NEW YORK STATE DEPARTMENT OF HEALTH

PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

DATE: August 4, 2011

CHAIRMAN: DR. WILLIAM STRECK
10:00

(The meeting commenced at a.m.)

DR. STRECK: Good morning, everyone. If you could take your seats, we're about ready to begin the meeting. Thank you. Let's see. Okay. It's ten a.m. and we're trying to establish precedence for our new Public Health and Planning Council to begin promptly and operate efficient meetings. So I'm Dr. Streck, the chair of the Public Health and Planning Council. I call the meeting to order, and I remind council members, staff, and audience that the meeting is subject to the opening and is broadcast over the internet. The are accessed at the Department of Health's The on-demand webcasts will be available no later than seven days after the meeting for a thirty days, and then a copy will be retained in the Department for four months. There are certain ground rules to -- and suggestions to make the meeting successful. We have synchronized captioning, so it is important for people not to talk over one.
August 4, 2011 - Albany, NY - Public Health

another. The first time you speak, please
state your name and briefly identify yourself as a
council member or Department of Health staff.

This company
will be of assistance to the broadcasting
to record the meeting. Please note that the
microphones are hot, meaning they pick up
sound. Therefore, it's best to avoid

papers next to the microphone and to be

sidebar conversations.

As a reminder to our

there's a form that needs to be filled out
you enter the meeting room. It's required

by the

New York State Commission on Public

Integrity in

accordance with Executive Law Section 166.

It's a pleasure today to welcome back Dr.

Theodore Strange as a member of the council, one of

the few escapees to return in recent history to the

former work. But Dr. Strange, who was a

returns as member of the Public Health Council, now

Health a new appointee to the Public Health and

Planning Council. Those of us who were able

to work with Ted in the past realize we are

greatly by his reemergence as a member of

group. So welcome back, Ted.
August 4, 2011 - Albany, NY - Public Health

DR. STRANGE: And just a question, Dr. Streck. Do I have to return plaque back?

DR. STRECK: There will be another one at the end of this term of service. I'd like to provide a brief overview of the activities for today. We'll begin with Department of Health reports. Commissioner Shah will provide his report. Mr. -- is Mr. Helgerson here.

MR. HELGERSON: Yes, sir.

DR. STRECK: Oh, Jason, I didn't see you. Good. He will give a report on the Office of Health insurance program. Ms. Block will provide an update on the Office of transformation. Dr. Birkhead will give a report on the activities of the Office of Public Health.

Mr. Cook will give an update on the Office of Health systems management, and we can probably all adjourn because that pretty comprehensive review of our activities. Under the category of health policy, Ms. Lipson and finance Mr. Abel will give a report on healthcare and restructuring initiatives, including the
August 4, 2011 - Albany, NY - Public Health

multi-state obligated groups and provider integration/collaboration legislation.

Following Ms. Lipson and Abel's report, under health planning, Dr. will give a report on the initiatives of the planning committee, and on a request for a center designation.

Subsequently, under public services, Dr. Boufford will give a report on initiatives of the Committee on Public Health. And under the category of regulation, Dr. will present regulations for adoption and discussion.

Project review

recommendations by Mr. that has addressed this. This will occur after a break. We will not serve lunch, but we will adjourn the meeting at noon and reconvene at thirty. At that time, the committee on establishment and project review will begin deliberations.

Members of the council and of our guests who regularly attend are now
August 4, 2011 - Albany, NY - Public Health

with the reorganization of -- of the agenda
topics or categories which capture the roles
responsibilities of council. Included in
format is the batching of certificate of
applications so that those applications that
consensus behind them are moved
without any extended discussion. And the
of this is to allow time for adequate
of -- of those applications, either C.O.N.
establishment, where more extended
necessary and appropriate.

I'll pause for a moment to
make
recusals
And with
Health
Good
busy
give you
the
Cuomo
And

DR. SHAH: Thank you, Bill.
morning. I know the council has another
agenda, so I'll just take a few minutes to
a brief update on some of the activities of
the
Department of Health.

On June 24th, Governor
signed the Marriage Equality Act into law.
following the passage of this historic law,
August 4, 2011 - Albany, NY - Public Health

Department of Health actually updated and printed the new state marriage license forms, over a hundred and fifty thousand of them to county clerks before the law became effective. It was a very exciting time.

The Department also conducted a series of webinars to provide information to nine hundred local clerks with information about their new responsibilities. I'm pleased to report that this transition went very well, and of the new law was seamless.

Governor Cuomo's Medicaid redesign team continues as budget implement reforms included in the state passed in April. The reforms are aimed at Medicaid costs while improving quality and for most -- for the most vulnerable New Yorkers.

We now have ten work groups focusing on a variety of issues. We're in the process of seventy-three proposals with more to come. As we work to lower the rate of spending growth while improving quality, some providers face significant challenges. We will work with those
August 4, 2011 - Albany, NY - Public Health

during this transition phase to ensure that
the public has continued access to the need.

Jason Helgerson will be giving you more specifics on several of the working groups, but I wanted to highlight the work of one we are Berger, who you all know from his work on hospital evaluations, to chair a workgroup that will assess the strengths and weaknesses of the Brooklyn Healthcare System and its future viability. The group, which includes highly qualified and experienced members, will solicit input and conduct site visits to develop recommendations to ensure a sustainable healthcare system for Brooklyn's two and half million residents.

Last week, the group hosted its first public meeting at New York City College of Technology in Brooklyn. Hundreds of individuals provided input, and we are continuing to collect information from the public. Another hearing is scheduled for this September. The group
August 4, 2011 - Albany, NY - Public Health

develop its recommendations and present them
to the department by November 1st.

On the federal healthcare
front, New York has begun the process of
reform developing
and operating a health insurance exchange as
exchange required by the Affordable Care Act. The
businesses to will be a centralized, consumer friendly
goal is marketplace for individuals and small
system purchase affordable health insurance. The
to reduce the ranks of uninsured with a
designed to meet our state's needs.

I serve on the governor's
task force to develop a framework for health
insurance exchange in New York. Based on the
recommendations of the task force, Governor Cuomo introduced
a health program bill to establish a health -- a
approved insurance exchange, and the state assembly
year's the legislation prior to the end of this
did not legislative session. Although the Senate
did not take up the bill, they have indicated they
may take up the issue later this year. I'll keep you
updated on the status of that important
measure.

At the core of all our efforts is the need
for solid and comprehensive data. Advancing
transformation in an effective and
manner requires that broader view of
health and the performance of the system as
that -- more than any current data resources
currently provide. Our data resources
reflect the same fragmentation of health and
healthcare that we are trying to eradicate.
We
cannot solve new problems using those same
tools.

The department is now
leading an
ambitious effort to establish an all-payer
database, starting with claims data and
possible enhancements to link with SPARCS,
health, and other databases. We are
working with a variety of stakeholders to
a short and long-term plan which Rachel
describe in a bit, in more detail.

I want to briefly review
some of
the other health and public health
initiatives
we're working on. We're working on a --
the number of New Yorkers enrolled in the
organ and tissue donor registry. Last week,
Kelly (phonetic spelling) and I were joined
by
federal, state, and local officials, and
August 4, 2011 - Albany, NY - Public Health

recipients at a media event in New York City announce a new partnership to encourage
give the gift of life by signing up to be an

donor.

New Yorkers represent

approximately ten percent of the entire

waiting list for organ donors -- for organs.

Each year, twelve hundred New Yorkers receive an

transport. However, an additional nine

state residents remain on waiting lists, and

unfortunately many die while waiting. Also

alarming is that minority and ethnic groups

fifty percent of the national waiting list.

This week, we conducted a

webinar

organizations

for community-based and faith-based

to reach out to diverse racial and ethnic

minorities for National Minority Organ Donor

Awareness Day on August 1st. New York is

committed efforts,

enrollment signature. We

improvement which

will save lives.
New York continues to
address the
largest cause of preventable death in our
state: smoking. On August 1st, the department
launched a
new statewide campaign to raise awareness
tremendous personal toll smoking is taking
on New Yorkers. The campaign includes television
ads, which you may have seen, and radio spots
featuring real people talking about how their lives
have been adversely affected by severe health problems
caused by years of smoking. New York's tobacco
control program has achieved significant success in
reducing the rate of adult and teen smokers
below national averages. We anticipate that
new ads will convince smokers to call the
department's smokers quit line and kick the
habit for life.

As a final note on public
health, the national Public Health Accreditation
Board will begin voluntary accreditation of state and
local public health agencies this year. The board
has established standards for public health
services, and the -- and the accreditation process
will document accountability with those standards
to policymakers and the public, thereby
quality and performance of public health
deptments throughout this country. Dr.
Birkhead will provide more information on
application process in his remarks today.
As I noted in our last council meeting, I
believe it is important for the department to take a
proactive and interactive role to highlight
important health issues across New York
a little over six months since I was
confirmed as commissioner, I've had the opportunity to
speak to numerous advocates, health industry leaders,
healthcare providers, and community partners
in a variety of settings. My travels have taken
me from New York City and Long Island to Lake Placid,
and stop, my national
transformation
must
build
protect
healthcare. I know we all share this goal. Your work
today
ready to
meet the challenges of the twenty-first
August 4, 2011 - Albany, NY - Public Health

Thank you. This concludes my report.

DR. STRECK: Thank you,

for the

Commissioner. Are there questions/comments

thank the

Commissioner? All right. Then we will

and the

Commissioner and move on to Mr. Helgerson

program

report of the Office of Health insurance

activities. Jason?

Well,

good morning, and it's a pleasure to be here.

It's

my first visit to PHHPC, and I'm glad to

give -- be
given the opportunity to give you an update

in

terms of where we're at with regards to the

A lot has happened in the

last

Medicaid redesign team and its process.

won't

seven months. This is our July update. I

it's

spend too much of your time going through it;

could

available on the website. But I thought I

update

use today as an opportunity to give you some

discuss a

on some of the key initiatives and also

phase two

little bit where we're at with regards to

which will

of the Medicaid redesign team's efforts,

take us to the end of this calendar year.

the

vision that the governor laid out, and --
think the governor, in -- in -- both in
his public addresses, whether it was a state
state address or the budget address, really,
think, clearly articulated the need for
reform in the state's Medicaid program. New
has the largest Medicaid program in the
and when you look at our spending on a per
basis, we spend roughly twice as much as the
national average in terms of Medicaid
And so seeing that and seeing the growing
the -- and the trends in costs, the -- the
felt strongly that substantive reform is
But I think the big difference between
efforts of the past and Governor Cuomo's
has really been to try to engage the
community in New York much more aggressively
collaboratively than perhaps has been done
past. And that really is what led to the
redesign team. And so far, I would say that
collaboration has been a success.

In terms of the M.R.T., we
created back in January through an executive
and was given really two tasks. Or as
Dr. Streck, and the Commissioner, and both
August 4, 2011 - Albany, NY - Public Health

of the Medicaid redesign team know, that at
that first meeting when we went around and gave
these new members an opportunity to speak, folks
like to think of the M.R.T. as sort of two teams.
Team number one was given the unenviable task of
trying to find roughly two point three billion
dollars in savings for this fiscal year, and basically
it's come up with that plan in roughly two months.
A huge task, and at the same time, also asked
to travel the state to try to identify strategies
and -- and tap into the knowledge and expertise of
all the residents of New York.

