STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

APRIL 3, 2012
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

I. CALL TO ORDER — **JOSEPHINE BOLUS, RN**

II. ADOPTION OF MARCH 13, 2012 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

III. INFORMATION ITEMS:

i. **2012-13 STATE FISCAL YEAR ENACTED BUDGET OVERVIEW**
WENDY SAUNDERS, ASSISTANT VICE PRESIDENT
OFFICE OF INTERGOVERNMENTAL RELATIONS

ii. **NEW YORK STATE HEALTH HOME AND HHC**
ROSS WILSON, M.D.
SENIOR VICE PRESIDENT/CHIEF MEDICAL OFFICER
OFFICE OF MEDICAL AND PROFESSIONAL AFFAIRS

IV. OLD BUSINESS

V. NEW BUSINESS

VI. ADJOURNMENT — **JOSEPHINE BOLUS, RN**

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

MARCH 13, 2012

The meeting of the Strategic Planning Committee of the Board of Directors was held on March 13, 2012, in the Board Room located at 125 Worth Street with Josephine Bolus, RN presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, RN, Chairperson of the Committee
Alan Aviles
Anna Kril
Bernard Rosen
Michael A. Stocker, M.D., Chairman of the Board
Andrea Cohen, representing Deputy Mayor Linda Gibbs in a voting capacity

OTHER ATTENDEES

M. Dolan, Senior Assistant Director, DC 37
M. Dubowski, Analyst, Office of Management and Budget
C. Fiorentini, Analyst, New York City Independent Budget Office
M. Meagher, Budget Analyst, Office of Management and Budget
J. Wessler, Commission on the Public's Health System

HHC STAFF

M. Belizaire, Assistant Director of Community Affairs, Intergovernmental Relations
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations
D. Cates, Chief of Staff, Office of the Chairman
L. Chang, Administrator, WTC Environmental Health Center
D. Green, Senior Assistant Vice President, Corporate Planning Services
L. Guttman, Assistant Vice President, Intergovernmental Relations
J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman

T. Mammo, Deputy Chief of Staff, President's Office
A. Marengo, Senior Vice President, Communications and Marketing
A. Martin, Executive Vice President and Chief Operating Officer, President's Office
K. McGrath, Senior Director, Communications and Marketing
T. Miles, Executive Director, WTC Environmental Health Center
K. Park, Associate Executive Director, Finance, Queens Health Network
S. Penn, Deputy Director, WTC Environmental Health Center
N. Peterson, Senior Associate Director, Planning and Operations, Woodhull Medical and Mental Health Center
J. Reibman, M.D., Medical Director, HHC WTC Environmental Health Center
S. Russo, Senior Vice President and General Counsel, Legal Affairs
W. Saunders, Assistant Vice President, Intergovernmental Relations
J. Schick, Chief of Staff, President's Office
D. Thornhill, Associate Executive Director, Strategic Planning, Harlem Hospital Center
J. Wale, Senior Assistant Vice President, Behavioral Health

CALL TO ORDER

The meeting of the Strategic Planning Committee was called to order at 10:20 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, RN. The minutes of the February 7, 2012, meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

Ms. Brown greeted and informed the Committee that her remarks would include brief updates on federal, state and city issues and the Corporation's Breakthrough work.

FEDERAL UPDATE

Ms. Brown reported that, on February 17, 2012, both Houses of Congress had adopted the Middle Class Tax Relief and Jobs Creation Act of 2012, which was signed into law by President Obama on February 22, 2012. This law includes a 10-month extension of the Social Security payroll tax holiday as well as an extension of the temporary Medicare physician payment rates fix. Without the enactment of this law, there would have been a 27.4% cut to physicians' Medicare payments. Ms. Brown noted that this payment fix will be renegotiated at the end of the calendar year.

Ms. Brown explained that to offset this spending the new law includes a one year extension of the Medicaid Disproportionate Share Hospital (DSH) funding reductions that are already mandated by the Affordable Care Act (ACA) to federal fiscal year (FFY) 2021. While this provision is proposed to save the federal government $4.1 billion, the estimated HHC impact is a revenue loss of $421.8 million for that year alone. Another offset that was included in the law is a reduction of the allowable reimbursement for Medicare bad debt payments from 70% to 65%. The new 65% allowable reimbursement level will begin on October 1, 2012. This provision is projected to save the federal government $6.9 billion over ten years but would cost HHC a total of $1.9 million over that same time period.

Ms. Brown noted that the proposal to cut Medicare payments to hospital outpatient departments for evaluation and management services was not included in the new law due to Senator Schumer's leadership on this issue. This proposed cut could have resulted in a revenue loss for HHC of $186 million over ten years.

President Obama's Proposed FFY 2013 Federal Budget

Ms. Brown reported that, on February 13, 2012, President Obama released the Administration's proposed FFY 2013 budget that included reductions to both the Medicaid and Medicare programs, totaling $364 billion over ten years. Ms. Brown noted that the specific health care cuts that were included in the Administration's proposed budget mirrored those that had been submitted to the "Super Committee" in fall 2011. The Administration's proposals, if enacted, would result in a revenue loss for HHC of $1.5 billion over 10 years.

Ms. Brown informed the Committee that there are three specific Medicaid proposals that were of primary concern to HHC. The first is a phase-down of states' current use of Medicaid provider taxes from FFY 2015 to FFY 2017 to 3.5% starting in FFY 2015. Currently, New York State's provider tax rate is 5.5%. The Administration's proposal would save the federal government $22 billion. However, HHC is projected to lose an estimated $687.5 million over 10 years, if this proposal is enacted.

The Administration's proposal to reconfigure states' FMAP (Federal Medical Assistance Percentages) by replacing the individual matching rates for Medicaid and Children's Health Insurance Program with a single lower rate is an additional concern for HHC. This provision is projected to save the federal government $18 billion over 10 years. While there are still no specific legislative details, it is estimated that HHC could lose another $277 million over 10 years.

Ms. Brown explained that the third proposal is a two-year extension of the ACA-mandated Medicaid DSH cuts to FFY 2022, which is projected to save the federal government $8 billion. Ms. Brown emphasized that the first year of this extension was included in the Middle Class Tax Relief and Jobs Act of 2012, which would result in a loss for HHC of $421 million for each of the two years.

