standards of care currently associated with *Fidelis Care*. One of the immediate advantages of such an approach is to eliminate the discontinuity of care and medical coverage associated with situations where a person is enrolled in a plan authorized in the Bronx, but needs to access care in a contiguous county such as Westchester or Manhattan where the plan does not have authority to operate. This situation is a daily occurrence and results in great confusion and hardship for those who are least able to deal with such circumstances. With respect to quality, *Fidelis Care* enjoys a fine reputation of adherence to consistently high standards. During the summer of 1995, the New York State Department of Health performed an investigation of the 18 licensed Medicaid managed care plans operating in New York City. Five of these plans were sanctioned and forced to suspend their enrollment activities. *Fidelis Care* was not one of these; their deficiencies were of a minor nature and they were permitted to file a plan of corrective action with the State, continuing ongoing plan operations.

A second advantage to the state-wide plan approach is to allow for the utilization of maximal revenues for provision of care, totally eliminating the returned to the shareholder. Any surplus (net) revenues will be directly return to plan and service expansion and/or enhancement. Given the fact that the Medicaid program is supported by tax levied funds, this approach is the only appropriate public policy position which should be acceptable.

A third reason why the proposed state-wide plan should be endorsed addresses the singular purpose of the proposed plan. All energies and resources associated with the plan will deal with the provision of healthcare to the Medicaid recipients. The plan will not be providing

other services or be engaged in tangential activities which would dilute its focus from the principal objective, that being the provision of care to the poor and medically under-served. It can with some justification be argued that many other New York State licensed HMOs, use the resources provided them by the Medicaid program to support other activities such as commercial (private) insurance offerings, subordinate corporations of data management and analysis, etc. The state-wide Catholic plan has a singular purpose and commits to adhering to this.

From the perspective of financial efficiency, *Fidelis Care* has demonstrated an admirable level of cost control throughout its three years of operation. In 1993 the New York State Department of Health issued a comparison of Medicaid HMOs and PHSPs, addressing administrative costs, medical service cost ratios and residual plan surpluses. *Fidelis Care* only began operations in November of 1993, and as such was not able to provide comparable data. In looking and the semi-annual data report of *Fidelis Care* for the year of 1995 however, we are able to get a sense of relative cost efficiency.

PLAN	*ADMIN COST RATIO*	*MEDICAL COST RATIO*	*SURPLUS RATIO*
HealthPlus (Lutheran)	10.4%	80.07%	11.20%
Centercare PHSP	19.82%	77.69%	31.63%
Syracuse PHSP	15.09%	80.32%	5.70%
Healthnet (Empire)	16.00%	41.68%	42.32%
Fidelis Care	15.7%	83.7%	.60%

Clearly, *Fidelis Care* compares well with its counterparts, representing a plan committed to allocating a high percentage of its revenues to direct delivery of care, with minimal surpluses accruing to the plan itself.

Finally, and in no way lastly, a Catholic-sponsored plan has an advantage over all other types of sponsorship, in that such a program will be linked to the vast network of Catholic

Finally, and in no way lastly, a Catholic-sponsored plan has an advantage over all other types of sponsorship, in that such a program will be linked to the vast network of Catholic Charities throughout the various dioceses. The Catholic Charities programs include home care, parish outreach programs, nutritional support programs, job training, health counseling and advocacy, hotline services, crisis interventions, hospice programs and a wide array of supportive programs almost too numerous to articulate. Each of these programs however will directly support the Medicaid managed care program, providing a seamless delivery of care to an otherwise fragmented healthcare delivery system. The network of services offered by the Church remains unparalleled in its depth and breadth, supporting patients who would otherwise be lost in the "cracks" or interfaces between programs and providers.

For the above reasons, we strongly urge you to consider support of the *Fidelis Care* application as it seeks to extend its authorities throughout the State of New York, in the name of the combined Roman Catholic Church and its health care ministry, and on behalf of the New York State Catholic Health Plan, Inc.

Appendix VIII

June 14, 2000

TO: His Excellency, Archbishop-Designate Edward Egan, and Their Excellencies, the Roman Catholic Bishops of New York State

FROM: John M. Kerry

RE: Report of Bishops' Committee on Public Relations for Health Care Issues

MEMORANDUM

The Bishops' Committee, chaired by Bishop James McHugh and consisting of Bishop Howard Hubbard, Bishop James Moynihan and Bishop Henry Mansell, has developed the enclosed proposal for a communications plan for Catholic health care.

The first section of the report focuses on developing a **comprehensive message** that includes the "good news" about Catholic health care, the challenges currently facing Catholic health care, and the need for grass roots action in response to those challenges.

The second section deals with strategies for transmitting the message to our Catholic people: through our priests, parish committees and organizations, Catholic educators, diocesan public policy networks, Catholic educators, Catholic media, and to some extent secular media. Key players in this effort would be the Bishops, State Catholic Conference staff, Catholic health care public relations people, diocesan communications leaders, diocesan Public Policy Education Network coordinators, and diocesan pastoral leadership.

A proposed structure for implementing this plan is included at the end of the report, followed by a brief listing of several actions to be undertaken immediately.