Team two was given the task of really looking at some more substantive
longer-term reform efforts. And interestingly, or
probably not surprisingly, when folks were given an
opportunity to speak at that first meeting, they
expressed a higher degree of interest in team two than
they did in team one. But I can say that despite the
challenge, the team really embraced this
effort, and the efforts of the group were
substantial. There are twenty-seven members to the M.R.T.,
and we're actually in the final stages, and an
announcement probably later today of some
additional members, some replacements of members. But the idea with the M.R.T. was really to bring together a diverse set of stakeholders, including obviously representatives from the healthcare industry, but also consumer representation, representatives from business. Also members of the legislature. The idea was whatever recommendations ended up coming out M.R.T. would have to be approved by the legislature, and so we had the chairs and members of the health committees in both legislature who were very active. So phase one, which, as I said, began in led to seventy-nine distinct proposals that recommended by the M.R.T. Those were the governor on February 24th. He accepted is and then proceeded to move those forward thirty day budget amendment that was the legislature. That bill went through budget process. And out on the other end, seventy-three of the seventy-eight proposals emerged, which I think that few would have predicted possible. But we're very excited about the fact that the -- the vast majority of
August 4, 2011 - Albany, NY - Public Health

Implementation of the M.R.T. is now moving into phase.

Phase two, which, as I mentioned, was more focused on comprehensive reform. We are now divided up into, as Commissioner Shah mentioned, ten workgroups. The final three are going to be launched early next week. The rest are now already beginning to engage, and -- and members are invited. In fact, the first wave of those teams have had several meetings. The topics they address are a wide array, from implementing managed long-term care, to how encourage the development of more supportive housing, to medical malpractice reform, to reform. A wide array of issues are being addressed.

What I think is also exciting, and one of the sort of critiques of the M.R.T. was there couldn't be workgroups are seventeen twenty
workgroups, so we definitely think that the
workgroups have given us a great opportunity
to expand the scope and net of participation by
the stakeholder community.

The recommendations of
these workgroups will be delivered in whole to the
governor by December of 2011 for his
consideration in the -- in the next budget.

So I'll skip ahead to the
major reform elements of phase one. Arguably, the
most significant reform element in phase one
the implementation of a new global Medicaid
It applies to the Department of Health
the Medicaid spend, which is the vast
It's a two year, state share actual dollar
it's actually a dollar amount of state share
we can spend this year as well as next
And then after that, the cap grows. And
the cap's life is four years, and it will
ten year rolling average of the medical
C.P.I., which has been roughly around four
And so this, in our view, is a significant
and it's one of the few such programs -- in
think it is nationally a unique effort to
August 4, 2011 - Albany, NY - Public Health

discipline into try to introduce a unique level of
the management of the Medicaid program. In

particularly, the Commissioner of Health

what the governor likes to call superpowers

establish mechanisms for controlling

and ensuring that the program stays within

budgetary caps. So it is a -- it is a cap

spending, but it also gives the -- the state
tools to rein in spending. Those measures
tools could be changes in provider rates or introductions

of new utilization controls. And so we've been

monitoring expenditures very closely, and I'll talk a

little

management

changes in provider rates or introductions

for a

utilization controls. And so we've been

monitoring expenditures very closely, and I'll talk a

little

Next is moving to care

for all. We've begun a process. We've had

most people call managed care in Medicaid

couple of decades, but a major segment,

particularly some of our highest cost

have really been left out in traditional fee

service Medicaid where they have to navigate

between a disparate set of really

unconnected providers with little support from the state

or

anyone else in terms of making sure they're

accessing the services they need.
August 4, 2011 - Albany, NY - Public Health

The M.R.T. set the state on a three year progression towards getting the state out of the fee for service business. And what that will mean is that the state will contract with a variety of different entities to provide management services. I want to emphasize, this is not your traditional insurance company care managed care model. We will have some insurance companies participating, as we do today, but we also look to other unique groupings of providers who come together to form care management organizations.

We also know that, as we move, it's brain populations for some of the special populations, whether injury waiver populations or people who are currently in self-directed waiver long-term care services, that we need to look at the benefit package and the care management strategies, the contracts, and make sure contracts and -- and strategies reflect the needs of these special populations.

Also contained in the M.R.T. is a significant expansion on the state's efforts in patients that are in medical homes and the launching of a
August 4, 2011 - Albany, NY - Public Health

A concept called "health homes." Almost a million New York Medicaid residents already benefit from having access to primary care through patient-centered medical homes as recognized by N.C.Q.A. We want to expend that number even further, potentially by another million. In addition, there's a new concept called "health homes," which is an even more comprehensive effort around effectively coordinating care between providers that includes social supports, behavioral services, encouraging silos to state management to effectively anticipate hundred time, as New York homes. And really, we're hopeful that this will
really are driving most of the costs in the Medicaid program. So just to -- and this just to give you a sense that not everything has been completely resolved. A lot of these strategies that have been launched, either in the past or more recently, we are working with stakeholders through the M.R.T. to come up with ways to ensure that these coordination strategies are, basically, integrated into a comprehensive plan that will ensure that our members are getting the services, but we do have unnecessary overlap and confusion. As you can see, there's a number of initiatives, and what I haven't even word behavioral health organizations, which is another effort. A lot of these are all sort of different strategies and different ways for sure we're managing care. And so what we're trying to do is come up with a strategy like this where we actually attempt to make sure that we have a coherent strategy.

This is still a draft. It will continue to evolve. I think it's important to say that our vision is that within say three to
August 4, 2011 - Albany, NY - Public Health

...years, all Medicaid recipients will be enrolled in some kind of care management organization that has basically a fully integrated capacity to manage the overall health and long-term care as well as behavior health needs of that population. That we will have a series of providers who either have patient-centered medical homes, be part of home networks, could be potentially delivery systems, accountable care that will work within that managed care environment providing the comprehensive management that the population needs.

Our belief is that this is where cost containment in Medicaid should be focused as opposed to ever lower rates to providers.

And then, finally, in terms of reform. This is something that came up through the process, probably one of the more controversial elements of the M.R.T. in terms of its discussions. But there's a strong belief that particularly in New York City that our costs for medical have grown substantially. The net result of
August 4, 2011 - Albany, NY - Public Health

The efforts was the creation of a very unique healthcare insurance which impacted we've actually already seen medical malpractice costs go down by as much as twenty percent, translates into three hundred and twenty dollars of costs actually taken out of the healthcare system, and that's even before medical indemnity fund has actually even been put up and running, which we anticipate on October 1st. So I will skip ahead to -- the bottom line phase one is two point three billion dollars savings for the next fiscal year. A lot of needs to be done to achieve that, distinct projects. And many people in the room have been very involved in this in terms of trying to get all those projects implemented in a timely fashion. It's really keeping us all extremely busy this summer.

Also, a number of these reforms actually will save more money next year and year before. Anticipated savings gross of point three billion. And the big part of
August 4, 2011 - Albany, NY - Public Health

was not just to look for immediate cost
but also plant some seeds of meaningful
would help bend the cost curve in the long
Also, obviously, capping the growth rate in
Medicaid spending, a very important
It's really changed fundamentally how we
the budget. It's forced us to learn a lot
we've been publishing. If you go to our
every month, we publish a new report in
tracking our expenditures.

But I think the key thing
that a lot of this work really has begun.
just the beginning, and there's a lot of
for the M.R.T. itself and then also for the
staff who are responsible for implementation.
So just a quick update in terms of phase two.
think I mentioned, we do have ten workgroups
are -- most of them -- seven of them have
been established. The final three, we're
early next week. Those groups are going to
meeting throughout the fall. As I said,
unique opportunity for us to engage even
stakeholders. These are the groups, and as
see, a wide array of topics covered. Dr.
instance, is going to be leading the basic
review, which is really an effort by us to
comprehensively look at the Medicaid benefit,
which hasn't been looked at in many, many years to
whether or not we're encouraging the most
cost
effective healthcare by the things that we
covered,
the cost sharing policies we have in place.
Also mentioned, payment reform, which Dr.
Streck,
along with Dan Sisto, will be leading. I
think
encourage
opportunity to explore how the state can
more fundamental changes in -- in the way we
pay
for healthcare. As we said before, even if
we move
everybody in the Medicaid program to care
management strategies, if all that happens
is those
same managed care organizations just use fee
for
service as their methodology, have we really
incentives
fundamentally changed the nature of the
- is --
in the program? The answer I would say is -
is no, and that more is needed and a lot of
important work there.

So in terms of just
timeline, as
I said, we're -- we've got -- all these
groups are
up and running. It's a lot of -- lot of
activity,

lots of meetings. But we're really hopeful
beginning in October, the first sets of recommendations from the first wave of waves of full of the public to websites.

Member was there's and workgroups.

look product of product of comprehensive really lead three to to

So just, finally, in terms public, we've definitely encouraged the be involved. We continue to use the Facebook, Twitter are great ways to follow online. We also have the e-mail listserv. Workgroups are holding all their meetings in public, so there's ample opportunities. workers are also holding public hearings, as mentioned for the Brooklyn. So I think definitely more opportunities, even above beyond the people who are on those

So what does this final product of M.R.T. like? Our goal is to actually take the the workgroups, combine that with the phase one, and really put that into a reform strategy for New York that will us from a policy standpoint for the next five years. That's really what we're trying accomplish.
This final play may require that the state pursue a comprehensive 1115 Waiver to implement some of those changes. In particular, with the federal government as it relates to dual eligibles, who are driving both Medicaid costs and Medicare costs, and who historically have well served by the disconnect between those programs. And to get some of what we need better coordination for that population, a will probably be likely. But we're very excited. We think we've made a lot of progress to that we still have work to do.

And then, finally, it's always something that comes up with any meeting with global spending cap. We have spending basically May, so the -- for the first two months of the fiscal year. As you can see, we have a overall of where spending is exceeding thirty-one million. That's still about only percent of total. We're currently in the process of finalizing the analysis for June, which will give us the quarter of the fiscal year's
August 4, 2011 - Albany, NY - Public Health

That report will come out soon, either late week or early next. But generally speaking, we feel like we're staying within striking distance of the target, but that we need to continue to this very, very closely.

So with that, I can answer your questions.

DR. STRECK: Thank you,

Questions for Mr. Helgerson? Mr. Robinson?

MR. ROBINSON: Thanks.

That was a great report. One of the things that you're working on is obviously coordination of care. One thing that doesn't seem to be up there -- it beyond the scope of M.R.T. -- is structural reorganization within the state. I'm specifically about the Office of Mental Health and the O.M.R.D.D., and maybe Commissioner Shah is right person to answer that. But it strikes me that if you want to do the right kind of coordination and eliminate silos, one thing on the table for consideration, whether the is the forum or not, is a look at how we're structuring government oversight of -- of healthcare delivery system in totality.
August 4, 2011 - Albany, NY - Public Health

DR. SHAH: Sure. So I can
that. So Paul Francis has reconstituted
at the state level, we're looking across all
agencies to figure out how to move that
forward over the next few months. So you
we -- several steps forward, we took a pause,
and -- and we had our first meeting just a
ago. And we're -- we're beginning that work
exactly along those lines to look at those
efficiencies across all state government.
specifically in health is where I'm involved.

DR. STRECK: Mr. Fassler?

MR. FASSLER: At a prior

meeting, the Commissioner presented a vision of
hospitals basically

With accomplished?
in terms

the

more

MR. HELGERSON: You mean

of like fundamentally restructuring the --
nature of hospitals and how they -- and the
services that they perform?