As a follow-up to a discussion at the Finance Committee meeting concerning the ACA-mandated DSH cuts, Ms. Brown described the impact of these cuts as the following:

	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	Total
Estimated New York State Medicaid DSH Cut Percentage (GNYHA)	5%	5%	5%	16%	45%	51%	37%	37%	
HHC's Losses (in millions)	**($56.5)**	**($56.5)**	**($56.5)**	**($180.8)**	**($508.4)**	**($576.1)**	**($421.8)**	**($421.8)**	**($2,278.4)**

Ms. Brown informed the Committee that there were several Medicare specific proposals that were of major concern to HHC that she would not present in her remarks in the interest of time but would include in the meeting's minutes. These Medicare specific proposals are the following:

- A reduction of Indirect Medical Education (IME) payments by 10% starting in FFY 2014. This proposal would save $10 billion nation-wide but would cost HHC $93.8 million over 10 years.

- A reduction of the Medicare bad debt reimbursements from the current rate of 70% to 25% over three years. This provision is projected to save the federal government $36 billion but would cost HHC an estimated $15.3 million over 10 years.

- Proposals targeting long term care facilities that would save the federal government an estimated $63 billion and cost HHC $36.7 million over 10 years. These proposals include:

    - Reducing payments to inpatient rehabilitation facilities (IRFs), long-term care hospitals, skilled nursing facilities (SNFs), and home health agencies by 1.1% beginning in FFY 2014 through FFY 2021.

    - Equalizing payments for IRF with SNF payments, beginning in FFY 2013, for three conditions involving hips and knees, as well as other conditions selected by the Secretary of Health and Human Services; and

    - Reestablishing the Medicare policy in FFY 2013 that required at least 75% of patients admitted to an IRF to have conditions that meet one or more of 13 designated severity conditions in order for that facility to qualify as an IRF.

Ms. Brown shared with the Committee that HHC's Washington, D.C.-based Lobbyist, Judy Chesser, had met with every single member of the New York Congressional Delegation and their staff to discuss the

Administration's proposed budget and its impact on HHC. Ms. Brown noted that the Delegation raised their concern of the lack of alternative strategies given the current environment in Washington, D.C.

STATE UPDATE

Ms. Brown reported that state budget negotiations were proceeding ahead of schedule. Both the Assembly and Senate have prepared their respective one-house budget bills and will be working out the differences between them and the Governor's Executive Budget. Ms. Brown presented a brief summary of the items in the Executive Budget that were of interest to HHC with the Senate's and Assembly's response to these budget items. This summary is provided below:

Executive Budget Proposal	Assembly Response	Senate Response
Housing		
$75M ($150 M All Funds) for Affordable Housing	$50M (Memo indicates program delayed for $25M savings. Budget language includes $125M All Funds)	$22.5M + $5M for DHCR (Memo indicates program delayed for $52.5M savings and $5M to DHCR. Budget language includes $92.5M All Funds)
Supportive Housing fund created from portion of funds resulting from hospital and nursing home closures/bed reductions. Funding cannot exceed savings, with annual adjustments. DOH to issue non-competitive grants Funds can be used for housing development and "other programmatic activities to ensure a stable system of supportive housing." Can include maintenance of existing providers	Limits applicants to local governments or 1+ year old NFPs primarily engaged in supportive housing programs. Includes all savings from closures/bed reductions without creation of methodology or downward adjustments Requires Competitive grant process Funds can be used for same purpose as Executive, but does not include maintenance of existing providers in grant criteria	Requires DOH to issue report with proposed legislation by 1/1/13 after stakeholder's consultation. Funding methodology to include all savings from closures/bed reductions, with downward adjustments to reflect actual savings Need legislative approval to distribute funds. Funds can be used for "maintenance of existing supportive housing and development of new supportive housing"
Excess Medical Malpractice Pool		
Makes changes that would disqualify HHC	Rejects proposal	Modifies proposal to require legislation to be passed after budget to ensure viability of pool.
Nursing Home Transition and Diversion Funding		
Includes current year funding only ($2.3M)	Current year + $2.3 M from 2011-12 with HHC-Barrier Free Living Demonstration Program	Current Year + $2.3M from 2011-12. No demonstration language.

Executive Budget Proposal	Assembly Response	Senate Response
State Inmates to HHC Facilities (730s)		
State could require HHC to take inmates	Modifies language to remove placement in HHC Hospitals. Maintains language to allow for outpatient restoration.	Rejects proposal
Behavioral Health Provisions		
Broad language allowing closure of Kingsboro and consolidation of Children's Psychiatric Centers in Bronx, Brooklyn and Queens	Rejects proposal	Rejects proposal and requires a Legislative MOU and report from the Behavioral health Services Council (old Mental health Services Council) before any service reductions affecting mentally ill or developmentally disabled (DD) population with stakeholder input and legislative MOU.
Extends CPEP authorization for 4 years	Accepts proposal	Accepts proposal
Merges Mental Health Services Council with other to create new Behavioral Health Services Council (affects HHC's two Public Health and Health Planning Council appointees)	Accepts proposal	Modifies proposal
Sets up framework for DOH and OMH to jointly operate Behavioral Health agencies and allows them to waive regulations or determine compliance with another agency's regulations	Accepts proposal but adds requirement for annual report	Modifies proposal
MRT		
Extends Global Cap and "Super Powers" by one year (through 2013-14), for total of three years	Accepts proposal	Rejects proposal and 1) requires the Office of the State Comptroller (OSC) to conduct audit of current cap and 2) establishes a methodology to share savings under cap
Provides Medicaid reimbursement for podiatry for diabetes patients, lactation consultants, harm reduction, coordinated hepatitis C care, prenatal care coordination and enteral formula for HIV/AIDS patients	Accepts proposal	Rejects harm reduction, coordinated hepatitis C care, and prenatal care coordination.
Requires pharmacies to provide translation services or other assistance to patients with language access issues	Accepts proposal	Rejects proposal
Establishes a Primary Care Services Corp Loan Repayment Program	Accept proposal	Rejects proposal

Executive Budget Proposal	Assembly Response	Senate Response
Managed Care		
Provides facilitated enrollers for movement to mandatory Managed Long Term Care Plans (MLTCPs). DOH can award non-competitive contracts	Modifies to require mini-bid process	Modifies to requires competitive contracts
Requires MLTCPs to offer the consumer directed personal care program	Accepts	Modifies proposal to allow, but not require
Health Insurance Exchange		
Includes the Health Benefits Exchange legislation that represented a 3-way agreement with the Legislature last year	Accepts with minor changes to findings	Rejects proposal

Ms. Brown informed the Committee that there is still more work to be done regarding the language for those proposals and/or responses that may adversely impact HHC.