COMMUNICATIONS PLAN

FOR

CATHOLIC HEALTH CARE

REPORT OF THE BISHOPS' COMMITTEE ON PUBLIC RELATIONS FOR HEALTH CARE ISSUES

Bishop James McHugh, Chair

Bishop Howard Hubbard
Bishop James Moynihan
Bishop Henry Mansell

THE MESSAGE

I. An Overview of Catholic Health Care

A Catholic health care public relations effort must be proactive in spreading the "good news" of Catholic health care—its history of service to New Yorkers, its wide range of current ministries, and its guiding principles, rooted in the Church's fundamental teaching on the inherent dignity of the human person.

There is a sense that even among Catholics, perceptions of Catholic health care tend to be drawn not from a comprehensive awareness of its mission, but rather through sporadic, isolated encounters—when one is sick and needs to avail oneself of services, or when some public controversy leaves the Church in a position of seeming to "constrict" health care options.

The general public—Catholics included—must be presented with a comprehensive understanding of the totality of the Catholic health care mission, so they can evaluate challenges to specific Catholic health care policies in the context of that total mission.

A. Church's Long History of Health Care Ministry in New York State

A brief overview of this history must be developed, emphasizing that the Catholic Church has been directly providing health care services to New Yorkers for far longer than the state government.

B. Current Ministries

The expansive range of current Catholic health care ministries must be emphasized: not only acute care, but elder care, continuing care, behavioral health care, as well as health care initiatives linked to Catholic Charities and other Catholic social services networks, parish-based health ministries, and also Catholic Church involvement in helping to meet health insurance needs. The efficiency and cost-effectiveness of Catholic health care should also be stressed.

C. Special focus on the needs of the poor and vulnerable—particularly women and children

Catholic health care has a long and admirable history of providing reproductive health services, care for infants and children, and implementation of newly developed programs to address women's health needs—with special concern for minorities, immigrants and the poor. This is extremely important to emphasize, given that detractors accuse the Church of being insensitive to the health care needs of poor women.

D. Guiding Principles

1. Broad-based Catholic moral principles must first be articulated:

   - Respect for the sanctity and dignity of every human life;
   - Service to the poor, immigrants, disabled and dysfunctional;

- Promotion of the common good through responsible use of resources;
- Caring for the whole person—body, mind and spirit;
- Inclusion of a spiritual element, including opportunities for pastoral care and the sacraments.

2. Then, stressing that Catholic health care is a *ministry*, not a commercial venture, it needs to be explained how these principles apply—in a positive way—to the mission of Catholic health care. In other words, they are not just arbitrary rules, nor are they narrowly applicable only to contentious ideological issues. Respect for human life, for example, is a consistent, guiding moral principle; it is **not** simply code for ideological opposition to abortion or euthanasia. The Church analyzes such health care issues **in light of** its moral principles. It does not make those principles up as it goes along, to respond to particular issues.

There is a need to stress that Catholic health care, grounded in the Church's commitment to the inherent dignity of the human person, is devoted to providing medical care in an environment of faith guided by moral principles. To avoid the appearance of laying exclusive claim to moral and ethical principles, Catholic-sponsored health care services should be presented as part of the Church's underlying commitment to serve all members of American society and to implement the universal goal of competent health care for all as a service to the common good.

II. Challenges to Catholic Health Care

A. Where and Why:

- Where such challenges are coming from: activist ideological groups prompting negative portrayals in media, and both inspiring government actions detrimental to Catholic health care

- Why — An agenda of active opposition to the moral values and ethical principles that are the foundation of the Catholic health care mission

- A broader context needed, to take into account the role that anti-Catholicism—and, even more broadly, rampant individualism, materialism, anti-institutionalism—plays in this opposition; i.e., this huge, hierarchical institution, the Catholic Church, wants to dictate our health care choices.

B. What:

- The issues: hospital affiliations, treatment requirements (i.e. emergency treatment for rape victims, referrals for AIDS "prevention", abortions, end-of-life treatment issues), participation in Medicaid managed care, government regulatory authority over Catholic hospitals, insurance requirements (i.e., mandated coverage for infertility treatments and contraception).

- Responses: Catholic people, as well as the general public, need clear explanation of these issues, and how they impact on the Catholic health care mission.

    1. **Proactive** espousal of Catholic moral values and ethical principles as **integral** to the quality and caring of Catholic health care.

    2. **Positive** articulation of what Catholic health ministries **do** provide in each of these areas:

        — Infertility treatments
        — Comprehensive treatment for rape, **including** truly preventive pregnancy treatment where appropriate
        — Care and treatment of AIDS patients
        — Special focus on the needs of the poor
        — Affiliations that **preserve** community health care

        *A comprehensive listing of Catholic health care services and the principles that inform them—provided in the Overview—should be reiterated. Then it can be shown how those principles are applied in a moral, ethical, medically sound and compassionate manner to specific issues like those listed above.

    3. **Freedom of Conscience** and **Freedom of Religion** threatened by these unwarranted state intrusions into the Catholic health care mission.