MR. FASSLER: So that a

sick -- more acute patient goes to a nursing
August 4, 2011 - Albany, NY - Public Health

sooner. The -- and again, this is one of
the things the Commissioner identified as part
of the model that he hopes to happen.

MR. HELGERSON:  Sure. And
Commissioner, you want to --?

DR. SHAH:  Yeah. I mean,
I -- I think the -- the -- the -- the vision I was
painting is that people get the level of
the least intensive setting possible for
their needs. So it -- it's not about pushing
out of the hospital. It's about getting the
appropriate care, whether you're in the
hospital or in the nursing home or in primary care, both
upstream and downstream. And -- and -- and
that's the vision of the future. Not only my
think it's the federal vision of -- in terms
do realign the healthcare system to meet
needs.

M.R.T. is working very
strongly in many of its efforts. You talked -- we
talked a little bit about medical homes and
strengthening the primary care upstream capacity. Maybe
more patients with better coordinated care will
stay there as opposed to going to emergency rooms,
August 4, 2011 - Albany, NY - Public Health

may be too high a level of care for many of patients. And downstream as well, with the subcommittee entirely looking at long-term So M.R.T. is front and center in all of efforts to redesign the healthcare system.

MR. HELGERSON: Right. I say -- I want -- just adding to that is that care management for all strategy, I think more integrated that care management is and creating financial incentives within a or near capitation environment to -- not get people to most appropriate environment and -- and basically hopefully relying less institutions and more upstream provision of services, but also, for instance, moving home residents into care management

We're convinced that there are thousands of people in nursing homes today that frankly prefer not to be there, their families would not to be there, that there are historically the state, because of lack of resources, hasn't really had the -- the -- boots on the ground, so to speak, to really effectively help those families move to
August 4, 2011 - Albany, NY - Public Health

and -- and -- and more appropriate settings. so I think that care management

And organizations will be far more effective at -- at doing that.

And I think those are the -- once you put those

all within capitation, you create the right financial incentives for that kind of

and work.

DR. STRECK: Dr. Gutierrez?

DR. GUTIERREZ: In your

slide number twenty-seven, "How the public can get involved," I notice that everything is web

related. I don't think the Medicaid recipients able to avail themselves to that. I think

some other way of -- should be created to facilitate the clientele to reach these

MR. HELGERSON: Understood.

And then I think that's what -- one -- one of the things we're trying to do with regards to workgroups are that the workgroup meetings public, and they are being held across the various locations. So in the case of the -- obviously, the people of Brooklyn have a degree of interest in what recommendations about changes to or improvement in the
August 4, 2011 - Albany, NY - Public Health

delivery system in Brooklyn. And that's why
it's very important that a public hearing was
held in Brooklyn at -- at a place that was, in our
view, fairly accessible. But we'll continue to
hold those public hearings and -- and try to make
it as -- as available to the -- to the public
we possibly can.

DR. STRECK: Dr. Rugge?

DR. RUGGE: Thanks for the
presentation. Could you comment on -- for
regard to health homes, the enrollment
also payment methodology and payment levels
are to be anticipated?

MR. HELGERSON: Sure. In
of health homes, we are working on a very
track. The application for health homes is
actually now available on the website, and
know there's a lot of activity and interest
this.

The -- in terms of
process, we are identifying populations that
the current federal requirements in terms of
eligibility. So it's people with multiple
conditions or who have a diagnosis of AIDS
August 4, 2011 - Albany, NY - Public Health

H.I.V. who will be eligible for health home enrollment. We're going to be sort of enrollment in over time, but the idea is hoping that we will have health homes
We'll have -- applications are actually due I believe, September 1st, and we're going to enrolling the first individuals into health on October 1st.

But I think what's point out is that what does enrollment mean? means that health homes will be assigned and given information about those members, health homes themselves will be responsible actually reaching out to that -- those actually getting them to document that willing to participate in health home. And basically, health homes will have three accomplish that. So that's one of the we're encouraging health homes to tap into community based organizations, because those community based organizations will often be effective partners in identifying some of people, particularly those who are the ones really need to get our arms around the most,
August 4, 2011 - Albany, NY - Public Health

are the folks who are intermittent users of healthcare, folks who bounce in and out of emergency rooms with significant behavioral needs. So it's -- there's a lot of work on it.

DR. RUGGE: And the money?

MR. HELGERSON: Oh, yes, the
the -- actual
a
there.
month
existing
other
on the
patient with
need,
higher level

money. Everyone asks about the money. So we'll be posting very shortly what the P.M.P.M. amounts will be. It's just there's little bit of tweaking, I think, being done. But the idea is that it's a per member per management fee. We're benchmarking it to care management programs and looking at some states. But that amount will vary depending on the level of acuity of the patient. So a higher levels of acuity, higher levels of need, higher level

DR. RUGGE: Just to say it, it's -- it's difficult to plan a program
knows, number one, how many enrollees and level of acuity they have, and then in --
August 4, 2011 - Albany, NY - Public Health

turn, what resources are available to care population. So I gather the initial just indicate there would be some capacity ability to reach out without any specifics regard to what's to be done on the ground?

MR. HELGERSON: That's correct. So in -- in the early phases of this, there's sort of two things going on. One is enrolling people who are currently sort of out there in the service world or out there in sort of care who have high acuity and we want to care, really, some -- some of those cases first time. We're also proposing to convert care, really, some of those cases who are in existing care management programs, including targeted case management, over to becoming health homes. Those are people who know of who are connected to a provider of management services. There's a little bit of both going on.

But yes, I mean, I -- one of the challenges we have is that these are people who haven't had a lot of connection. We'll -- be providing health homes with information them to the extent we have it. But I think
August 4, 2011 - Albany, NY - Public Health

the challenges that the health homes are
have -- and then also, I should -- should
from the payment side that there's also gain
sharing on the back end with health homes,
to fifteen percent of the savings, state
that's generated from better care management
go back to the health home. So our hope is
the health homes will effectively identify
people, reach out to them, sign them up, get
into better care coordination, and then as a
result, both the state and the health home
savings from it.

DR. STRECK: Dr. Bhat,
then Ms. Hines.

DR. BHAT: Thank you. You
mentioned about the dually eligible,
Medicare/Medicaid. I think the proposal is
away the twenty percent that's going to pay
coopayment. An analysis in this fee is one
sixty to seventy percent of the patients are
eligible. Taking off the twenty percent off
table, the whole industry is going to have
consequences because they cannot just
The industry as a whole has approached the
people and won't be looking at it because probably one of the quirks of just across making a move to just take the twenty the table. That's something that already addressed, and I'm pretty sure that Health will probably come up with some kind solution for that.

And the question that I Dr. Shah is saying that there's increasing that -- especially in the downstate area practicing, a lot -- lot of people do not where -- I think their knowledge about is very little, that literally health probably about eighty percent in Brooklyn of Queens. In all the reforms that we are here, is anybody looking at the health well -- addressing that issue?

DR. SHAH: Yes. Actually, have a working group as part of M.R.T. disparities. And as part of the disparities working group, that's a forum where issues health literacy can be addressed and policies, certainly -- not only health, but language, there are many other barriers that
August 4, 2011 - Albany, NY - Public Health

these disparities. That's the forum where
potential reform ideas can be introduced.

So we
have a specific committee that will look at
And Dr. Birkhead, who will speak a little
later, is
supporting that committee.

DR. STRECK: Ms. Hines?

MS. HINES: Good morning.

So
clearly, change is happening at an
impressively
rapid pace, and it will have both intended
and
unintended consequences. And since it's
driven
largely by financial targets, I wonder is
there a
framework or a process around which we will
assess
the impact on access and quality?

MR. HELGERSON: Very good

question. So one of the things that the
payment
reform committee, not that it doesn't have a
broad
enough scope as it is, is also going to be
looking
at -- we -- we, as a state, have used a
variety of
measures to measure the overall
effectiveness of
the Medicaid program. To be honest, those
care
have really been focused primarily on those
populations currently enrolled in managed
where we have a paper form and strategy and
measures that are published on an annual
long-term care effective
And so at comprehensive entire in the services measures relevant track mid-term, then mentioned, type of those very at a we

But whole swaths of our population, for instance, we have not had a very assessment mechanism of quality and access. what we're going to be also doing is looking making sure we come together with a set of measures that really look across the roughly five million people who are enrolled Medicaid program and the full scope of that are provided. And then within those that we identify as the ones that are most and important, the ones we really need to against, is really just that short-term, and long-term goals for those measures. And track that very closely because, as you there are unintended consequences to any reform. And you have to be watching for closely, especially when you're proceeding pace that we are in terms of how -- how much have to save in such a short time.

So our hope is that by identifying those key measures, setting goals, and then monitoring that and being transparent about the monitoring of that, collectively, not just the state health
August 4, 2011 - Albany, NY - Public Health

but the entire stakeholder community who
care about
these individuals as well as the services,
that we
collectively can see how we're doing, and
then, if
necessary, change path, make modifications
to
proposals, do different things to help us
minimize
and mitigate those impacts.

The last thing I'd say
about that
is that one of the things we tried very hard
to do
throughout the implementation phase of the
Medicaid
redesign team has been to try to work with
particularly effective providers as closely
as
possible to -- we've given ourselves
flexibility in
terms of implementation to try to minimize
some of
those unintended consequences. And we've
tried
very hard to listen, and I -- I'll give you
-- a
more perfect example of this would be the
nursing
home industry in the state, which
traditionally has
not had the most positive of relationships
with
the -- with the department. I -- I think
somebody
told me that in the last ten years, the
state has
been sued a hundred times by the nursing --
what
elements of the nursing home industry. But
really
we've tried to do with -- with them is to
engage them. And I -- I give them a
August 4, 2011 - Albany, NY - Public Health

untold
M.R.T. was
was a --
methodology for
been
And the
problem
which was
of
retroactively,
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didn't
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of a
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at
in a
way
disparate, and

amount of credit.

I think one of the sort of
success stories of the -- of -- of the
that -- what was called a rebasing, which
basically adoption of a -- of a new
payments to nursing homes, which had sort of
left unimplemented for a couple of years.
home administration sort of inherited this
and was sort of given a Hobson's choice
if we implement, we redistributed hundreds
millions of dollars between homes,
that we were told basically would put about
hundred homes at risk of closure. If we
implement, we have homes out there who had
financial decisions based on the assumption
new rate -- those are the -- these are
under the implementation -- who now would be
financial distress because they'd made those
financial decisions. So basically, we were
situation where we thought we'd lose either
with the implementation.

We took -- we went to the
industry, which you know is somewhat
basically the industry itself came up with a
August 4, 2011 - Albany, NY - Public Health

implement rebasing that minimized the
impacts to a great extent and ensured that
vulnerable homes saw no reductions. And so
we really feel that that level of unanimity
was reached by them is a good example of
trying to do, which is -- we understand that
exercise is trying to take about -- gross
dollars -- four billion dollars out of the
healthcare sector in New York, and we're
do it as -- you know, as smartly as we can,
think that's been one of the challenges.
think that as I had said, there's example in
nursing home, there's other examples out
that, I think if you engage stakeholders in
meaningful ways and are willing to listen, I
you can -- you can do these things in -- in
destructive fashion.