CITY UPDATE

Ms. Brown reported that President Aviles would be testifying before the City Council's Health Committee on HHC's preliminary budget on March 19, 2012. She noted that President Aviles' testimony would include a review of HHC's financial state, fiscal challenges and an update on the progress HHC is making to close its budget gap. His presentation will also include the status of HHC's major initiatives including HHC's work to develop innovative care models, implement more efficient processes, and upgrade HHC's infrastructure (including clinical information technology) to transform into a more integrated health system that is patient-centered, efficient that ensures better patient outcomes through coordinated care delivery. Ms. Brown noted that it is important to share this information with the Council to demonstrate that HHC's unrelenting commitment to excellence in spite of its significant financial challenges. Ms. Brown noted that the Council will also be reminded that those HHC programs that they had funded in the past will require funding restoration this year. Ms. Brown also reported that the Council would hold a second set of budget hearings later in the spring, in late May or early June.

BREAKTHROUGH UPDATE

Ms. Brown reported that Harlem Hospital Center had successfully launched Breakthrough at the end of calendar year 2011. Accordingly, Harlem Hospital will be deploying Breakthrough tools to aid with the implementation of the move to the new patient pavilion. Ms. Brown also reported that there had been a remarkable Breakthrough event focused on the Corporation's roll out of care management services at all HHC's Emergency Departments (EDs). The executive sponsor of that event was Anne Sullivan, M.D., Senior Vice President, Queens Health Network. Ms. Brown explained that this was a unique Breakthrough event because it involved a supersized number of team members with representation from all HHC hospitals and from across all disciplines. The event also included the participation of both medical and administrative staff from the EDs. Mr. Aviles explained that the event included 32 team members who tackled the flow redesign in the EDs around care management. He explained that, over

the course of that one week, a very detailed work plan was developed including a marketing/communications plan so that staff in the various EDs could understand why these changes were being undertaken. Mr. Aviles added that, over the course of the subsequent two weeks, each facility worked on their facility specific gap analysis and implementation plan. Mr. Aviles commented that this was the first time that HHC had undertaken such an ambitious initiative in making fundamental changes in order to create standard work across the entire enterprise simultaneously. Ms. Brown reported that the team had also developed a model that will be reviewed at each of the local sites as part of their implementation plan. She noted that the staff wholly understands the importance of what they are doing in support of HHC's strategic goals to reduce readmissions; to help extend patients' community tenure; to ensure that discharge plans are effective; and to link patients to primary care.

INFORMATION ITEM

World Trade Center Health Program Survivor Program Update

Joan Reibman, M.D., Medical Director, HHC WTC Environmental Health Center

Ms. Brown informed the Committee that there had been a lot of discussion in the media concerning a new World Trade Center (WTC) Registry and new surveys about the health concerns of individuals who had been affected by the World Trade Center disaster. She noted that HHC's WTC Health Program team had been engaged in those discussions over these last several years focused on the health care implications and research related to the same. She informed the Committee that she had invited Dr. Reibman to present the findings of her work to the Strategic Planning Committee and to discuss the long term implications for HHC's WTC Health Program in treating those individuals who had been affected by the WTC disaster.

Mr. Terry Miles, Executive Director, HHC's WTC Health Program informed the Committee that the implementation of the James Zadroga 911 Health and Compensation Act in July 2011 included the establishment of a Scientific Technical and Advisory Committee (STAC). The first meeting of the STAC occurred in fall 2011. The STAC is comprised of physicians, attorneys, and laypersons from across the country. Mr. Miles reported that Dr. Reibman was invited to present information about HHC's WTC Health Program at that first STAC meeting. Mr. Miles stated that Dr. Reibman would be sharing with the Committee a modified version of that presentation. Mr. Miles acknowledged individuals who had been integral to the WTC Health Program from its inception. He recognized Judy Wessler, who represented the Commission on the Public's Health System (CPHS); Andy Cohen of Deputy Mayor Linda Gibbs' office and LaRay Brown, HHC's Senior Vice President for Corporate Planning, Community Health and Intergovernmental Relations.

Dr. Reibman began her presentation by sharing the history of HHC's WTC Health Program which was formerly known as the WTC Environmental Health Center (WTC EHC) prior to the implementation of the Zadroga Act. She stated that the WTC Health Program represented an unusual and special collaboration between the public hospital system, the academic community, community groups and the City. This collaboration provides a model to respond to emergencies and disasters in the future.

Dr. Reibman emphasized that what is now taken as dogma is the understanding that the WTC destruction was an environmental disaster. However, the city, the hospital system and the medical community were not prepared to deal with environmental disasters. It is now known through the work that had been conducted by the responder community that rescue and recovery workers had exposure to dust, fumes, gases from the WTC destruction that were enormous and ongoing. She commented

that, in the early days, a lot of advocacy was necessary to make people understand that the WTC dust/fumes might not be good for these workers.

Dr. Reibman reported that, through the work conducted by the academic community, it was determined that the WTC dust was very alkaline (pH level at 9-11) and was comprised of:

- Construction materials (cement, concrete, wallboard);
- Particulate matter (calcium sulfate, ca carbonate, crystalline silica);
- Fibers; and
- Combustion products (polycyclic aromatic hydrocarbons, hydrocarbons).

Dr. Reibman reported that a lot of information was gathered about the WTC dust composition from a firefighter who was brought to Bellevue Hospital two weeks following the WTC event. The firefighter was critically ill and was placed in the intensive care unit (ICU). He was bronchi scoped and his lungs were washed out. She reported that they were able to pull out from the washings of his lungs pieces of asbestos, fly ash and fibrous glass. The importance of this finding is that these particles were larger than what was known to be able to get down into the lung. Dr. Reibman added that they learned that there were a lot of products in the dust; that an individual can breathe in both the small and large particles, which increases the potential for damage. Dr. Reibman noted that these findings and lessons learned had been published.

Dr. Reibman reported that the ongoing medical and mental health illness of the responder community had been documented through the enormous efforts of the Fire Department (FDNY) and the multi-hospital consortium which includes Bellevue Hospital Center. However, as a public and community-based hospital, it became clear that there was a population at risk that included at least 60,000 local residents, approximately 300,000 building evacuees/local workers and between 15,000 to 25,000 children. She noted, however, that this fact was not readily recognized and accepted.