    This will draw response that since Catholic health facilities accept government funds, they forfeit freedom of conscience. Responses:

    - What Catholic facilities receive from government are not subsidies, but payments for services provided. Since they are performing a public service they are entitled to these payments, as is any other entity that performs these services. No money is appropriated to Catholic hospitals for services that they do not provide.

    - The enormous costs of health care make it morally and pragmatically imperative that public agencies collaborate with private—including faith-based— providers. If Catholic facilities are denied public resources, it is not those facilities alone that will suffer, but the millions of people who depend on those facilities to meet their health care needs.

    - Catholic health care is in fact not only supplementing government's role. As indicated in the Overview, it was there well before government was.

- Catholic health care is more efficient and cost-effective—reducing the burden on taxpayers, while making more effective use of limited resources. [Data will need to be developed to support this statement.]

III. Grass Roots Actions Needed

Once the Catholic faithful are aware of and educated about the good news regarding Catholic health care and the challenges it currently faces, they need to be urged to take certain action steps:

A. **Make their voices heard** in the public square, promoting the "good news" about Catholic health care and refuting unfair criticisms, through media (letters-to-editor, radio call-in shows, etc.), public forums and every day conversations.

B. **Write letters, make phone calls, advocate** with government officials in support of Catholic health care, and in opposition to detrimental actions and proposals.

Although the Catholic Conference already assumes the primary advocacy/lobbying responsibility in this area, much more of this needs to come from the grass roots—and that means:

- Better education, beginning with priests (clergy conferences, etc.), then reaching out to the faithful;

- Diocesan and parish networks (i.e. Public Policy Education Networks), that can respond quickly and effectively when there is a need for calls for letters and phone calls on a particular piece of legislation;

- Leadership from the Conference in communicating with diocesan and parish networks;

- More coordination of communications efforts between the Conference, Catholic health care organizations, dioceses and parishes, in terms of public relations and public advocacy;

- Assistance from Catholic media, particularly diocesan newspapers, in providing alerts when advocacy/lobbying efforts are needed on a specific issue or bill.

This will involve development of a structure to coordinate the three primary activities needed: education about Catholic health care; public relations; and public policy advocacy. A suggested outline of such a structure is at the conclusion of this report.

STRATEGIES FOR DELIVERING THE MESSAGE

1. Priests and other Catholic leaders

In order to reach Catholics in the pews, education efforts must first focus on priests and other Catholic leaders who have direct contact with parishioners. Recommendations include:

- Develop a "speakers bureau" of experts on the issues to go into dioceses to make presentations to priests, teachers, religious educators, parish leaders, etc. The Catholic Conference, working with Catholic health care organizations, diocesan health care and public policy leaders, and diocesan experts in the fields of ethics and moral theology, can put together such interdisciplinary teams (ethicist, physician, public policy person, etc.) for this purpose.

- Offer special study days on Catholic health care for priests in each diocese. These should be obligatory, and scheduled with some urgency, rather than simply put on the agenda for future diocesan priest meetings.

- These educational efforts must include the comprehensive message outlined above: the "good news" about Catholic health care, the "what and why" of current challenges, including the cultural influences that contribute to anti-Catholic sentiment, and the need for specific action to respond to these challenges.

2. Direct Communication with Parishioners

Following education of priests, educators, parish and diocesan leaders, these leaders would then help to educate parishioners on Catholic health care issues.

A. Sunday Mass:

- **Homilies** — Sample homilies could be developed that communicate the good news of Catholic health care, challenges facing Catholic health care, and the need for specific actions on the part of parishioners.

- **Hand-outs**, containing educational information and/or directions for specific actions (letters, phone calls, etc.), could be inserted in the weekly bulletin or distributed at the doors after Mass, either in conjunction with that week's homily, or as an immediate follow-up.

- **A letter from the Bishop** to be read at Masses could be used to highlight some urgent matter, i.e., critical legislation nearing a vote.

B. Parish Events, Parish Organizations

- **Confirmation homilies** are an ideal time to educate young people and challenge them to become involved in defending their faith and spreading the "good news."

- **Parish societies, organizations and committees**—Holy Name & Rosary Societies, Knights of Columbus, Respect Life, Social Justice Committees, Parish Outreach, Adult Education programs, RCIA, Youth and Young Adult Ministries—should all be educated (through speakers, literature, etc.), and then urged to take needed action.

C. Talking points and **issue alerts** on specific issues involving Catholic health care, to be provided on a regular basis to pastors, educators, diocesan and parish leaders and diocesan public information offices.

D. Public Forums at the parish, deanery or diocesan level, dealing with various Catholic health care issues.

3. Catholic Media

Catholic media—particularly diocesan newspapers and broadcast media—should be enlisted to assist in education, public relations and advocacy efforts.

A. Diocesan Newspapers

- Letter or op-ed column by the Bishop, highlighting vital ministry of Catholic health care, current threats, need for specific actions.

- Positive feature articles on work of Catholic health care—i.e., individual institutions, specific kinds of care and treatment, individual human interest stories involving patients, medical personnel, support staff, etc.