DR. STRECK: I think we'll
allow
hands
you
have
about
two more questions, and I -- these two
over here were up first. I think, Dr. Grant,
were prior to Ms. Hautenburg, and then we'll
her.

MS. HAUTENBURG: This is
the basic benefit package with D.H.H.S.
August 4, 2011 - Albany, NY - Public Health

accepted the I.O.M. recommendations for care for women. Will New York State be willing to go above and beyond with their own money to expand that list? And I'm particularly interested in the issue of abortion, which has always been covered by the Medicaid program in New York State with state-only dollars.

MR. HELGERSON: That's -- correct. It is covered. I think the state will have to have a -- I think once the benefit package is completely finalized and we get the complete guidance, an analysis is going to have to be made that looks at all of the mandated levels of benefits that exist in New York. Chances are that, in aggregate, our mandates will be greater than the basic benefit package.

For those of you who may not be familiar, that if -- if the benefit package is greater, and the state maintains those mandates, that individuals coming through the health insurance exchange with -- looking for tax credits, that the state on its own would have to, in essence, finance the difference between tax credits would -- would make up and what
August 4, 2011 - Albany, NY - Public Health

And -- very the questions Dr. issue of that is make client self-empowering to costs that is at so the me basically the targets of affordability are. well, I think that the state will have a interesting set of decisions to make, given potential financial implications of that.

DR. STRECK: Dr. Grant?

DR. GRANT: Two quick and comments for you, Mr. Helgerson, or you, Shah, Commissioner.

On the M.R.T., the whole prevention and wellness, I would hope that being underscored. That's a big effort with N.C.Q.A., C.M.S., et cetera, and we've got sure that we're looking at getting the educated about how to be -- be take care of this so that you can keep those down.

And secondly, I would hope the insurer would like to hear what the role with the department in getting the insurers the -- at the table right from the beginning that you can make sure that they're part of process for reducing costs, too.

DR. SHAH: Let me -- let answer the first part first. Certainly,
August 4, 2011 - Albany, NY - Public Health

wellness and benefit --
We can can look are get into the I'm around the allow us

to just here, vision for
At -- two there's four, this everything. going

many opportunities for insuring that prevention gets incorporated into the you know, a benefit redesign subcommittee.
look at the payment reform committee. We at the disparities committee. I think there multiple avenues where these important ideas incorporated from different perspectives future of Medicaid for New York State. So confident that we have the right folks table and the process is such that it will to -- to do this well.

And -- and I -- I'd like also suggest, maybe I'm going out on a limb you know, the governor set a real strong what he wanted for the Medicaid program, and Jason's been fantastic at implementing it. when we started, we didn't know what phase would look like. I would suggest that probably going to be a continual phase three, who knows, through this administration. And is not a one stop, one chance to fix

We will continue this process in some form forward.

DR. STRECK: Though I'm
August 4, 2011 - Albany, NY - Public Health

to give Mr. Fensterman the last word, he did
his hand, so -- but I have one more question

MR. FENSTERMAN: Thank you, Doctor. I appreciate that.

You opened the door, so I
have to ask the question on the issue of
homes and rebasing. I personally -- I -- my
firm represents approximately a hundred and
fifty nursing homes. I personally know many
homes who, as a result of the implementation
what was a very difficult decision, as you
described it, who are literally losing now
excess of a hundred thousand dollars per
month. Many of them say that they have been told
there is going to be regional pricing that
considered. And many say that the
they've heard -- I'm not sure how they have
ascertained this knowledge that that is
contemplated being implemented sometime in,
about October of this year. My concern, of
is besides the fact that there is a -- that
gargantuan sum of money for a nursing home
to lose, that also ultimately can impact
care in those facilities because it would
August 4, 2011 - Albany, NY - Public Health

very difficult to render the appropriate

care while concomitantly losing that amount

money. And it was done in one fell swoop.

And unfortunately, there are literally some

homes who were earning a good deal of money

now earning twice as much as they were

before as a result of the implementation of

And I understand, and I -- and I agree that

were faced with an extraordinarily difficult
decision, but there are inherent

inequities in what occurred. And the

effects that you alluded to are now -- are

actually in the process of occurring. Are

moving forward towards regional pricing in --
effort to remediate these inequalities?

MR. HELGERSON: The answer

that -- just so be clear, that rebasing, to

extent, as I said, was a policy that sort of

evolved over multiple years. It has a much

very complex history to it. And -- but the

and -- and we were able to, at least across

various associations, achieve some degree of

unanimity in terms of how to address what

mentioned was an extremely difficult
That said, clearly there are homes who are worse off by the implementation of the -- of the initiative.

So the -- the issue is now moving forward, what's going to be done? And what we've said is that the current system of paying nursing homes, which is based -- historically been cost-based, is not really a system that is sustainable or creates the right set of incentives, in our view, moving forward. The idea is -- and this is -- we've thrown back to the industry again to see if they could reach a consensus -- we'll see if they can consensus -- was to adopt a pricing system, that it would be less about cost and more specific factors that contribute to -- and had greater uniformity, I guess, in payments. What the current system has and has had for quite a while, is a -- sort of an interesting myriad of different rates that nursing homes were paid. Oftentimes, it was very hard to explain the differences between what one nursing home was getting paid and what another nursing home was getting paid.
Now in terms of the pricing system, we've really left that up to another regional you use a wide think the that you overnight. we are no implement these the think we've idea is strategy so going to going one, Now moving forward, I got a little bit more flexibility. And the actually to adopt a four year phase-in that homes will know what their rates are be at full phase in, but are not necessarily to be, you know, fully implemented on day which hopefully gives everyone a little bit
August 4, 2011 - Albany, NY - Public Health

time to adopt -- adapt to the -- the new
structure.

The other confounding
factor, as
for
for
which
paid
by
rather by
plans use
very
the
homes
a
exists,
what
managed care.
flexibility,
direct

I mentioned, we're moving to care management
all, and we're trying to get out of the fee
service business within the next three years,
means that nursing homes will no longer be
with -- at the end of that three year period,
the state Medicaid program directly, but
plans. And so the question will be, will
the state's same rate methodology? It could
well be. And I suspect it'll be initially
standard. But I do think particularly for
that are of vital importance who are serving
population in a community where a shortage
they will have some potential to negotiate
potentially rate add-ons, which is kind of
happens today in other sectors within
So I think there'll be some greater
especially when the state gets out of the
payment business.

DR. STRECK: Thank you, Mr.

Helgerson. And obviously Medicaid and the
redesign team and all the work that is
August 4, 2011 - Albany, NY - Public Health

its
here for
best we
participants

has a wide-ranging impact on this state and budget, so we will continue to allow time that discussion and monitor that process as can. And certainly there will be within this group over the course of those deliberations.

We're going to move now to the report of the Office of Health Information Technology, and Ms. Block's going to provide report.

MS. BLOCK: Thank you very much. But a brief actively database. were context of

Uncharacteristically, I do not have slides, that's because I'm going to be giving a very update on some of our key activities.
The Commissioner mentioned that we are pursuing the development of an all-payer This is pursuant to the authority that we given as part of the budget and in the M.R.T. to really enhance our data capability significantly so we can look not only at the Medicaid program, but really at the totality healthcare system in a -- in a much more comprehensive way. So we're very excited at the opportunity to be moving forward with this.
Briefly, in terms of process and timeline, we have convened a small stakeholder advisory council that is representative of a broad range of interests who have a database. We'll make to you can to try making to been individual to offer tap into. are already can in this the the make a will have need to be very much involved in and -- and stake in the development of the all-payer We've had two meetings of that group, and have another by the end of August. So as see, we're really pushing through the summer to come up with the preliminary framework of recommendations that we would like to be the Commissioner sometime in September. In addition to that stakeholder group, we've been actively reaching out to a number of organizations who have particular capacity or a particular expertise that we need to And we're also talking to organizations that also involved in other states who have established these all-payer databases so we gain from the learnings of their experience field.

So as I said, hopefully by end of September, we'll be in a position to make a formal proposal to the Commissioner that will have been pretty thoroughly vetted with a wide
August 4, 2011 - Albany, NY - Public Health

council of groups. And if there is anyone on the
who has specific subject matter expertise or
interest in this who would like to be
would like to talk to us about this, please
council staff know, and they can give you my
contact information.

With regard to the
Health Information Network of New York, many
are familiar with this. Really, the first
investment that we made in developing a
health information infrastructure was
HEAL Five program. And I'm very pleased to
announce that actually on July 31st, the
program was completed. And we have -- now
the process of finalizing/collecting all the
documentation from those projects as to the
successful implementation which we believe
achieved by all the projects in terms of
their project goals that they set out with
particular program.

So what this really

into in practical terms is we now have
availability of health information exchange
services that any provider who joins a RHIO
August 4, 2011 - Albany, NY - Public Health

really just able to access. And obviously, this is
in time if we look at whether it's M.R.T. or
federal health reform or any of the other
things that we need to support, having this health
information technology infrastructure
really going to provide the necessary tools
really help clinicians, consumers, and the
department figure out how we can further
the healthcare transformation that the
described.

In terms of next steps,
currently with the New York eHealth
and the stakeholders that they have pulled
to continue the implementation of the HEAL
Seventeen programs, which, as many of you
have focused on supporting patient centered
homes, connecting them to other providers in
communities who are involved in providing
patients with chronic diseases. In HEAL
we expanded that to include a focus on
patient centered medical homes and behavior
So again, the development of this
and the care coordination models that are
from these HEAL funded activities obviously

we're

Collaborative
together
Ten and
know,
medical
their
care for
Seventeen,
integrating
health.
infrastructure
resulting
August 4, 2011 - Albany, NY - Public Health

represent a good jumping off point in terms of health homes, patient-centered medical homes, and eventually A.C.O.'s as we move forward with initiatives as well.

We're actively outreaching to the RHIOs right now to ensure that they're fully aware of the health home requirements and to try to tie them into potential health home applicants in their communities so that they can do some of the work to make sure that those health homes can take advantage of the health information that's available in their communities to those care management plans that the health will be responsible for developing. And worked very closely with Jason's staff in integrating health information technology requirements into the various programs which they're moving forward with.

Finally, I'd like to give a brief report of the New York eHealth Collaborative and the New York City REACH program. Both contracts from the federal government to implement the regional extension center program in New York. This program is really geared to
August 4, 2011 - Albany, NY - Public Health

primary care physicians in particular to get certified E.H.R.'s to get them to meet the meaningful use requirements which are order for those physicians to get Medicare Medicaid payment incentives, which are for the next few years for that particular And we're extremely proud to announce that over five thousand physicians between the programs signed on and -- and in flight, in of moving forward with those efforts. And result of -- of the incredible work that (phonic spelling) and New York City have are now respectively number two and number the county in terms of performance among the regional extension centers. So we're very at that progress and -- and it seems as month, a really much greater interest is expressed by physicians across the state to participate in this program.

I think all of this really translates into a tipping point in terms of health information technology adoption over the next couple of years in New York State. And said, clearly that will only benefit the
August 4, 2011 - Albany, NY - Public Health Commissioner

and public health goals which the expressed.

That is the end of my Thank you.

DR. STRECK: Questions or comments for Ms. Block? Dr. Martin?

DR. MARTIN: Hi. One of the virtually faces is the regulatory/legal situation where the laws, the state's regs, the state's federal laws, regs, and practices are not -- overlap, but they're not necessarily in synchronicity. Right now, as you know, NICE, the RHIOs and all stakeholders are participating in looking over the policies procedures that sort of govern the health information exchange, because they were basically, as I understood it, through the Five contracting process to a large extent, point out. And thankfully, for somebody who one of those HEAL Fives, we're pretty much with that.