Dr. Reibman described the community impact of the 9/11 event. She stated that what is now known is that the community had enormous exposure and potential risk resulting from that exposure. To illustrate that point, Dr. Reibman shared pictures of students, community residents, and local workers who had been caught in the dust cloud on 9/11. Dr. Reibman described the two potential types of exposure to WTC dust/fumes as either acute or chronic. Acute exposure relates to those community members who were caught in the dust cloud. Chronic exposure relates to those community members who were exposed, on an ongoing basis, to dust that had settled inside buildings/ventilation systems; re-suspended dust from incompletely cleaned ventilation systems; and ongoing exposure to the fumes from fires that burned through December 2001.

Dr. Reibman described how HHC got involved in this work. As a pulmonologist and researcher, Dr. Reibman also serves as the director of Bellevue Hospital Center's asthma program, since 1991. Dr. Reibman recalled being invited to a panel discussion at Pace University after 9/11. She stated that she was asked about the impact of the WTC destruction on local residents but had to admit that she had no knowledge of those issues. Following that discussion, Dr. Reibman worked with the New York State Department of Health to conduct first studies of local residents and was later able to document some adverse respiratory health effects in that community. Dr. Reibman reported that, at that time, many community residents had become very concerned. As a result, community residents coalesced to form a number of community groups to begin looking at these issues. One such organization that emerged was called the Beyond Ground Zero Network. Key leadership staff at HHC was approached by the Beyond Ground Zero Network about caring for residents who became ill. A pilot program was set-up within Bellevue Hospital's Asthma Clinic to care for these patients. The program was staffed by fellows.

Dr. Reibman described the funding history of HHC's WTC Health Program from its inception as the following:

Year	Funding Entity
2005	Private Philanthropy o American Red Cross o New York Times Neediest
2006	New York City Mayor's Office
2008	Federal Government o Centers for Disease Control/ National Institute of Occupational Safety and Health (NIOSH)
2011	Federal Government o World Trade Center Healthcare Program (WTCHP) as a result of the James Zadroga 9/11 Health and Compensation Act

Dr. Reibman reported that working with the community early on, the WTC Health Program was launched as a treatment program for individuals with presumed WTC-related illnesses. Geographic boundaries were developed. Due to limited funds, the program focused on the treatment of community members with symptoms rather than becoming a screening program. With funding provided by the City, the program was expanded to include mental health services. She explained that the community had identified a great need for mental health services but it was known that the target population would not present for mental health services as a primary health concern. In response to this need, Dr. Reibman stated that importantly, this program became a multidisciplinary treatment program (i.e., a joint medical and mental health program) that was targeted to residents, local workers, students and clean-up workers. Dr. Reibman reported that, by September 2011, a total of 5,600 individuals had been enrolled in the program for medical or mental health treatment.

Dr. Reibman shared some descriptive statistics of the program enrollees. She reported that, unlike the other WTC programs, nearly 50% of program enrollees are female. This is unusual for the responder programs. She added that the program is predominantly adult, very racially and ethnically diverse. Forty-percent (40%) of enrollees reported that they were caught in the dust cloud on 9/11.

Dr. Reibman reported on the distribution of symptoms among the total population of residents, local, clean-up and rescue workers. She reported that they all had the same complaint of cough, wheeze, dyspnea on exertion, chest tightness, sinus/nasal congestion and gastrointestinal problems. This distribution pattern of symptoms remained consistent years following the WTC event.

Dr. Reibman reported that they did not know what they were treating but fully understood that these were complex illnesses. She stated that program enrollees presented with a wide range of respiratory conditions including nasal/sinus issues, unremitting cough, atypical asthma, airway damage (bronchiectasis), sarcoidosis, and interstitial lung disease or scarring of the lung. Dr. Reibman reported that it is not yet understood who would acquire these illnesses but factors including the amount of exposure to WTC dust and individual susceptibility (i.e., allergy, tobacco usage, immunity, genetics etc.) may play a role.

Dr. Reibman provided the Committee with a description of a typical or a classic WTC Health Program patient. She described this patient as the following:

- 37 year old resident of Lower Manhattan (Beekman Street)

- Previously healthy (training for marathon), no history of childhood asthma/lifelong nonsmoker
- Not in dust cloud
- Stayed in apartment and cleaned dust-covered apartment
- Onset of shortness of breath and wheezing 6 months later
- Presented to WTC EHC in 2006 with persistent upper airway symptoms (nasal congestion, post nasal drip) and daily lower airway symptoms (shortness of breath, wheezing)
- Treated aggressively for asthma
- Continues to need therapy to control symptoms

Dr. Reibman informed the Committee that not enough is yet known about the children who had been affected by the WTC disaster. Dr. Reibman reported that a pediatric program was created but there had been significant challenges with the recruitment of children for that program. She explained that this was in part due to the fact that children have their own doctors. Dr. Reibman reported that there are currently 148 self-referred children that are enrolled in the program. Both sexes are represented in this group, which is racially and ethnically diverse. Forty percent (40%) of these children were caught in the dust cloud because they lived or attended school near the World Trade Center. There is a high rate of asthma among these children. There may also be some endocrine disruptors. She noted that these are important things to begin to study.

Dr. Reibman stated that a key aspect of the WTC Health program is the complexity of the medical and mental health illnesses. Forty percent of patients scored positive for Post Traumatic Stress Disorder (PTSD) symptoms, depression or anxiety. The risk factors for PTSD include sex (female), low income, exposure (dust cloud), but also include physical symptoms (upper and lower respiratory symptoms, and severity of shortness of breath). Accordingly, there is a huge load and demand on the program to provide mental health services.

Dr. Reibman described the effectiveness of the program over time. She stated that lung function over time was recently analyzed for enrolled patients. She reported that there had been improvements in lung function in the group as a whole. However, this improvement is not complete and it depends on the type of characteristic of the lung function. While lung function is improved, patients do not return back to a normal state. Dr. Reibman reported that, among the various local exposure groups, local workers had the least improvement compared to residents and clean-up workers. This is a very important finding because many of the local workers were caught in the dust cloud and many returned to work one week after 9/11, resulting in both acute and chronic exposure to WTC dust.

Dr. Reibman explained that there are a lot of medical questions. These questions include what is the cancer risk; what is the progression of the lung disease; are there other illnesses like connective tissue disorders, are there neurological disorders and how to manage vulnerable populations. Dr. Reibman stated that the questions concerning mental health include who is at risk for persistent PTSD; what are the long term outcomes; and are there cognitive defects with intractable PTSD.

Dr. Reibman concluded her presentation by stating that an important finding is that it is now known that this is not an acute disease. The WTC Health Program provides care for chronic illnesses both physical and mental health. She noted that the program is now undergoing a lot of transition relating to the implementation of the James Zadrogra 911 Health and Compensation Act.