- News coverage of challenges to Catholic health care, with ongoing updates of pending legislation and other government actions, and information for readers on actions they can take in response to these government initiatives.

- Columns, editorials addressing various Catholic health care issues.

- Letters-to-Editor.

- Ad campaigns by Catholic health care entities that can be used to tell the "good news" and also to inform on critical issues and the need for public response.

B. Diocesan Television

- Documentary-type shows highlighting positive work of Catholic health care.

- Talk shows featuring individuals involved with Catholic health care—medical personnel, support staff, patients, families, etc.

- Discussion shows on major issues confronting Catholic health care—medical, financial, ideological, legislative, etc.

- Public service announcements, both promoting Catholic health care, and alerting viewers to threats and need for action—i.e., letter-writing to public officials.

C. Catholic Radio

- Hosts of Catholic shows on secular stations should be encouraged to do shows on Catholic health care—again, these can focus on the ministry as a whole, individual institutions, various kinds of care and treatment, individuals involved in Catholic health care, threats to Catholic health care and calls for action.

- Catholic radio stations should be encouraged to work Catholic health care issues into their programming in various ways.

D. Other Catholic Media

While Catholic periodicals, like *Commonweal, America, Crisis*, etc., are not specific to New York, the issues involved confront Catholic health care throughout the nation. Therefore, Catholic periodicals should be kept abreast of all developments via news releases, communications with editors, reporters and columnists, and encouragement to help educate their readership on Catholic health care issues.

4. Catholic Education

A. Catholic Elementary and High Schools

- Actively present students with positive information about Catholic health care, through speakers, visits to health care facilities, interaction with patients (many already do this, particularly in nursing homes).

- At high school level, students could also be introduced to some of the issues challenging Catholic health care, through speakers, classroom discussion and reading assignments.

B. Catholic Colleges

- Encouraged to hold forums on issues impacting Catholic health care, inviting input from medical, ethical and legal authorities.

5. Secular Media

As detailed below, most of the secular media, given their approach to news reporting, do not generally lend themselves to in-depth education efforts. Yet interaction with them is critical in terms of public relations. An active and skilled effort is needed to present the Church's perspective, respond to negative characterizations, and encourage and assist those in the media who truly want to present fair and balanced coverage.

A. Daily Newspapers

- ***News reporting*** — Tends to focus on the controversial, and given to brief quotes rather than in-depth analysis. Still, effective spokespersons are needed who, when asked for comment, can get the Church's message across in a brief, succinct format. A proactive effort is also needed, involving news releases, news conferences, and alerts on Catholic health care events, activities, and items of interest.

- ***Feature stories*** — There is some potential for success here; an example was *Newsday's* positive coverage several years ago of Bishop McGann's pastoral on end-of-life issues. Again, a proactive effort is needed in calling the media's attention to newsworthy items, such as human-interest stories, unique features of various health care facilities, localized developments, treatment and care ministries, etc.

- ***Opinion pieces*** — Contact with newspaper columnists and editorial writers, especially those who tend to be sympathetic, should be developed and maintained. Opportunities should also be sought to offer op-ed pieces. This will also require development of a network of people capable of writing quickly and effectively when such opportunities present themselves.

B. Television Stations

- ***News reporting*** — Even more than with newspapers, the focus is on the controversial and the quick sound byte. Again, spokespersons must be available to respond to requests for comments, and aggressive efforts must be made to alert TV outlets to Catholic health care news.

- ***Talk shows*** — Daily morning talk shows, and especially Sunday news talk shows lend themselves to more in-depth exploration of issues. This presents an opportunity to establish contacts, make speakers available and even suggest topic ideas. Spokespersons will be needed who are comfortable handling opposing points of view, sometimes expressed in hostile fashion.

C. Radio Stations

- ***News reporting*** — Same as television, i.e. controversy and sound bytes, but there is a variety of viewpoints among local stations. Some will be more friendly to the Catholic perspective.

- ***Talk shows*** — These abound on radio, and they are always in need of topic ideas and guests. Contacts should be established, and again, spokespersons are needed who are quick on their feet, can deal with opposition and still present a positive face for the Church and Catholic health care.

D. Weekly Community Newspapers: Always in need of material, they offer fertile ground for news and feature story ideas, possible guest op-ed columns, and letters-to-the-editor. Also important to get to know and maintain contact with editors, reporters and regular columnists.

PRELIMINARY STEPS

1. Convene health care and diocesan public relations and communications leaders, to solicit their input on strategies for communicating the message.

2. Begin to identify and recruit potential members of educational speakers bureau.

3. Develop more in-depth background on Catholic health care, to be given to pastors and priests, distributed at study days and educational forums, and provided to diocesan communications leaders.

LEGISLATIVE AGENDA 2001

APPROPRIATE CARE FOR THE TERMINALLY ILL AND MAINTAINING A BAN ON ASSISTED SUICIDE

SUMMARY OF LEGISLATION: This package of legislation would help to ensure that terminally ill patients receive appropriate palliative care and pain medication, rather than lethal actions, with the aid of their physicians, to end their lives. It would accomplish this by: providing for education of health care professionals to increase the competencies of those providing care to the dying; breaking down financial barriers that thwart people from accessing hospice and home care; affirming the appropriate use of controlled substances to alleviate pain and suffering; and maintaining the state's current prohibition on physician-assisted suicide.