But -- so the -- the --
August 4, 2011 - Albany, NY - Public Health

guess the legal landscape still remains
bit of a mix. It's unclear what we're now
as well as what we're doing going forward.
understand the Commissioner has statutory
to make a fair amount of changes, but it's
to me what sort of timeline we're thinking
how the NICE process is fitting into this.
you could just clear that up a little bit,
might be helpful.

MS. BLOCK: Sure. So as
Martin indicates, we've undertaken a
review of federal and state privacy policies,
and -- and we're going to align that with
existing privacy and security policies which
governed the programs to date.

And in terms of timing, as
understand it, the -- the plan is to have
review completed by the end of the year.
have begun the process of -- of some initial
development of the regulations governing the
statewide health information network
this point just to create a bit of a
and -- and -- and decide with legal counsel
should approach the level of specificity and
August 4, 2011 - Albany, NY - Public Health

the unique relationship that we have with
eHealth Collaborative in a regulatory
context.
So we've begun sorting through some of those
issues, and I think that -- that we have an
opportunity to align the timing of the
completion of that review, the result of the
discussion of the results of that review,
and blend that into the regulation. And that would
suggest that we would be advancing the -- the
regulation early next year, which should dovetail
pretty well with the end of the remaining HEAL contracts,
which is really what continues to bind everybody
to the statewide policy guidance as it currently
exists. So fingers crossed, we should be able to
have a pretty good alignment and -- and not drop
the ball at the point that the HEAL program formally
ends as it relates to health information technology.

DR. STRECK: I have a
question regarding the all-payer database. About ten
years ago, I chaired a group for the state that
was looking at oncology services in the Medicaid
population, and I remember quite distinctly
distinguished president of a large insurance
company testifying at one of our hearings
pointing out -- pointedly pointing out --
of his company's data was proprietary and
available for any comparative analysis to
any parameters on the Medicaid population
the insured population.

So my question is, how are
insurers responding to this opportunity that
been presented to them?

MS. BLOCK: Well, I'm very
pleased to tell you that times have changed,
think, in part because there are already
states that are implementing their own laws
implement these all-payer databases, and as
result, particularly the national plans have
develop policies and procedures to work with
states to provide their data in the context
those particular state programs. So that's
thing that has changed.

I think that there is a
recognition that the value of this data for
well as for us in terms of being able to
more effective policies and procedures in
payment reform, responding to A.C.O.'s, all
other things that we know are coming down
August 4, 2011 - Albany, NY - Public Health

We had a meeting with the Health Plan Board, and just yesterday, I had an opportunity to meet with probably forty staff from health plans across the state. They're extremely enthusiastic about participating in this opportunity and -- and have -- have really already started to conduct assessments of their own capabilities to determine what would be the quickest and easiest way that they could provide the data that likely to be requesting from them.

So I think that at this point, we have a pretty strong commitment from both Health Plan Association as an association of the individual insurers across the state to be proactive participants in the development of this database. And we've indicated to them that we really do see this as a partnership with well as with all of the other healthcare stakeholders who will be participating in

DR. STRECK: Other comments? Dr. Ruge?

DR. RUGGE: I'd just make a comment about this in light of the
experience that we've had an agreement, in principle, and I think true willingness on the part of the payers to participate in a regional database, you know, highlights the -- the necessity of better defining what is particular and public, and that despite that, it has taken many months of working through nine different legal departments, nine different privacy determination what standards and to come up with simple data use agreement. So there's a need for imposition of -- of public terms of what kind of agreements are -- are appropriate and needed by all concerned, be providers or -- or insurers. Without that, be enmeshed for decades in the process of -- combining data.

DR. STRECK: Thank you for pointing out that complexity can strangle enthusiasm, but we will nonetheless trust in Block and the work ahead here. It -- it is encouraging from the payer perspective, I think. Other questions? Peter?

MR. ROBINSON: It's -- actually more of a comment. I think that
you'll find is a distinction between the for and not for profit insurers in the state. our way of seeing it, the not for profit seem to be much more willing participants in processes. The Rochester region has its payers on the governing body of the RHIO, is a good exchange of information and good participation. I think that in areas where have the for profit companies, you have a situation. I think it mainly raises the let's hope the state doesn't actually more transition of not for profit payers to profit in order to get onetime financial out of it and -- and perhaps give up some of local accountability that comes from their profit status.

So I think it's a policy that we have to be mindful of, and maybe as M.R.T.'s look at issues of financing, that off the table.

DR. STRECK: Other questions for Ms. Block? Thank you very

We'll now move to a report of the Office of Health Activities. Dr. Birkhead?
August 4, 2011 - Albany, NY - Public Health

much,
council
undertaking

DR. BIRKHEAD: Thanks very
today about a new activity that we're
at the State Health Department, which is
accreditation, actually, of the State Health
Department. And you may -- may ask, "What
public health accreditation?"

Over the past several
new national group has formed called the
Health Accreditation Board. This is a
accrediting agency that has been put
through a combination of efforts by C.D.C.,
Robert Wood Johnson Foundation, the
State and Territorial Health Officials, and
And just this July, it issued its -- it --
for state and local health departments to
accredited.

So what is public health
accreditation? It's a measurement of health
department performance against a set of
recognized practices and -- and
standards. There is recognition that comes
with this of achievement of accreditation by
national entity. So this is -- this is
first time, as I mentioned, that there is a
national entity accrediting state and local
departments, And this body will also
develop. This is the first pass, the first
of -- of guidance. There was a beta test,
really we are -- all the states are all
guinea pigs in this process of working
accreditation. And so this is -- is -- may
be modified or change or over time.

This is very heavily
endorsed by
C.D.C. Here are statements by Tom Frieden,
the
major
director of C.D.C., that accreditation is a
help
accomplishment for health departments to
addressing key community health problems.
And just
as the public expects hospitals, law
enforcement
agencies, and schools to be accredited, so
they come to expect public health
accredited.

At this point in time,
voluntary
 accreditation is a voluntary thing, a
goal for states and locals. It's possible
in the
future, although not certain, that some
federal
funding might be -- or other funding might
be
conditioned on being an accredited agency.
future. think important for improvement Department accreditation health probably in the -- in the distant For the time being, it's voluntary. But I for a number of reasons, it's -- it's us in New York to look at -- at doing this. This really fits in with our focus on at the -- at the -- at the State Health as well. One goal of the national program is to improve and protect the -- the of the public by improving the quality and performance of public health departments. basically, this is a process if you've been through -- in an academic or other kind of accreditation -- a process of evaluating and continuously improving the processes and and interventions within the department. have -- C.D.C. has simultaneously issued health departments. We have a performance improvement grant that will help support our efforts in developing this.

The Public Health Board has -- has set up the accreditation twelve domains. These are the ten essential health services, which I think I've talked council before about, plus an -- an
August 4, 2011 - Albany, NY - Public Health

talk a domain and a governance domain, and I'll little bit more about these.

will -- they've established a set of standards and

measures for those standards, and then finally, the

documentation that the health department
to produce to show evidence that they are

the measures and -- and have the standards place.

So again, the standards

the core public health programs and
ten essential public health services relate

For example, environment health, health chronic disease, communicable disease, et

This accreditation process, since different health -- health departments are different

of their scope, this does not include

of, for example, the Medicaid and health programs, hospital nursing service or

surveillance -- healthcare surveillance

or the health information technology piece, in New York, are part of the state health
department. In other states, they may not be.

However, I think because this process of
August 4, 2011 - Albany, NY - Public Health

accreditation draws in stakeholders and -- looks for the health department to have these other areas, insurance, hospital health information technology, I think the fact that they are in with the department is benefit our approach, because we already strong links with these other -- with these entities. So that will benefit our The three prerequisites that we need that of the accreditation: First, we need to state health assessment. This is an the -- of the health of the population, and with that, a state health improvement plan, this point, the prevention agenda which spoken, I think, many times to the council constitute a state health assessment. We series laid out over ten goal areas of -- of measures and health -- health elements that tracking as well as the improvement plan encompassed within the prevention agenda. that agenda will end its five years in 2012. as I talked at the last meeting, I think we then look -- work with the Public Health of the council to renew it. But that is
August 4, 2011 - Albany, NY - Public Health

will use essentially, with -- with tweaks, what we
to meet the requirements for accreditation
of the assessment and -- and the state health
improvement plan.

And then the third aspect

is a D.O.H. strategic plan. And we will
begin the process this summer under Dr. Shah's
direction, to bring together the executive staff to begin
to develop a -- an updated and more formal
strategic plan for the state health department. We've
had strategic plans in the past, but I think
this is an opportunity to really look afresh with a new
plan executive staff and develop a comprehensive
the going forward that will meet our needs with
accreditation department, but also help with this
process.

So there -- there are
seven steps in the process, which is, just very quickly,
a pre-application phase, then the application,
the document submission. There will be a site
visit by an accreditation body, and then if all goes
well, a five year accreditation. And this sets up
then a cycle of reaccreditation, as you may be
familiar with from academic or other settings, where
improvement. Here's roughly the timeline that we've laid
out for the readiness gaps to orientation the
from now then site the work manner an but functioning

and roles that I just wanted to highlight. The
agency, involved in called an

There are key participants

and

agency, involved in called an

The Commissioner, obviously, as the lead of the
provides support for the process and --
the -- in the site visit. There's what's
appointing authority, which, in New York, we
August 4, 2011 - Albany, NY - Public Health

we will believe is -- represents the governor, and
application that get the governor's support for the
which goes in. And then a governing authority,
We're still probably is a combination in New York.
the trying to sort of figure out the language of
authority is accreditation board and how it fits with our
and particular state, but the governing
and probably a combination of the Commissioner
regulatory potentially this council, the Public Health
Sanitary Health Planning Council, which has some
authorities over, for example, the State
Code. So we'll still work that out.

In any event, we would want to use this council and the Public
Committee as -- as a key, both stakeholder
and as a key group to -- to bounce our ideas
our -- our strategic plan off of for -- for
reality check. And then I -- I -- I think
it's laid out, there may be some formal role
well for the council in supporting our
for accreditation.

And then the -- the health
department and the stakeholders -- and part
process of accreditation will involve a
August 4, 2011 - Albany, NY - Public Health

input, public comment process that we still
have to
work out what the details of. But that --
that is
one of the requirements that we will -- we
will
need to work on.

So really, the next steps
-- so
we will work with the Public Health
Committee of this council to review our -- the -- the
prerequisites that I mentioned, the -- the
prevention agenda, the state health
assessment, and as we -- as we then come to the completion
of this five year phase of the prevention agenda and
into the next phase, which will overlap with our
accuracy process, I think we would
bring the strategic plan to the group as
well when that's completed after this summer's work
and ask also to -- the council's assistance in
reviewing some of the standards and documentation that
we need to put together for -- for this process.

So it's -- it's an exciting process. I
think really the -- the -- the benefit will
be in -- in improving our ability to function
as a department. We have very good interactions
and cross-functional activities going on now.
But in some cases, it's not -- it could be -- use
August 4, 2011 - Albany, NY - Public Health

increased formality. It's a -- it's a
to -- to work through. And so I think this
accreditation will help us to really develop
higher functioning quality improvement
organization that will hopefully result, in
end, in the improved health in the state,
that's our ultimate goal.