Mr. Aviles acknowledged Dr. Riebman's extraordinary dedication to treating those who had been adversely affected by the WTC disaster; and her exhaustive research to elucidate the long and short term implications of this disaster. Dr. Reibman responded that this is a joint effort with central office and facility staff. Dr. Stocker, HHC's Board Chair, inquired about an estimate of the size of the population

at risk. Dr. Reibman stated that this has been a huge issue. She added that all that is available are estimates. The actual size of the population is unknown.

Ms. Bolus asked if there will be a Brooklyn component of the WTC Health Program. Dr. Reibman responded that the program's service area includes some parts of Brooklyn which allows for these individuals to seek care at any of the three program sites. Ms. Brown added that the program's funding structure does not allow for the propagation of new sites. Going forward, the program's efforts will be focused more deeply on ensuring that HHC is providing the most comprehensive and highest quality care at the three program sites. Ms. Brown also noted that the geographic boundary of the program was established by the federal government.

Andy Cohen, representing Deputy Mayor Linda Gibbs in a voting capacity, commented that the New York City Department of Health had recently closed a mental health program that provided vouchers to patients allowing them to seek geographically appropriate care. She asked about the impact of the closure of that program on the volume of patients now being cared for by the WTC Health Program. Dr. Reibman responded that a fair number of those people are coming into the program. Additionally, the New York City Department of Health's WTC Registry in collaboration with the WTC Health Program had conducted an outreach initiative targeting individuals who needed care. This outreach has also generated an increase in individuals seeking mental health services. Dr. Reibman added that the program is very overwhelmed with people with mental health needs. These needs include psychology, therapeutic intervention, and psycho pharmacological intervention.

Dr. Stocker asked how well is the WTC Health Program's work informed by the response to other types of exposures like coal miners, asbestos etc. Dr. Reibman responded that what is currently known about occupational and irritant exposures is being utilized. However, things may or may not be the same with this exposure.

Mr. Rosen asked if the occupational health group at Mount Sinai is also doing similar work. Dr. Reibman responded that the WTC Health Program worked very closely with Mount Sinai. She added that there are now four WTC Centers of Excellence which include the Mount Sinai Consortium that works with the responders (one of the Consortium's sites is located at Bellevue Hospital), the Fire Department of New York, the New York City Department of Health and Mental Hygiene (NYCDOHMH) in addition to HHC's WTC Health Program. The four programs work together, meet regularly and exchange information. All four programs are now part of the federal program with federal government oversight.

Dr. Stocker asked what will be the follow-up. Ms. Brown responded that this was the first time that Dr. Reibman was invited to discuss the WTC health issues. She noted that periodically the Committee had heard reports about the WTC Health Program contracts and outreach efforts. She added that it was important for the Committee to understand the long haul implications; that individuals who had been affected by the WTC disaster now have chronic conditions. This has very important implications on how HHC will structure the program in terms of new patients to be served by the program. The other critical issue is the predominance of mental health needs.

Mr. Rosen asked if the program served first responders. Dr. Reibman responded that the WTC Health Program served community members not first responders.

Mr. Rosen further commented that, it appeared that the WTC Health Program has had quite a bit of success medically with those community members who had been treated. Dr. Reibman responded that there have been some successes. She explained that, it is like the asthma model. The program does not cure but control. Ms. Brown stated that the important factor for the Committee to understand is that the program is now caring for people who have multiple chronic conditions. As a result, the cost of providing

that care will increase. She recommended that as a follow-up, the Board Chair and other Board members may wish to confer about sharing this information with the full Board.

Andy Cohen asked about the demographic profile and the insurance status of the population. Dr. Reibman responded that, under the Zadroga Act, the program must bill private health insurance carriers first. The WTC Health Program is the last payer. Mr. Miles stated that at Bellevue Hospital, 40% of the program's patients are uninsured; and 60% or more patients served at Elmhurst Hospital and Gouverneur are uninsured. Dr. Reibman informed the Committee that the Bellevue Hospital program site serves 4,000 patients. A total of 1,500 patients receive care at Gouverneur and 300 patients receive care at Elmhurst Hospital. Mr. Miles commented that the federal government had taken over the enrollment process directly. He stated that, it is a very different process and it may possibly take months for someone to get into the program. This is one adjustment with regard to the new law.

Dr. Stocker commented that there were several grade schools located close to the WTC disaster site. He asked if there were plans for long term follow-up. Dr. Reibman stated that many different efforts working with community groups and the program's Community Advisory Council had been conducted to reach these children. Additionally, outreach to the Department of Education and local pediatricians have also been conducted. Mr. Miles noted that, in spite of all of the outreach efforts, there are many who are still unaware of this program. Dr. Stocker noted the importance of ongoing efforts to reach these children.

Dr. Reibman noted that the goal of the program had been twofold. That is, to provide care to a population in need and to learn as much as possible to be prepared for the next environmental disaster. She announced that a pediatric environmental specialist and a pediatric pulmonologist had been recently hired. This will aid with the recruitment efforts and will provide more highly specialized care for children, which will be different from the care that is being provided by community physicians.

Andy Cohen commented that the Department of Health's WTC Registry is also following 70,000 people who had been exposed to WTC dust through the Registry. The Department of Health sends out period surveys to inquire about the physical symptoms of these individuals. Dr. Stocker asked if this is being done in the schools. This information was not confirmed.

Mr. Miles informed the Committee that the WTC Health Program had collaborated with the Department of Education in the past to conduct a targeted mailing for children who had been enrolled in schools in the target areas, from September 2001 to spring 2003. The mailing was sent to 16,000 households but yielded only slight increases in the number of adult and pediatric patients. Mr. Miles also noted that various social media strategies had been utilized in an effort to reach these children.

Ms. Bolus inquired about advertisement efforts focused on the borough of Brooklyn. Mr. Miles responded that the program had always served patients who lived in Brooklyn from the very beginning. Specifically, residents from the targeted areas in Brooklyn and those Brooklyn residents who worked and attended school in the WTC targeted areas.

Ms. Bolus asked Mr. Miles and Dr. Reibman if they would be amenable to presenting this information to the full Board. They both responded affirmatively.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:35 a.m.