CONFERENCE OBJECTIVE: The Catholic Conference seeks to ensure increased support, resources, care, appropriate pain relief and treatment for the terminally ill, while maintaining New York State's current prohibition on assisted suicide.

RATIONALE: Most medical schools currently offer little, if any, instruction on the important issues surrounding dying patients and their needs. A 1997 survey conducted by the American Board of Internal Medicine found that physicians believe they are not well prepared to deal with end-of-life care issues.

One way the legislature may directly impact health professional awareness in this area is by encouraging medical and nursing schools to include palliative care and pain management in their curricula. To date, South Dakota is the only state that has made such a request. Other states are considering legislation that would require continuing medical education courses on palliative care as a condition for maintaining licensure.

The legislature should also review the financing and delivery of end-of-life medical care to ensure that reimbursement is adequately available for palliative and supportive home care services, as it is for more aggressive, curative inpatient care. Hospitals should be required by law to provide appropriate palliative care to address the unique physical, mental and emotional needs of terminally ill patients. Individuals should be appropriately informed of their right to request and receive quality palliative care.

Medicaid should cover the provision of adequate symptom management and home health aides for the terminally ill. Medicaid hospice eligibility should be extended beyond the six month survival criteria mandated by the Medicare definition of "terminally ill."

New York State should also ensure that its controlled substances laws balance the potential for abuse of controlled substances with recognition of their appropriate medical uses. The federal "Pain Relief Promotion Act of 1999," (S.1272/HR.2260) attempts to accomplish this at the federal level by establishing a uniform national policy against the use of federally regulated drugs for assisted suicide and euthanasia.

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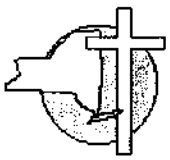

Finally, New York State must maintain its current prohibition on assisted suicide, which was upheld by the U.S. Supreme Court in June 1997 in the case of *Vacco v Quill*. Lifting the ban would provide a deadly, unnecessary option to dying patients, many of whom are elderly, poor and especially vulnerable. Terminally ill patients, who legitimately fear pain, depression and abandonment, can be significantly helped through pain relief, palliative care, the hospice environment and compassionate loving care.

FIDELIS CARE

"BUILDING CONSENSUS"

Report of the Board of Directors'
TASK FORCE ON PLANNING

FIDELIS CARE

NEW YORK™

NEW YORK STATE CATHOLIC HEALTH PLAN, INC.

MOST REV. JOSEPH M. SULLIVAN, D. D.

Board Chair

MARK L. LANE

Chief Executive Officer

REV. PATRICK J. FRAWLEY

Chief Operating Officer

TASK FORCE ON PLANNING

REV. MSGR. ALAN J. PLACA

Chair

MARY HEALEY-SEDUTTO, PH.D.
JOHN R. KENNEDY
JAMES M. CORRIGAN
JAMES MCCORMACK, PH.D.
PATRICIA BARRY

Consultant

THIS "PLANNING DOCUMENT" represents the culmination of discussions, and ultimate approval, which the Board of Directors undertook over the past year. Since the inception of the New York State Catholic Health Plan, Inc., d/b/a Fidelis Care New York (Fidelis), the Directors have provided their perspectives on the intent and purpose of establishing a Catholic sponsored statewide insurance plan. The majority of the Directors are providers who have served Fidelis well, but hold diverse opinions as to the mission and vision of Fidelis.

During Calendar Year 1998, the Directors embarked upon a process aimed at achieving a unified vision of what Fidelis is meant to do and how it achieves its mission. The Directors undertook a full-day planning session focused on this objective on May 15, 1998. The consulting firm of Jennings, Ryan & Kolb was retained to assist and suppport this Board initiative. The results of this planning retreat affirmed the diversity of opinions among the Directors, which were provided both verbally and in writing.

At the June 1998 Board of Directors' Meeting, Bishop Sullivan appointed a Task Force to review the results of the planning retreat and prepare specific recommendations and actions. The purpose of the Task Force was to provide clarification and consensus of the mission that would result in an enhancement of the future viability of our insurance plan. The Task Force was chaired by Rev. Monsignor Alan J. Placa, and included James Corrigan, Mary Healey-Sedutto, Ph.D., John Kennedy and James McCormack, Ph.D. The Task Force was assisted through the consulting services of Ms. Patricia Barry from Medimetrix. The Task Force met several times, and produced a draft planning docu-

ment, which was presented to the Board at a special planning session on February 23, 1999. Prior to this planning session, each Director was asked to review and consider the recommendations emanating from the Task Force, and provide their input directly to Ms. Barry.

At the planning session on February 23rd, the Board reviewed the survey results of the proposed document, in which the majority of Directors concurred with the recommendatioons included in the draft planning doument. However, there were additional amendments and/or modifications made to the document, based on the discussions which ensued at the special planning session.