So thanks, and I'll be
answer any questions.

DR. STRECK: Questions or
comments? Dr. Boufford?

DR. BOUFFORD: Yeah, I --
this is very exciting, and it's great to see
York early -- early out of the -- out of the
gate. I -- I wonder if you could comment on
the implications of the accreditation
local health departments -- in local health
departments, your relationship with them?
the other thing is the New York City
question. How -- how does that fit into all
this conversation?

DR. BIRKHEAD: Well, this
accreditation process is set up for both
local health departments. In fact, just
August 4, 2011 - Albany, NY - Public Health

this week, NYSACHO, the Association of State New York State Association of County Health Officials, had a day-long session on
So this is very much, I think, on the minds counties in New York, and New York City is a of that group. We had one county, upstate, a beta test site for the accreditation, so that -- that -- there have been reports that county for the past year or two to the process, and we are committed to working support the counties in -- in their accreditation.

As you know, in New York, the Article 6 program, which funds -- funds local public health services. As part that process, counties need to have a health assessment. They need to have a health services plan. So some of the the accreditation may already be placed processes under Article 6. What we need to sort of look -- do a side by side with the 6 and the accreditation requirements. We want to create a duplicate process for the counties, so we may need to be flexible in -
August 4, 2011 – Albany, NY - Public Health

how we work with them.

But this is certainly

something that we would ultimately hope all counties

in the state would also -- also become accredited.

DR. STRECK: Gus, on a one
to ten scale, we have a new accreditation process,
but if two questions -- what's the --
ten scale of public health competence against these

would capabilities at the state level? And where

a sense be if ten were full accreditation, just for

of the country?

DR. BIRKHEAD: Well, it's

a good question. The country is very diverse in

terms of how public health services are -- are

organized. In some states, there really aren't local

health departments. They are only entities of the

state that are -- provide those services. I think

there's probably a wide range. I -- I think

in New York, a couple of years ago, we went through

the National Public Health Performance Standards

process, which was sort of a self-evaluation

process, but we -- we came up pretty strong

in many areas, disease surveillance, for
August 4, 2011 - Albany, NY - Public Health

So I think -- I think as health departments go, we are a very strong department laboratory. I think we are exceptionally strong in that area. So -- so think we're -- we're in good shape. You are in the process of trying to do more to incorporate quality improvement, and there are a few other states that may be ahead of in -- in sort of being formal about quality improvement in every -- in every program.

Washington State comes to mind as one that's been quite well organized in this area for a while and website, this something to think local here. of with though

So we certainly have learn from -- from other states, but I -- I we're pretty well positioned. And -- and certainly, our -- our process of funding health departments has maintained capacity That's a kind of a unique system. Not a lot states have a system of funding as we do Article 6. So I -- I think the hope is even it's tough times at all levels of government,
August 4, 2011 - Albany, NY - Public Health

we are able to maintain the core of our health, state and local, and we'll be able through this process.

DR. STRECK: Well, thank you for that report. We'll move now to Ms. Lipson Abel on the multi-state obligated groups. Charlie, who's going to lead?

MR. ABEL: We -- I just

DR. STRECK: I skipped Mr. I apologize. So we have the report of the of Health Systems Management.

MR. COOK: Thank you, Bill. happy to be --.

DR. STRECK: I apologize.

MR. COOK: I'm going to be brief because of that. I got the message. I just wanted to bring the group up to date couple of issues. I think one of the great stories that we have had in the department move to electronic submission of C.O.N.'s. those of you know -- who have been here know that beginning in December, that system live. And in May of this year, we now allow entities that have not been established to
August 4, 2011 - Albany, NY - Public Health

submit applications.

Since May of this year, we
have
seen almost eighty percent of the
applications
being submitted electronically. You have a
chart
before you that shows, in the first three or
four
months, the overwhelming number of
applications
were actually not coming in electronically.
So we
are approximately at eighty percent. And I
think,
Mr. Chairman, one of the things we could
like this
council to help us on -- we would like to
set a
date at which at that point, all
applications would
need to be submitted electronically unless
there
was some unique circumstance.

value
submitted
heard
much
seeing
twenty
go
able to
then

There's been tremendous
internally for us in -- in having these
electronically. As well as everything we've
from the industry, it has made their lives
more easy. But one of the things that we're
is we've already been able to document a
percent reduction in the number of days to
through a full C.O.N., and we've also been
understand where there are opportunities for
improvement. If you looked at some our data,
what you find is a significant percentage of
August 4, 2011 - Albany, NY - Public Health

is sent -- is when the C.O.N. comes in, it
back to the applicant for additional
information. And one of the things that we're working on
now is how can we begin to correct that back and
forth in order to further expedite and -- and make
process easier? And that represents about
twenty-eight percent of the time that's
for a full review.

So we're learning more
ourselves, how to be more efficient. We're
learning a great deal more about how we can
with the industry to try and eliminate this
and forth that exists. One of the things
will have for the council in the fall is a
performance report card that will lay this
and you'll be able to look at time that is
for full administrative and limited reviews,
because obviously one of the things the
Commissioner has reminded me of, and that we
hear, is the amount of time that it takes to
applications. But I think this electronic
submission system has really begun to
for us to assess. It also has already seen
significant results.
August 4, 2011 - Albany, NY - Public Health

So I really want to compliment Charlie Abel in the Division of Health planning. They've done just an extraordinary job in implementing this. This has not been an easy thing to go forward at a time of reduced resources. They have just simply done an extraordinary job. So Charlie, thank you.

A couple other small issues.

Commissioner's

A couple other small issues.

There was a brief discussion in the remark -- remarks and in Jason's discussion of Brooklyn M.R.T., and I want to just reiterate a couple of issues relating to the process going on led by Steve Berger. We've had one hearing. We had over sixty-eight people testified. We've gotten significant data, but I think the importance of this are really two things. Number one, we have emphasized over and over that this is not Two. This is not an effort to go in and close hospitals. This is really a regional effort to try and understand and assess, how improve the healthcare delivery system in a Brooklyn that right now is undergoing fiscal stress, but also faces significant poverty.
August 4, 2011 - Albany, NY - Public Health

issues and significant inefficiencies?

If you looked at Brooklyn have begun to -- to look at, what you will a significant percentage of admissions, quality indicators that are represented in hospitals that could be avoided with better community and preventive care. And it's thirty-four thousand admissions that we've able to identify. Now we're not grazing or criticizing the hospitals for not doing If anything, the hospitals are admitting patients because they need care. But we've highlighted indices, like --.

(Off the record)

MR. COOK: -- understand that is an opportunity for efficiency. That can find ways to avoid those admissions, we improve the health of individuals, and we improve the cost effectiveness of the system.

We have also seen, across the state, more interest in trying to understand how do we excuse me -- regional planning. And the Commissioner met with a group of about hospitals from the northern Adirondacks who
August 4, 2011 - Albany, NY - Public Health

we're beginning to ask the same questions that asking in Brooklyn. What are the efficiencies that we can come up with so that we're prepared for the changes down the road? How do we do a better job of recruiting and retaining primary care physicians? How do we avoid admissions that are not necessary? How do we begin to link with each other so that we're doing a better job in collaborating? So this first effort in

Brooklyn, I think, is -- really will lay the foundation for a series of ongoing discussions across the state of how do we assess communities? How do we and encourage and build community health systems?

Finally, I just very briefly want to talk -- as -- as you may know from the reports, we've received a closure plan from Peninsula Hospital on the Rockaways. The administration of Peninsula has submitted notices, which are ninety day notices to warn employees that layoffs are imminent within those ninety days, and the closure plan is now being reviewed. We're working with both the union, Peninsula Hospital, St. John's, and the surrounding hospitals,
August 4, 2011 - Albany, NY - Public Health

particularly South Nassau, and Franklin, and Jamaica, who are likely to see the impact of closure. And right now that process is -- ongoing.

So I'm happy to answer any questions.

DR. STRECK: Questions for Cook? Mr. Berliner?

DR. BERLINER: Rick, are Brooklyn hospitals strong enough to stay during the M.R.T. process until --.

MR. COOK: Yeah. I mean, think, you know, our recommendations are due November 1st. There obviously are several hospitals that are fiscally challenged, but the one thing that is already occurring discussions among the hospitals of what -- kind of relationships might be built in the interim. So I -- I think they'll get process, but we're obviously engaged in discussions with several who are having some particular problems.

DR. STRECK: Other comments? Thank you. I've already
August 4, 2011 - Albany, NY - Public Health

Karen. And Charlie, you may now begin.

MR. ABEL: Thank you. I was asked to -- to put together a little presentation draft
Hopefully, you review that.
I would discuss
M.R.T. -- healthcare formation obligated -- many
through -- are be that
cross entering

Now this is part of the an M.R.T. initiative to expand access to facilities to -- to capital through the of multi-state obligated groups. Now groups, as -- as you folks know, you -- you of you have seen in -- through Public Health Council, obligated group applications come for establishment. And obligated groups are composed of a number of entities. It could healthcare. Obviously, most of the projects you've seen before you have been healthcare institutions. It could be other institutions/entities brought together to collateralize one another's debt. And in -- entering into what is called the
August 4, 2011 - Albany, NY - Public Health

facilities -- in group through individual achieve. State, facility, -- that must receive the -- the Department of Health Commissioner's approval. Now on an basis when there is an individual instrument, instrument, we -- we do that internally, administratively. But for an obligated formation, because that obligated group is the M.T.I., it has an ongoing need to -- to borrow and make decisions among the -- the as to -- as to how to make payments on loans, et cetera, that's an ongoing basis. And as a -- as a way to grant authorization on behalf of the Commissioner, we've established the going through an establishment action submitting an establishment C.O.N. and
August 4, 2011 - Albany, NY - Public Health

forward through the -- now, this council for
enable approval to form that obligated group, and
be, then the Article 28 facilities to, if need
institutions support the debt payments of other
within that obligated group.

Historically, over the
last twelve years, the -- those obligated groups
that have been formed have been intrastate
obligated groups, facilities within -- all the
facilities within that obligated group has -- have been
New York State. Not all of them healthcare
couples facilities. We actually had a couple of --
with of obligated groups form that were formed
other healthcare facilities, but also other --
related facilities in an effort to, again,
achieve a better rating for the agencies and -- and
-- and for banks, and be able to achieve lower
interest rate going forward.

So through this initiative,
this M.R.T. initiative, we were asked to -- to
look at multi-state obligated groups. What would be
the challenges for us to be able to -- to
co-establish through some model the Article 28 facilities
with these multi-state obligated groups? Now
August 4, 2011 - Albany, NY - Public Health

large -- obligated groups is a -- it's a --
term of art in -- in the -- the financial
They exist throughout the -- the nation.
are very large multi-state obligated groups,
and we
have had discussions in the past with a
large obligated groups that are -- that were
seeking to bring in New York State
facilities.

In our obligated group

establishment applications, as you know, we
the character and competence of all the --
members that are forming the obligated group.

examine the financial aspects of all the --
members. We -- we want to make sure that
the -- the formation of this obligated group
going to hurt any one facility, and then the
aggregate will improve the -- the financial
position of -- of the group. So -- so we'll
look at it from -- specifically, from the
competence perspective, from the financial
perspective.