2012-13 State Fiscal Year Enacted Budget Overview

STRATEGIC PLANNING COMMITTEE

APRIL 3, 2012

2012-13 Enacted State Budget

- Closes $2 Billion deficit
- Second year of 2 year agreement on Medicaid
- Increases overall spending in Medicaid by 4%
- No significant new Medicaid cuts
- Continues budget cuts from 2011 with total impact of $174.5 Million to HHC (excluding reductions due to new nursing home reimbursement system)
  - ✓ No inflation factor for providers
  - ✓ 2% across-the-board rate cut

Global Cap on Medicaid

- Extends Global Cap on Medicaid spending by one additional year (three years total)
- Includes 4.2% increase in Medicaid spending for 2013-14
- Continues SDOH's "superpowers" should spending exceed projections
- Spending is on target through January 2012
- Enrollment increases must be covered under Global Cap

Enacted Medicaid Redesign Team (MRT) Proposals

- Provides new benefits for Medicaid patients and eliminates ineffective benefits
- Creates a Supportive Housing Reinvestment Program and provides new funding for Affordable Housing
- Requires language accessible prescriptions
- Expands data collection for disparities
- Creates Primary Care Service Corps

Enacted MRT Proposals

- Provides targeted increase for Fair Hearings for move to mandatory enrollment in managed long term care
- Requires managed care plans and Managed Long Term Care Plans to offer Consumer Directed Personal Care
- Provides enrollment assistance for Medicaid patients enrolling in mandatory managed long term care

Enacted MRT Proposals

- Phases in State takeover of growth in local share of Medicaid spending
- Phases in State takeover of Medicaid Administration
- Allows electronic asset verification for certain Medicaid patients

Enacted MRT Proposals

- Consolidates NYC Children's Psychiatric Centers
- Allows for up to 400 bed closures and consolidations in SOMH facilities after notification of Legislature and Mayor
- Establishes framework for SDOH and SOMH to jointly operate Behavioral Health Agencies (can waive requirements/deem compliance)
- Extends the Comprehensive Psychiatric Emergency Program (CPEP) for four years (2016)

Other Enacted Proposals

- Replaces 2012 nursing home bed hold provision with new rules for adult residents to be issued by SDOH ($ 40 million savings). HHC impact to be determined
- Extends the potentially preventable readmissions cut until 2013 and allows SDOH to implement an adverse events policy in outpatient settings
- Allows SDOH to include CMS quality measures for potentially preventable complications

Adopted Legislative Proposals

- Creates a Workgroup on Medically Fragile Children
- Creates a Prescription Pain Awareness Program, including development of a CME program for health care providers and new reporting on opiod overdoses
- Institutes “prescriber prevails” for atypical antipsychotics
- “Grandfathers” existing providers in the Excess Medical Malpractice Liability Pool and requires a study by 11/1/12

Adopted Legislative Proposals

- Requires SDOH to report on transition to mandatory managed long term care
- Requires SDOH to develop transition and continuity of care requirements for mandatory managed long term care
- Requires SDOH to consult with stakeholders on reimbursement for nursing homes' capital costs in managed long term care
- Requires SDOH to facilitate the use of triage systems in emergency rooms and report results

Rejected Governor's Proposals

- NO changes for reimbursement of charity care/ Disproportionate Share Hospital (DSH) funding
- NO Health Benefits Exchange legislation. Governor has indicated he may issue an Executive Order to create a New York Exchange
- NO new authority for SDOH to close facilities or replace Operators or Board Members for repeat violations, significant mismanagement or criminal activity
- NO Closure of Kingsboro Psychiatric Facility

Questions?

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

NYS Health Home and HHC

Ross Wilson, M.D.

Senior Vice President/Chief Medical Officer

Presentation to the Strategic Planning Committee

April 3, 2012

What is Health Home?

- Health Home is a good opportunity to improve the care of patients with chronic illness ("Medicaid high utilizers") by using care coordination to assist the patient with navigation and communication
- Is funded from the *affordable care act* through a NY state plan amendment that was recently approved by CMS
- Implementation is complex and needs more clarity and certainty from NYS

Federal Health Home Requirements

Section 2703 of the federal Patient Protection and Affordable Care Act (ACA) establishes authority for states to develop and receive federal reimbursement for a set of health home services for their state's Medicaid populations with chronic illness. Health home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care.

Health home services include:

- comprehensive care management,
- health promotion; transitional care including appropriate follow-up from inpatient to other settings,
- patient and family support,
- referral to community and social support services,
- use of health information technology to link services.

Medicaid eligible individuals must have: (1) two chronic conditions; (2) one chronic condition and are at risk for a second chronic condition; or (3) one serious persistent mental health condition to qualify for health home services.

For additional information on federal health home requirements, view the following:

Federal Legislation ACA Section 2703
http://www.ssa.gov/OP_Home/ssact/title19/1945.htm#ftn490

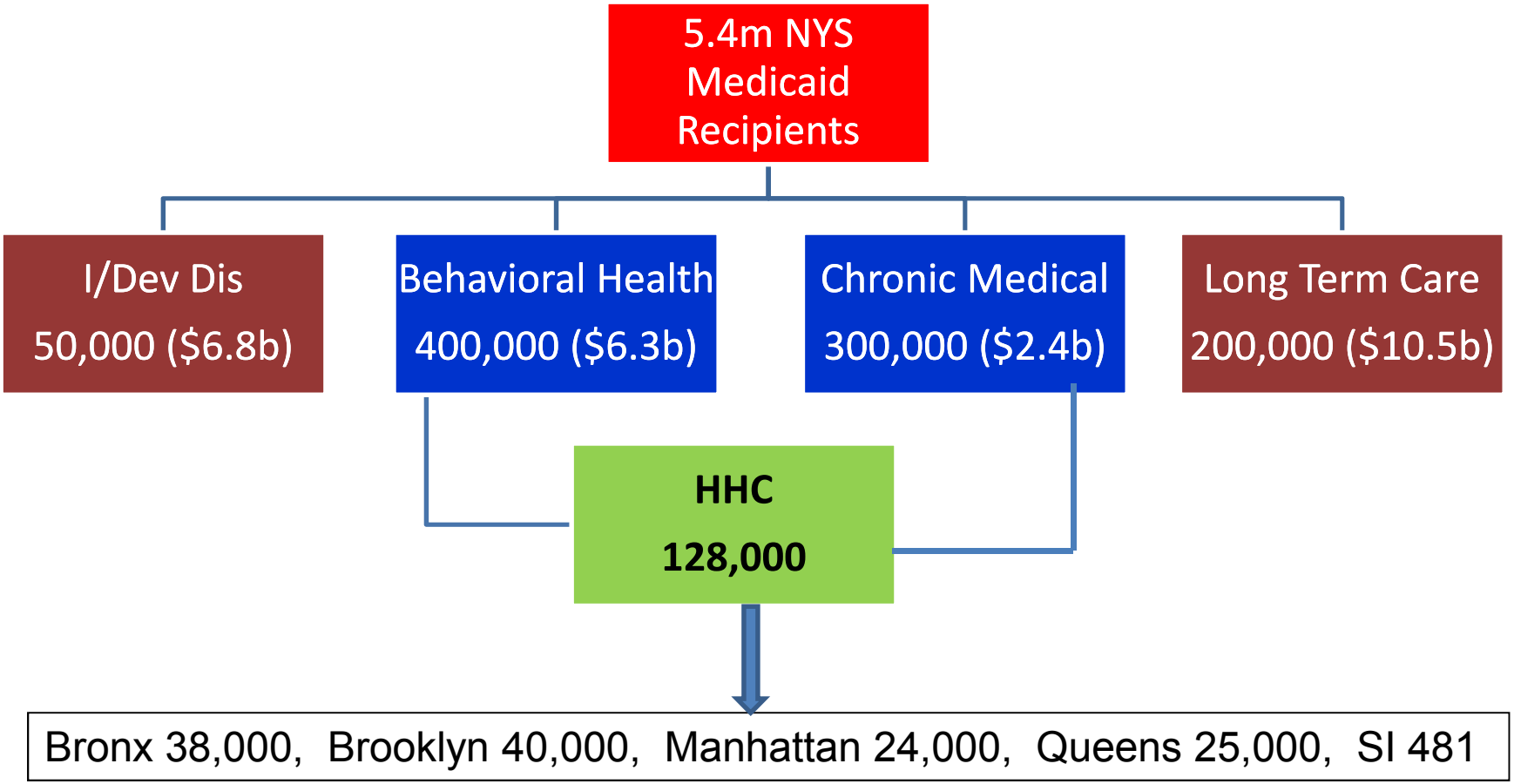
State Medicaid Director's Letter 10-024
https://www.cms.gov/smdl/downloads/SMD10024.pdf