At the April 23rd Board of Directors' Meeting, the Board reviewed the final planning document and voted unanimously for approval, and thereafter, submission to the Members of the Corporation.

On June 4, 1999, at the meeting of the Corporate Members, the Most Reverend Joseph M. Sullivan, Chairman, presented the Planning Document. Bishop Sullivan reviewed the process and acknowledged the work of the Task Force which provided the reaffirmation of the Mission and Value statements. Reverend Monsignor Alan J. Placa, Task Force Chairman, reviewed the highlights of the document and the recommended structural changes.

Following the presentation, His Eminence, John Cardinal O'Connor, President of the Corporate Members, expressed his support and encouraged the acceptance of the Planning Document. The Corporate Members unanimously approved its acceptance, and agreed to consider appropriate by-law amendments, in January 2000, to effectuate the implementation of the Planning Document.

I. BACKGROUND

Bishop Sullivan, Chairman of the Board, appointed a Task Force to develop an approach to consensus building for the Board of Directors on the following:

- -Design of a decision process for the Board of Directors to build consensus on key issues
- -Clarification of the essential business demands of Fidelis
- -Clarification of the role of the Board of Directors versus the Investors
- -Development of a mutually agreeable definition of return on investment
- -Development of Fidelis business strategies for future market success

The Task Force was appointed following the Board Retreat in May 1998 which identified that the Board of Directors had not developed a unified consensus on the mission and vision of Fidelis. The central issue identified related to the differing views of the organization's core purpose.

Building consensus among the Board of Directors on these key issues was viewed as an essential consideration in meeting the goals of the Corporate Members for Fidelis.

The Task Force included the following Directors of the Board:

Reverend Monsignor Alan J. Placa, Chair
Mary Healy-Sedutto, Ph.D
James M. Corrigan
James McCormack, Ph.D.
John R. Kennedy

Patricia Barry, CSC Consultant was named to provide support to the Task Force. Mark Lane, CEO and Reverend Patrick Frawley, COO attended the Task Force meetings to provide input and clarification on the key issues reviewed by the Task Force.

The Task Force deliberations and conclusions are contained in the following document. The draft document was circulated to all Board Members and discussed and reviewed at the Board Planning Retreat on February 23, 1999. The review of the draft Task Force Report included a series of questions to measure the degree of agreement and consensus of the Board of Directors on the critical issues and policy statements developed by the Task Force and presented in the document.

The results of the Board of Directors' review strongly supports the positions developed by the Task Force related to mission, vision and future directions of the health plan. The following table indicates the degree of consensus reflected by the survey results on key issues identified by the Task Force.

Summary of Board of Director's Review

Issue	Agree	Disagree
Fidelis is an instrument of the ministry	93%	7%
Fidelis provides care in compliance with the *Ethical and Religious Directives*	100%	0%
Fidelis must operate and manage an adequate provider network	100%	0%
Fidelis maintains a unique relationship with Catholic Institutions	87%	13%
Fidelis was created to support the commitment of the Catholic Bishops of New York to sustain and expand the Catholic health care ministry within the changing healthcare environment of managed care	93%	7%
Fidelis provides a vehicle for the Catholic healthcare ministry to have a direct role in advocacy for the poor at the state and local level	100%	0%
Fidelis requires autonomy from investor concerns to effectively pursue a strategy of continued market expansion and growth. Fidelis must have the ability to evaluate expansion of the lines of business in consultation with Catholic providers, the Board of Directors and Corporate Members	67%	33%
Consensus on key business strategies of Fidelis:		
-Market expansion into additional counties	100%	0%
-Create and implement strategies for increased enrollment of members within Catholic provider network	93%	7%
-Develop incentives and risk sharing contracts with Catholic provider networks	93%	7%
-Develop improved medical management and quality outcome initiatives	100%	0%
-Increase member satisfaction and retention	100%	0%
-Increase provider satisfaction	100%	0%
-Develop business planning process for coverage of special needs populations	93%	7%
-Position Fidelis to be competitive as programs emerge for the uninsured	100%	0%

Issue	*Agree*	*Disagree*
Recommendations:		
-Restructuring of Board of Directors	80%	20%
-Strategic coordination of Fidelis and Catholic healthcare provider initiatives	67%	33%
-Consensus on revised mission statement	100%	0%
-Return of capital to investors strategy	100%	0%

The survey results also indicate areas in which continued development work needs to occur related to building Board consensus and furthering the goals of Fidelis in partnership with Catholic healthcare providers. These specific areas are:

Relationship to Catholic Healthcare Providers

The unique relationship with Catholic healthcare providers is clearly an area in which additional development work is required. Fidelis has focused on building its membership and positioning the plan as a statewide entity. Positioning Fidelis for expansion, regulatory approval, and member access, has required the inclusion of non-Catholic providers to ensure an adequate network and sufficient access to care for enrolled members. Future success will require the ongoing participation of non-Catholic providers. The key issue going forward is how to maintain an adequate provider network to support the growth projections and develop unique preferential relationships with Catholic healthcare providers.