Multi-state obligated
groups that
may have dozens, and there are those that
have well
over a hundred entities, maybe all
maybe a mix of healthcare and non-healthcare
the states. That presents, obviously, a
not only from the character and competence
perspective, but also from the financial
perspective, understanding the regulatory
environment of all the states involved for
healthcare facilities. For the
facilities, even a greater dimension of
Where does that healthcare -- where -- where
that entity reside in its market for its
How can it impact on the New York State
Obviously, we want to protect the New York
facilities from the potential of having
siphoned from that -- from that New York.
facility to support a problem facility in
other state, or a problem entity in some
state.

So those -- those were the
challenges that presented themselves. On
the flip side, there seemed to be great
because many of these multi-state obligated
already are rated and are rated very highly
in the -- in the A and double A category.
the -- the -- the -- the -- the prospect of
August 4, 2011 - Albany, NY - Public Health

enabling a New York State healthcare facility -- by the way, we have very few A rated healthcare facilities in New York State. Many of our healthcare facilities are not rated. The vast majority, in fact, are not. So the benefit of having a New York State healthcare facility participate in a -- in a borrowing that -- rated obligated group and being able to achieve a lower interest rate for a major modernization project, for example, the -- the financial benefits for a million dollars of millions of dollars saved over the life of a loan that could be a result of -- of a New York State borrowing through an A rated obligated group.

So what -- what this paper did was to lay out some of that background for you, lay out how we have handled obligated groups in -- past through the establishment process, and then on page four, it begins to lay out the proposed policy that we would like to -- to implement to -- to enable us to -- to --
August 4, 2011 - Albany, NY - Public Health

to achieve those -- that lower cost of New York State facilities who apply, who
wish to join a multi-state obligated group. See --
you see the benefits there. It facilitates the --
the introduction to new sources of capital
investment. Clearly, that gives New York State
facilities the ability to access new markets, not only
through -- with lower interest potentially for its debt,
but -- but also more creative financing
vehicles than what is currently existing in New York
State. And -- and through the obligated group
structure that we are recommending, which includes an
active parent entity over the entire obligated
group, it introduces an expertise that exists in that
active parent entity that -- that we have seen from
the -- approached us only from the obligated groups that have
borrowing, but that we believe is very beneficial to not
-- at achieving efficiency with respect to
the efficiency with respect to best practices in
operating healthcare facilities. At -- at a
multi-state level, bring that expertise to
New York State healthcare facility. So --
and of course, leveraging that -- that
larger facility's borrowing potential of -- and --
August 4, 2011 - Albany, NY - Public Health

using that for the benefit of the New York facility.

So how -- how would be that? Excuse me. It would -- it -- we --

essentially proposing that we limit our and competence review to the active parent

Now I -- I -- I probably should back up just in New York State, historically, we've been

approve and -- well, you folks have also approve two different models of obligated groups.

multiple healthcare facilities with an parent co-established operator to oversee

That active parent may have any one group. That active parent may have any one of the Section 405 powers that -- that -- to

in the operation of that Article 28 facility.

We've also approved a model where, without an active parent, but each of the facilities involved are jointly and separately liable for that debt.

And so there's no central decision-making body, but there's no ability for some entity to make decisions with respect to how to operate individual facilities.

Those facilities are really simply coming together to leverage, you know, their financial
August 4, 2011 - Albany, NY - Public Health

with respect to joint borrowing. So the --
the M.T.I., the master trust indenture, is
the only entity that dictates the -- the --
degree of integration of those facilities.
The M.T.I. dictates what the financial
necessary to -- for withdrawal. In addition
of -- of entities to the obligated group, it
dictsates the -- the conditions when a draw
assets from one or more of the -- of the
to support one of the entity's debt service
payments if those sort of conditions exist.
Clearly, for us to be able to embrace a
obligated group structure that would include
state -- New York State facilities, we would
to have an active parent model so that that
parent model -- that active parent needs to
demonstrate to us the ability -- the
operate healthcare facilities with adequate
character and competence and in a
financially feasible manner. So our review
establishment purposes would be limited to
character and competence on the board or
the -- the critical decision makers are at
at the active parent entity, the -- the
August 4, 2011 - Albany, NY - Public Health

was applying to the active parent, and the compliance review for the healthcare within New York State.

We are proposing that we -
we not view the character and competence of board members or all the proprietary whatever exists outside of New York State.
financial perspective, we would view -- we look at the financial performance of the New State entities and the -- and -- and the -- financial performance of the obligated group which the New York State entities seek to -- to join and determine that it would be for the New York State entities to join that obligated group. Where -- where there is an where there is an obligated group that has a borrowing history, these entities again are generally rated by the major credit agencies, and -- and we are proposing that the major agencies -- at least one of the major credit agencies has -- is rating that obligated an investment credit level, which is for our purposes a triple B level or -- or higher.
So we want to make sure that there is an

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August 4, 2011 - Albany, NY - Public Health

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So we want to make sure that there is an
established track record of sound financial
due for documentation
the -- also any of the group. So and
endorsement of -- that we this
first of all, we don't believe that we -- need to have an approval here. We wanted to present this because we believe we can do within the existing statute and regulations.

DR. STRECK: Okay.

MR. ABEL: But we wanted a discussion. We wanted to seek your input into this proposal so that -- so that we
that into consideration.

DR. STRECK: So it's a presentation, and the question really revolves around due diligence or character and competence on the parents of the obligated group, but not committing the department to review every subsidiary trail for the -- for the parents, other than those in the New York State component, institutions in New York State, which would reviewed for character and competence. really the question that has been presented, we're open for discussion. Mr. Berliner?

DR. BERLINER: Charlie, is this a strategy in search of a mission? I mean, anyone actually been interested in this?

MR. ABEL: Yes, yes.

DR. BERLINER: And is it clear out-of-state obligated group would be better, financially, anything they can get from financial institutions inside New York?

MR. ABEL: We -- we have -- we went through extensive discussions with one obligated group approximately four years ago.
August 4, 2011 - Albany, NY - Public Health

we were, at that time, not able to get our
hands around embracing this healthcare facility
that obligated group. That healthcare
sought and obtained financing for a major
project through, at the time, the local
industrial development agency, which as --
see in the paper, the I.D.A.'s don't exist
for healthcare financing. They -- their
legislation subset it.

We took a look, and we --
we have since worked with -- at the time
multi-state obligated group entity made the
that they could lend the -- absorb that
debt into its debt structure and provide a
aggregate interest rate for that facility,
saving on the order of thirty million
the life of the project. And we've -- in --
interim years, we've taken a look at the
performance of that obligated group and its
structure that it extends to the facilities
relative to what this healthcare facility
through the I.D.A. It -- it -- it provides
substantial savings -- it would have
substantial savings along the lines of what
August 4, 2011 - Albany, NY - Public Health

You're obligated group has projected.

DR. STRECK: So again, proposing this because you see that it has advantage. From the council's perspective, such commitment would have to come here for character and competence review of the debt?

MR. ABEL: That's correct. We would continue to bring obligated group --

DR. STRECK: Group.

MR. ABEL: -- proposals through for establishment approval. It's just that the -- our review associated with that establishment action would be limited to the character and competence of the active parent and current compliance for the New York State facilities.

DR. STRECK: Other comments or questions? Mr. Fensterman?

MR. FENSTERMAN: Thank you, Mr. Chairman. Charlie, I think this is a great concept and necessary, particularly given the reimbursement issues that various facilities are facing and how lenders are going to look upon that in terms
August 4, 2011 - Albany, NY - Public Health

their ability to service debt. I just want clear, and the chairman mentioned it. Your proposal suggesting that the character and competence of the active parent outside the state would be reviewed. And does it also include in -- in New York State, activities of any possible boards in New York?

MR. ABEL: It -- it -- it absolutely would be a character and competence review of the -- of the board, assuming it's for profit active parent entity that may exist outside of New York State and -- having -- limited co-establishment of that entity with New York State facilities. The New York facilities -- at this point, we are proposing a current compliance review. Not a full and competence review of all the board a ten year look-back as we do with full and competence, but current compliance of New York State entities with respect to any -- problems that the facilities is encountering.

And the -- and the reason for that, obviously, the -- the New York State facilities are already established Article 28 facilities.
August 4, 2011 - Albany, NY - Public Health

DR. STRECK: So you mean the subsidiaries of the parent, not the
would -- would go through that process,
In-state subsidiaries of the active parent,
necessarily applicants for the -- the joint
financing.

MR. ABEL: That's --
correct.

DR. STRECK: Okay.

MR. ABEL: The New York
State entities.

DR. STRECK: Right. Okay.

MR. FENSTERMAN: Mr.
could I just follow up with one more

DR. STRECK: Yes.

MR. FENSTERMAN: When you
the term "active parent," are you describing
wholly owned subsidiary by this active
the New York State facility contemplated to
wholly owned by the active parent?

MR. ABEL: We are -- we
proposing that there be an active parent
And -- and in the -- and in the -- the
groups that have approached us, they have an
functions
already, as an active parent over all of the
out-of-state entities. It -- that -- that's
structure that already exists. We're --
proposing to -- not to have that active
up a New York State entity that we will
but rather to -- to establish -- take --
take through the establishment process that
for that current active parent entity.

MR. FENSTERMAN: And have
contemplated analyzing the out-of-state
of Health -- their respective Department of
rules and regulations as it relates to
which differ from state to state? My
that we would not want an out-of-state
subject to default which would affect our
facilities. So are we analyzing -- you know,
very -- for example, in a -- in banking
there are things called "covenants," and you
to remain within your covenants or else
default. In our own statute, as it relates,
example, to nursing homes, there's certain
financial requirements that you have here
the Public Health Law and under Department
August 4, 2011 - Albany, NY - Public Health

out of regulations. And if you go what I'll call "covenant" for purposes of this discussion, it could bring about certain consequences from the Department of Health. Are we analyzing what those rules and regulations are of the Department of Health?

MR. ABEL: I'm -- I'm not sure we're -- we're reviewing all of the things that you're proposing. We would be reviewing the M.T.I., which would dictate the -- the -- the transactions -- the financial transactions and the entry and departure of individual members.

We would -- we would not be looking at the individual out-of-state loan instruments that exist for the facilities. And -- and also, this is important, we are -- we are saying that for any entry and exit to the obligated group by non-New York State entities, would not be subject to review -- prior review and approval by the Department.

MS. LEFEBVRE: I -- maybe I can jump in here. I -- I -- I -- Mr. Fensterman, I think -- I think that the things that you're concerned about, and what -- what -- that
August 4, 2011 - Albany, NY - Public Health

raising, really do get embodied in the --
the master trust indenture that Charlie's
to. Because what we expect is this
obligated group that's interested in
York State entity in, will come in as a --
know, a rated credit that will, in that
demonstrate, and be able to demonstrate, all
legal, you know, requirements having been
any state that they -- that they operate in

MR. FENSTERMAN: My --.

MS. LEFEBVRE: --

particularly
covenant-wise.

MR. FENSTERMAN: My
just for your consideration, is to perhaps
estoppel certificates from their various
the onus is not on the Department, but it
on the out-of-state facility to go to their
or credit agency. And by getting an
certificate, that's a certification to the
department that they're within covenants,
that's my suggestion.

MS. LEFEBVRE: And they
have to do that --

MR. FENSTERMAN: Right.
August 4, 2011 - Albany, NY - Public Health

MS. LEFEBVRE: -- in any financing --

MR. FENSTERMAN: Right.