NYS Implementation of Health Homes

Implementation of Health Homes for Medicaid enrollees with chronic conditions was recommended by the Governor Cuomo's Medicaid Redesign Team. As a result, this initiative was included in the Governor's SFY11/12 Budget and was adopted into law effective April 1, 2011. Social Services Law (SSL) Section 365-L authorizes the Commissioner of Health, in collaboration with the Commissioners of the Office of Mental Health, Office of Alcohol and Substance Abuse Services, and the Office of People with Developmental Disabilities, to establish health homes for NYS Medicaid enrollees with chronic conditions.

The Department is in the process of developing the Health Home program. More information about health homes will be available on

Breakdown of NYS Medicaid High Cost Enrollees



HH Functional Flow

Patient Assignment	• Eligible Patient • Determined by NYS DOH
Patient Engaged	• Located • Agreeable
Patient Assessed	• Clinical Team linked to Primary Care (PCMH) • Social needs
Management Plan	• This drives the care coordination and delivery – the lynch-pin
Care Coordination	• Includes care management and monitoring
Outcomes	• Patient has improved health status • Reduction in IP and ED use

Bronx Designated Health Homes

- Montefiore Medical Center (establishing the Bronx Accountable Healthcare Network) with Acacia Network; Albert Einstein College of Medicine; Morris Heights Health Center; St. Barnabas Hospital; & Union Community Health Center

- **NYC Health and Hospitals Corporation + MetroPlus Health Plan**

- Visiting Nurse Service of New York Home Care + Institute for Family Health; Argus Community; Help PSI Inc.; Urban Health Plan, Inc.; & Community Healthcare Network

- Bronx Lebanon Hospital Center + CBC/FEGS Health and Human Services System, Inc., IHealth/Help PSI Inc.; Bronxworks; Allmed Medical Centers; Corinthian IPA, Essen Medical.

Brooklyn Designated Health Homes

- Maimonides Medical Center + Lutheran Medical Center; Institute for Community Living; FEGS Health and Human Services System, Inc.; Visiting Nurse Service of New York; First to Care Home Care; Jewish Board of Family and Children Services; Promoting Specialized Care and Health; Center for Urban and Community Services
- **NYC Health and Hospitals Corporation + MetroPlus Health Plan**
- Community Health Care Network
- Institute for Community Living + Coordinated Behavioral Care, Inc.

January 27, 2012

- ***UPDATED*** **Phase-in plan for Health Home Applications**

- **Phase I** - 10 counties:
  - Bronx, Clinton, Kings (Brooklyn), Essex, Franklin, Hamilton, Nassau, Schenectady, Warren, Washington
  - HH application due date for **Phase I counties only is November 1, 2011**.
  - Implementation is scheduled for February 1, 2012
- **Phase II**** – 16 Counties:
  - Dutchess, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Richmond (Staten Island), Rockland, Suffolk, Sullivan, Ulster, Westchester,
  - HH application due date for **Phase II counties only is February 15, 2012**.
  - ***UPDATED*** Implementation is tentatively scheduled for April 1, 2012

Projected Average Health Home Payments by Base Health Status and Severity of Illness -

Excludes LTC and OPWDD Populations

FINAL RATES (January 2012)

Base Health Status[1]	Severity of Illness[2]	State-wide Average Case Manager Ratio [3]	Downstate			Upstate		
			Eligible Recip-ients[4]	Average CRG Acuity Score[5]	Average Monthly Payment[6]	Eligible Recip-ients[4]	Average CRG Acuity Score[5]	Average Monthly Payment[6]
Single SMI/SED	Low	79:1	50,346	6.3406	$148	25,182	6.3382	$119
	Mid	61:1	18,790	8.0873	$189	9,772	8.0239	$150
	High	12:1	260	16.5071	$385	60	16.6197	$312
Single SMI/SED Total		**73:1**	**69,396**	**6.8704**	**$160**	**35,014**	**6.8419**	**$128**
Pairs Chronic	Low	116:1	276,712	3.1258	$73	89,006	4.0091	$75
	Mid	76:1	103,983	6.4740	$151	36,731	7.0456	$132
	High	37:1	18,169	10.9285	$255	6,031	11.4136	$214
Pairs Chronic Total		**100:1**	**398,864**	**4.3631**	**$102**	**131,768**	**5.2032**	**$98**
Triples Chronic	Low	89:1	15,593	5.4311	$127	5,155	5.7358	$108
	Mid	62:1	21,559	7.9278	$185	7,608	8.2540	$155
	High	34:1	7,527	11.3893	$266	2,609	11.8749	$223
Triples Chronic Total		**65:1**	**44,679**	**7.6082**	**$177**	**15,372**	**8.0018**	**$150**
HIV/AIDS	Low	93:1	18,667	5.1243	$120	1,686	5.1243	$96
	Mid	51:1	19,157	9.2749	$216	2,215	9.0280	$169
	High	12:1	2,069	16.7259	$390	247	16.7148	$313
HIV/AIDS Total		**64:1**	**39,893**	**7.7507**	**$181**	**4,148**	**7.9328**	**$149**
Grand Total		**91:1**	**552,832**	**5.1654**	**$120**	**186,302**	**5.7903**	**$109**

Case Manager Payment Breakdown

- These changes increased the statewide average cost/payment per case manager to over $110,000, with the following estimated allocations;
- direct salary and fringe benefits - $71,500,
- agency admin and program admin (direct supervision) - $15,000,
- non-personal service - $10,000,
- other admin including data management – $6,500,
- capital - $7,200.