Fidelis and Catholic healthcare systems should identify opportunities in specific markets for collaboration and joint initiatives that mutually benefit the growth of Fidelis and support the local Catholic healthcare system's market initiatives. These initiatives will also require a commitment by Catholic providers to collaborate with Fidelis when planning healthcare initiatives.

Autonomy from Investor Concerns

The need for balance in managing investor concerns and Fidelis' business needs for continued market success will be essential. Freedom from conflicts on the Board of Directors is an over-reaching concern. The objective of restructuring the Board of Directors is to bring the needed market expertise to successfully guide the business development strategies and address the concerns of the investors, the networks and providers.

The Task Force Report has been modified based on the review of the Board of Directors and the discussions conducted during the Board Retreat in February.

The Board of Directors and Fidelis management will work in the coming months to further refine policy in the above two areas and develop criteria for Board membership.

II. INTRODUCTION

The Board Task Force has reviewed the issues identified for its consideration and determined that it is critical for the Board of Directors and Corporate Members to have a unified view of the mission and vision of Fidelis as an essential first step towards issue resolution. This document reflects the Task Force's deliberations focused on development of a shared vision of the mission of Fidelis and the problems that have emerged in the absence of mission consensus. The Task Force formulated the following Problem Statements as a framework for deliberation and resolution.

- -Lack of clarity with respect to the Governance of Fidelis
- -Lack of consensus on the mission of Fidelis
- -Lack of understanding of what Fidelis is at the level of the Board of Directors, Corporate Members, Investors
- -Uncertainty on repayment of subventures and/or additional capital requirements
- -Lack of statewide coordination and strategic planning for Catholic healthcare providers

To this end, the Task Force examined and considered the following critical questions as they relate to building a shared vision of Fidelis:

- -What is Fidelis?
- -Why was Fidelis created?
- -What are the benefits and operating principles of Fidelis to the Catholic ministry?
- -What are the operating principles of Fidelis related to Catholic providers?
- -What are the future directions and possibilities of Fidelis?

WHY WAS FIDELIS CREATED?

Fidelis was created to support the commitment of the Catholic Bishops of New York to sustain and expand the Catholic health care ministry within the changing healthcare environment of managed care, particularly for low-income individuals covered by Medicaid, Child Health Plus and other underserved populations. These groups have been a traditional focus of the Church's mission of service.

The growth and expansion of managed care presents new competitive challenges to traditional Catholic healthcare providers. Fidelis was created as a vehicle for Catholic providers to participate directly in contracting with the state for services to Medicaid and other special needs populations. Special needs populations include low income workers and the elderly, as well as persons with HIV, children, the developmentally disabled and the mentally ill. Fidelis includes both Catholic and non-Catholic providers in its statewide network

How Does Fidelis Benefit the Catholic Healthcare Ministry?

Fidelis provides a vehicle for the Catholic health care ministry to have a direct role in advocacy for the poor at the state and local level. Fidelis benefits the ministry by providing a new organizational expression of the healing ministry. Fidelis also provides a vehicle for the support of the *Ethical and Religious Directives* in the provision of Catholic healthcare services under direct contract with government programs.

Fidelis is an effective vehicle for collaboration of various sponsors in the overall healing ministry of the Church. Fidelis' unique relationship with Catholic providers offers the opportunity for Catholic providers to participate directly in the shift to managed care by Medicaid and other government programs by offering:

- -A vehicle for church advocacy to address the mission of care to the poor and underserved
- -A managed care product that conforms to the *Ethical and Religious Directives*
- -A financial plan with net revenue targets available for internal investment or return of capital for investment in local communities through future grants in support of the ministry
- -A commitment to limited provider networks of Catholic institutions where feasible, tied to local market conditions, regulatory requirements and the competitive environment
- -An opportunity to improve the health status of low income families within local communities in partnership with Catholic providers
- -A competitive alternative for Catholic providers in local markets to maintain patients and market share, particularly for individuals covered under government programs

III. Critical Issues for Board Consensus

Fidelis: An Instrument in the Evolving Health Care Ministry

Fidelis must be viewed within the historical perspective of the Church's ministry. The mission of caring for the health care needs of the community has been a constant in the Church's history. The Church founded hospitals in the early centuries for the poor. Over time, the ministry has sustained and expanded its traditional role of service to the poor in a variety of settings and institutional vehicles including the parish ministry and the work of the religious congregations.

As managed care becomes an increasingly significant factor in the delivery of healthcare services; a variety of challenges to the traditional role of Catholic healthcare providers have emerged. Specific to the development of Fidelis, the decision of the state to enroll Medicaid beneficiaries in managed care plans represented a major shift in the traditional access of low-income families to healthcare services.

What is Fidelis?

Fidelis is a healthcare apostolate sponsored by the Catholic Bishops of the State of NewYork. Fidelis operates as a Prepaid Health Services Plan (PHSP) authorized by the state to assume risk for the provision of care to distinct populations. Fidelis operates on an insurance model via the assumption of risk for covered lives to provide healthcare services for a predetermined monthly premium.