MS. LEFEBVRE: -- I would suspect anyway.

MR. FENSTERMAN: Uh-huh.

MS. LEFEBVRE: Thank you.

DR. STRECK: So I think we've have a presentation -- Sue? I'm sorry.

MS. REGAN: Charlie, I have a concern about the -- the affiliated entities in the group that are not in state, the out-of-state ones. And I -- I think I have somewhat less confidence in I would character process more diligence a... a... these affiliated entities represent significant liabilities, even -- either financial or compliance liabilities. I -- I think the character and competence process has -- has
August 4, 2011 - Albany, NY - Public Health

not been elegant in doing that. But we, the
need some way of doing that, not only for
inside the state -- now -- now I don't think
rating agencies do that effectively, but
can come up with some way of doing it.
have ideas about how they do that.

I -- I do think we need to
at these out of state, otherwise, we become,
know, sort of a honey pot for large groups
there who might be -- I'm not speaking about
current one, but, you know, we may be
opportunity that is not best for the state.

MR. ABEL: That's --
good point, and certainly we can take a look
bond counsel letters for the most recent
offerings that -- that were done for the
group. That shouldn't be a problem.

MS. LEFEBVRE: And Sue, I
also anticipate -- as we were reviewing
know, certainly, rating agencies do a
of jobs, but we -- I don't think we would
to pick up the phone and ask questions about
we were seeing in their credit reports or
the financial statements because all of that
rolls up into this parent's financial
statement.
So I mean, I think that, you know, we would
imply that we are going to do due diligence on those. And if we had
questions, we would certainly ask. And we
certainly be working with DASNY, also if --
are the financier in these instances.

DR. STRECK: Dr. Bhat?

DR. BHAT: One of the
questions that I have, all the hospitals in New York
State are not for profit. And outside New York
there are a lot of hospital chains that are for profit. Can a not for profit could be a
obligated group which is for profit outside
state? And what are the implications of

MR. ABEL: Just a couple
things. First of all, while all the
currently in New York State are not for profit.
there is no restriction for for profit
The last for profit hospital we had closed, I
think, about six or seven years ago. But
policy that we're proposing is specifically
for profit hospitals for -- within New York
There are -- I -- I -- I believe there can
structured such an arrangement where there
August 4, 2011 - Albany, NY - Public Health

hospitals, profit subsidiaries of not for profit
State as and those things could exist in New York
practical well as other states. So you know, as a
in an matter, could there be a for profit entity
profit New obligated group that contained a not for
York State facility? I suspect there very
could be.

MS. LEFEBVRE: I would go

a little further also, and as -- as Charlie

our -- referenced, this is part of the -- you know,

really our response to M.R.T. recommendations that

enabling were asking us to explore and push on
capital access for the healthcare industry.

In addition to this idea, which is limited to

not for profits, it's clear that the group, the --

the M.R.T. group is -- has been asked to look at

other forms of for profit financing. We haven't

really touched that here in this, but I think that

something that the M.R.T. group was

interested in exploring at some point in time.

DR. BHAT: Would -- would

that allow these for profits outside the state to

get their foot in -- to the -- to have for

profit hospitals in New York State?
August 4, 2011 - Albany, NY - Public Health

MS. LEFEBVRE: This action does not. I think that the M.R.T. asked that be looked at. And I think there's a lot of research and certainly a lot of feelings on both sides about -- about the issue. But I think, you know, just doing the data -- data gathering is what the M.R.T. was looking for.

DR. STRECK: Mr. Booth?

DR. BOOTH: I believe a profit can be the member of a not for profit, it's possible that the -- the parent -- parent could be for profit here.

I -- regardless of how up and whether you cut that off at the pass, would tell you my biggest concern about what hearing here is we are giving up our own our own community assets to potentially out-of-state entities in order to get and that's essentially what we're doing. not sure -- I understand the short-term not sure that's in the long-term needs of -- communities.

MR. ABEL: Just a point of clarification. While I think we're all
August 4, 2011 - Albany, NY - Public Health

there's no reason why a for profit couldn't
be in
an -- an obligated group, that we are
talking about
potentially -- a multi-state obligated group,
that
we're potentially just talking about an
talk about
entity.
We -- for the purposes of this policy, we
are only
considering obligated groups with not for
profit
active parents.

DR. STRECK: So the -- oh,

Mr.
Robinson?

MR. ROBINSON: A follow up.

To -- to -- to follow-up on Mr. Booth's

FROM THE FLOOR: Talk into

the
microphone, please.

MR. ROBINSON: I will try.

Thank
of
authority of
mean,
these
this
is the
currently
you. Are we actually, through this process
gaining financing, yielding governance
New York State Article 28 facilities -- I
total governance authority to these -- to
obligated groups? Is that a consequence of
mechanism that you're putting into place?

MR. ABEL: There certainly
potential for -- and -- and -- and -- and
what happens when we set up an active parent
August 4, 2011 - Albany, NY - Public Health

through -- through an establishment process, fact, they become a limited cooperator of
the Article 28 hospital. In this -- in this
example, that would -- that philosophy is consistent.
It would apply to the not for profit entity
that could be out-of-state active parent over an
obligated group.

MR. ROBINSON: I'm amazed
New York State would not have sufficient
entities within its boundaries to be able to
provide this mechanism without needing to go
multi-state operators.

MS. LEFEBVRE: It -- it --
it's -- it's just a fact that in -- inside
York State, there are very few healthcare
that could come together and leverage as
interest rate benefit as, for example, some
larger multi-state not for profit obligated
It's -- it's -- it's just -- it -- it's --
interest rate, you know, plan. When you
when you have stronger entities, you know,
through -- throughout the country, it -- it
for a significant benefit to a stand-alone
facility.
August 4, 2011 - Albany, NY - Public Health

MR. ROBINSON: I -- I just think this runs the risk of getting into the practice of medicine. I -- it -- it -- I understand the benefits, but I think that perhaps, as Vick said earlier, unintended consequences sometimes for some of these decisions. So I -- I think this is not a very advisable strategy if we want to maintain the kind of primarily not for profit healthcare New York State that we currently have.

MS. LEFEBVRE: Mr. Robinson, even if it's limit -- I mean, this has been, I hopefully, really clear that this is limited for profit practice.

MR. ROBINSON: Yes, but actually seen conversions of not for profits profit in New York State alone. And even -- and that has at least had a governance kind oversight to it. I -- I think that when we yield this authority to out-of-state actually ultimately lose significant control the operation of healthcare services in the

DR. STRECK: Dr. Rugge?

DR. RUGGE: Just as --
two considerations. In several areas around state, on the boundaries of the state, there natural medical service areas that overlap state to another, which has implications for New York State institution may choose to and affiliate with an out-of-state As another observation, clearly any move on part with regard to obligated groups has implications for how we regard restructuring healthcare organizations in new fashions to accountable care organizations, super groups, regional entities. So we need to be mindful precedent that we may be setting through changes, in terms of even more profound the delivery system coming forward.

DR. STRECK: Ms. Regan?

MS. REGAN: I -- I have to disagree with -- with one fear here because this -- this has been around. If you ever covenants in something like a HUD document, guarantee document, it's, you know, You give away all your budgeting authority. They can come in at any moment and audit. I mean, things are already there, the -- these --
August 4, 2011 - Albany, NY - Public Health

...giving away of this authority.

...I think what -- what is

...about this is not so much that we're giving

...theoretical budgeting authority. I think

...largely theoretical. But the fear is that

...going to have bad guys doing this. If -- if

...we were all invited to become members of the

...system or the Mayo Clinic, we might feel

...terrific thing. Or if we lived in -- in the

...Adirondacks and we were going to do an

...Fletcher Allen, I mean, we would think this

...great thing. And what -- what we need to

...to avoid the sort of knee jerk theoretical

...and look at the substance of these deals,

...that's hard to do. But that's what we've

...and I think we have to avoid the -- you know,

...of course, this not -- this for profit thing

...always been -- it sits out there scaring us

...But what's really scary is the bad guys, and

...need to be able to go into business with the

...guys.

DR. STRECK: Mr. Cook?

MR. COOK: I just -- I --

...want to kind of emphasize a couple of points.
mean, number one, I don't see how we're
ceding any
authority. I mean, once established, we
still have
the authority with that active parent to
apply all
the rules and all the regs and all the
pressures
that we can apply as a department.

I think, secondly, it's
important
to understand the context. Part of the
issue that we have heard over and over again is how --
the
difficulty of hospitals and others
throughout this
state to get access to capital. And I think,
to begin
Sue's point, what this allows us to do is to
opportunities
understand, what are some of the
that may
beneficial to many of the hospitals
across the
state? We don't know everything that we're
going
looking for, but it's certainly worth an
opportunity to
have a process where we can begin to
understand,
what are those proposals?

DR. STRECK: Thank you.

Mr.

Berliner?

just a
I

issue when

mean, it seems to me we confronted this
we were dealing with dialysis centers. And
August 4, 2011 - Albany, NY - Public Health

we found that, in fact, we had no control over the active parent. That if the active parent wanted to withdraw its funding or change its policies, there wasn't much we could do because we really -- that was one of the reasons we allowed the profits to come in directly because we didn't have that control. But I think it's still an issue of, you know, what can we do once we cede the authority?

it's always going to be an issue. I mean, I -- I think, you know, we learned -- right now, we know that the world is changing significantly. And we know really to do that to be able Healthcare to even buy hospital beds in some small communities. And some of them do have opportunities through, perhaps, Catholic Healthcare that East or others that are concrete examples think, in really can make a difference. I mean, I some respect, we have to begin to -- and it sounds odd for the director of O.H.S.M. perhaps saying this -- to be more flexible in inviting the
August 4, 2011 - Albany, NY - Public Health

of proposals that may have a benefit to hospitals.

And that's really what this debate -- this is -- that was the debate to this. This has been a debate that's been ongoing within the Department over the last year and a half where we interviewed bond counsel, interviewed Wall Street firms, we've interviewed the entities that might be interested, and come up with this proposal.

DR. STRECK: So to -- to bring this particular discussion to its first conclusion, I suspect we may have more to say about this. It was a very well, very clearly presented proposal. I think that the concerns in terms of governance carries or at some concern. And the potential benefits, least the exploration of benefits is what the department is advocating with this policy.

MR. ABEL: Now I -- I can tell you that the concerns that I've heard have been our internal concerns that we've had to struggle and try to balance a policy that will hopefully enable New York State facilities to access
August 4, 2011 - Albany, NY - Public Health

healthcare, cost capital resulting in lower cost of
state's lower cost to the Medicaid system and the
goal insurers. That -- that's the -- that's the
that have here. We clearly understand the concerns
this been expressed, and -- and we think through
inherent policy, we've -- we've -- we've addressed
procedures that we envision moving forward
with, hopefully, we will eliminate those kinds of
good concerns along the way. Did pick up a few
consider tidbits and -- and comments that we will
and move in -- in our next internal meeting on this
forward. Thank you.

DR. STRECK: So we will
view this as you're moving ahead with cautious
concurrency from the Public Health and Health Planning
Council. There will be opportunity for this group to
discuss this if members of the council wish to do so.
And certainly, with the first proposal that
should ever come before this group, we will have the
most active opportunity to discuss active parents.
So thank you for that presentation.

We'll now move to report

of the Committee on Health Planning. Dr. Rugge?