Shared Savings Model?

- (additional)10% of the pmpm fee is available based on performance metrics
- Currently unknown:
  - Which measure(s)
  - Which threshold
  - Graduated or all or none?

NYS plans on calculating all of these measures using existing resources, and sharing the results with each Health Home provider. Measures will be calculated minimally annually and possibly quarterly to monitor the effectiveness of each Health Home.

Evaluation					
Hospital Inpatient	Hospital Admissions	Claims and Encounters	Hospital Utilization and cost per member per month	BH/SA, CC	Claims and Encounters
Hospital Inpatient	Preventable Hospitalizations	Claims and Encounters	Hospital Utilization and cost per member per month	BH/SA, CC	Claims and Encounters
Hospital Inpatient	Potentially Preventable Readmissions	Claims and Encounters	PPR Utilization and costs	BH/SA, CC	Claims and Encounters
Hospital ER	Potentially Avoidable ER Visits	Claims and Encounters	Potentially Avoidable ER visits and costs per member per month	BH/SA, CC	Claims and Encounters
Skilled NH Admissions	NH Admissions	Claims and Encounters	Nursing Home Utilization and cost per member per month	BH/SA, CC	Claims and Encounters

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

Table 2: Wave One Health Home Rollout by SFY and FFY - Mental Health/Substance Abuse/Chronic Medical Cohort

Health Home Enrollment Phasing			Phase	Tier									Total
				Phase 1			Phase 2			Phase 3			
State Fiscal Year	State Quarter	FFY & Qrt	High Cost	Mid Cost	Low Cost	High Cost	Mid Cost	Low Cost	High Cost	Mid Cost	Low Cost	
SFY '11-'12	Qrt 1	FFY '10-'11 Qrt 3	-	-	-	-	-	-	-	-	-	-
	Qrt 2	FFY '10-'11 Qrt 4	-	-	-	-	-	-	-	-	-	-
	Qrt 3	FFY '11-'12 Qrt 1	-	-	-	-	-	-	-	-	-	-
	Qrt 4	FFY '11-'12 Qrt 2	3,715	10,661	16,401	-	-	-	-	-	-	30,778
SFY '11-'12 Total			3,715	10,661	16,401	-	-	-	-	-	-	30,778
SFY '12-'13	Qrt 1	FFY '11-'12 Qrt 3	9,289	26,652	41,003	3,663	10,510	16,168	-	-	-	107,285
	Qrt 2	FFY '11-'12 Qrt 4	-	-	-	9,157	26,274	40,421	807	2,314	3,560	82,533
	Qrt 3	FFY '12-'13 Qrt 1	5,573	15,991	24,602	-	-	-	2,016	5,785	8,901	62,869
	Qrt 4	FFY '12-'13 Qrt 2	3,715	10,661	16,401	5,494	15,764	24,253	-	-	-	76,289
SFY '12-'13 Total			18,577	53,305	82,007	18,313	52,548	80,842	2,823	8,100	12,461	328,976
SFY '13-'14	Qrt 1	FFY '12-'13 Qrt 3	1,858	5,330	8,201	3,663	10,510	16,168	1,210	3,471	5,340	55,751
	Qrt 2	FFY '12-'13 Qrt 4	-	-	-	1,831	5,255	8,084	807	2,314	3,560	21,851
	Qrt 3	FFY '13-'14 Qrt 1	1,858	5,330	8,201	-	-	-	403	1,157	1,780	18,729
	Qrt 4	FFY '13-'14 Qrt 2	1,858	5,330	8,201	1,831	5,255	8,084	-	-	-	30,559
SFY '13-'14 Total			5,573	15,991	24,602	7,325	21,019	32,337	2,420	6,943	10,681	126,891
SFY '14-'15	Qrt 1	FFY '13-'14 Qrt 3	-	-	-	1,831	5,255	8,084	403	1,157	1,780	18,511
	Qrt 2	FFY '13-'14 Qrt 4	-	-	-	-	-	-	403	1,157	1,780	3,340
	Qrt 3	FFY '14-'15 Qrt 1	-	-	-	-	-	-	-	-	-	-
	Qrt 4	FFY '14-'15 Qrt 2	-	-	-	-	-	-	-	-	-	-
SFY '14-'15 Total			-	-	-	1,831	5,255	8,084	807	2,314	3,560	21,851
Total			27,866	79,957	123,010	27,470	78,822	121,263	6,049	17,356	26,702	508,496

* Low Cost Members are not slated for health home enrollment under the current plan but this could change as the project progresses and as high and mid cost members are assigned in a given region.

Wave One HH Member Assignment Algorithm

Eligible health home members will be assigned directly to approved HH networks by the State and will be assigned through health plans for members enrolled in Medicaid Managed Care. Initial assignment to State approved Health Home providers will be based on:

1. Higher Predictive Risk for Negative Event (Inpatient, Nursing Home, Death)
2. Lower or no Ambulatory Care Connectivity
3. Provider Loyalty (Ambulatory, Case Management, ED and Inpatient)
4. Geographic Factors

Some of the Next Steps

- Finalize governance structure
- Identify
  - Lead person for HHC Health Home
    - Clinical policy & Training leads
    - Operations lead
  - Facility HH Coordinator
- Finalize IT requirements
  - RFP for Care Plan
  - Registry
  - Alerts
- Budget
  - model

Some Strategic Implications

- HH is an important opportunity to reinforce the importance of the role of our ambulatory services in delivering the triple aim
- HH program must be integrated with our work on PCMH for primary care
- Thus HH will perform some important ‘integrating’ for our IDS which underpins our future ACO direction

Major Related HHC Activities