The key operational characteristics of Fidelis are:

- -Fidelis is an instrument of the ministry required by the circumstances of the time
- -Fidelis provides care in compliance with the *Ethical and Religious Directives*
- -Fidelis is a vehicle for Church advocacy on behalf of the poor and under served
- -Fidelis is a regulated business under state statute operating in a highly competitive environment
- -Fidelis is authorized under licensing requirements that demand compli ance with county, state and federal standards
- -Fidelis is required to assume risk and manage care for covered lives under direct contracts with network providers
- -Fidelis must operate and manage an adequate provider network to assure regulatory compliance with accessibility standards and the competi tive market environment
- -Fidelis maintains a unique relationship with the Catholic healthcare apostolate in each Diocese and with Catholic institutions

What Are the Operating Principles of Fidelis Related to Catholic Providers?

Fidelis shares a unique relationship with Catholic providers. As such, a major goal of Fidelis is to support the market position of Catholic providers whenever feasible, balanced against the market requirements of the business. The operating principles of Fidelis support this goal through:

- -Provision of competitive reimbursement rates by local standards to Catholic providers
- -Support of Catholic providers related to managed care initiatives and other market opportunities
- -Board participation and a means of input for Catholic providers to assist in shaping the local market initiatives directed towards Medicaid and the Child Health Plus Program
- -Partnerships with Catholic providers to conduct joint marketing and

enrollment efforts shaped to local markets
-Development of limited Catholic provider networks when feasible and in the future consolidating the provider network
-Development of opportunities for Catholic provider networks to assume full risk for members as markets mature

WHAT ARE THE FUTURE DIRECTIONS AND OPPORTUNITIES OF FIDELIS?

The Task Force deliberations considered the importance of creating autonomy from investor concerns for Fidelis to effectively pursue a strategy of continued market expansion and growth. Market growth is the essential factor in the generation of sufficient revenues and fund balance to meet investor commitment. Fidelis must have the ability to evaluate expansion of the lines of business in consultation with Catholic providers, the Board of Directors and Corporate Members.

The key business development strategies to support continued market expansion include:

-Develop market presence in additional counties for Medicaid and Child Health Plus
-Create and implement strategies for increased enrollment of Medicaid and Child Health Plus Program members in Catholic provider net works
-Develop incentives and risk sharing contracts with Catholic provider net works
-Develop improved medical management and quality outcome initiatives
-Increase member satisfaction and member retention
-Increase provider satisfaction
-Develop business planning process for coverage of special needs populations
-Position Fidelis to be competitive as programs emerge for the uninsured
-Evaluate the feasibility of Fidelis to develop a Medicare risk product in conjunction with Catholic providers and/or provide Medicare administrative support services to Catholic provider initiatives

IV. RECOMMENDATIONS

The following recommendations are proposed by the Task Force to resolve the issues identified for resolution and position Fidelis for continued expansion of the ministry.

1. BOARD COMPOSITION

The composition of the Board of Directors should be restructured to reduce potential investor conflicts and clarify the governance structure of the Board. The proposed restructuring of the Board of Directors is designed to reduce present and future conflicts of interests. The purpose of the proposed restructuring is to enhance the capacity to achieve the mission of serving the poor and medically underserved populations while at the same time to assist, support and collaborate with Catholic healthcare ministries including, but not limited to, Catholic healthcare institutions and Catholic Charities.

RECOMMENDED BOARD STRUCTURE

Board Composition	Directors
Designation of one Director per Ordinary	8
Individuals would be recommended through the Board's Nominating Committee, based on established criteria, considered and approved by the Board and thereafter ratified by the Corporate Members	6
Enrollee Advocate	3
Ex-Officio Directors (Fidelis CEO, Executive Director of the New York State Catholic Conference)	2

Board Criteria: Business and insurance industry expertise and diversity of talent including:

- -Participants from Catholic Charities and other Catholic Health and Human Services ministries
- -Financial expertise
- -Insurance and/or HMO industry experience
- -Legal expertise
- -Physician Representation
- -Hospital representation limited to two hospital/system CEOs

2. CONSENSUS ON MISSION

The Board of Directors must build consensus that the Mission of Fidelis as a new form of ministry is designed to advocate and serve the poor and local communities.

3. Return of Capital to Investors

The Board of Directors, Corporate Members and investors need clarity on the return of investment (subventions) by Fidelis. The organization is committed to begin return on investor capital commencing in 2002, contingent upon achieving the goals and objectives defined in the updated five-year Business Plan. Future distribution of Fidelis fund balances will be directed towards providing grants to the ministry.

4. Develop Strategic Coordination of Fidelis and Catholic Healthcare Ministry

Fidelis as a statewide organization needs to avoid potential future strategic conflicts that may arise between Fidelis initiatives and Catholic providers' healthcare initiatives. A planning and coordination function needs to be developed by Fidelis to avoid future strategic conflicts.

Fidelis' unique nature as a statewide organization will be responsible for bringing together Catholic providers and other Catholic sponsored organizations to secure consensus around future strategic initiatives. Fidelis' goal will be to build collaboration and mutual support for strategic initiatives of the plan, as well as the strategic initiatives of Catholic providers and organizations, as appropriate.

Approved

Board of Directors	April 22,1999
Corporate Members	June 4, 1999

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