State of New York
Public Health and Health Planning Council

Minutes

August 4, 2011

The first meeting of the Public Health and Health Planning Council was held on Thursday, August, 4, 2011, at the Empire State Plaza, Meeting Room #6, Concourse Level, Albany, New York. Chairman, Dr. William Streck, presided.

COUNCIL MEMBERS PRESENT:

Dr. William Streck, Chair
Dr. Howard Berliner
Dr. Jodumutt Bhat
Mr. Christopher Booth
Dr. Jo Ivey Boufford.
Mr. Michael Fassler
Mr. Howard Fensterman
Dr. Carla Boutin-Foster
Dr. Ellen Grant
Dr. Angel Gutierrez
Ms. Victoria Hines
Mr. Robert Hurlbut
Mr. Art Levin
Dr. Glenn Martin
Ms. Ellen Rautenberg
Ms. Susan Regan
Mr. Peter Robinson
Dr. John Rugge
Dr. Theodore Strange
Dr. Ann Marie Theresa Sullivan
Dr. Anderson Torres
Dr. Patsy Yang
Commissioner Shah (ex-officio)

DEPARTMENT OF HEALTH STAFF PRESENT:

Mr. Charles Abel
Dr. Guthrie Birkhead
Ms. Rachel Block
Ms. Anna Colello
Mr. Richard Cook
Ms. Barbara DelCogliano
Mr. Christopher Delker
Ms. Sandy Haff
Mr. Jason Helgerson
Ms. Mary Ellen Hennessy
Ms. Gloria Jimpson
Ms. Lora Lefebvre
Ms. Karen Lipson
Ms. Karen Madden
Mr. Keith McCarthy
Ms. Sylvia Pirini

Ms. Linda Rush
Mr. Robert Schmidt
Ms. Kelly Seebald
Dr. Roger Sokol
Ms. Suzanne Sullivan
Ms. Jane Thapa
Ms. Lisa Thomson

INTRODUCTION:

Dr. Streck called the meeting to order and welcomed Commissioner Shah along with Council members, meeting participants and observers.

Dr. Streck informed the meeting participants that the meeting would be broadcast over the internet which would give greater access to the public.

Next, Dr. Streck reminded the audience that the New York State Temporary Commission on Lobbying is requiring that a form be filled out before entering the meeting room which records their attendance.

DR. THEODORE STRANGE

Dr. Streck welcomed Dr. Theodore Strange who had just been appointed as a new member of the Council filling Mr. Friedman's vacant seat. He announced that Dr. Strange was a former member of the Public Health Council.

MEETING OVERVIEW:

Dr. Streck gave a brief overview of what would be covered at the Council meeting.

Dr. Streck then introduced Commissioner Shah to give a report of the Department of Health Activities.

REPORT OF THE DEPARTMENT OF HEALTH ACTIVITIES:

Commissioner Shah began his report by welcoming the members.

MARRIAGE EQUALITY

Commissioner Shah announced that on June 24, 2011, Governor Cuomo signed the Marriage Equality Act into law. The Department has updated and printed new State marriage license forms and distributed 150,000 forms to county clerks before the law became effective July 24th. He also informed members, the Department also conducted a series of webinars to provide local clerks with information about the new law and answer questions regarding their new responsibilities. He was pleased that this transition went well, and implementation of the new law was seamless.

MRT UPDATE

Commissioner Shah noted that the work of Governor Cuomo's Medicaid Redesign Team continues, as implementation reforms included in the State Budget passed in April. He indicated the reforms are aimed at reducing Medicaid costs while improving the quality of care for the most vulnerable New Yorkers. Currently there are 10 workgroups focusing on a variety of issues, and are in the process of implementing 73 proposals, with more to come. As the Department works to lower the rate of spending growth while improving quality, some providers face significant challenges. The Department will work with these providers during this transition to ensure the public has continued access to the health care they need. Commissioner Shah noted Jason Helgerson would give more specifics on several of the workgroups, but he wanted to highlight the work of one workgroup in particular as an example of how we are progressing.

BROOKLYN HOSPITALS/HEALTH CARE SYSTEM

Commissioner Shah stated that he asked Stephen Berger to chair a workgroup that will assess the strengths and weaknesses of the Brooklyn health care 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 high-quality, financially secure, and sustainable health care system for Brooklyn's 2 1/2 million residents. The work group hosted its first public hearing at the New York City College of Technology in Brooklyn. Hundreds of individuals provided input, and the Department is continuing to collect information from the public. Another hearing is scheduled for September. The Group will develop its recommendations and present them to the Department by November 1, 2011.

HEALTH INSURANCE EXCHANGES

Commissioner Shah commented on the federal health care reform front, New York has begun the process to develop and operate a Health Insurance Exchange, as required by the Affordable Care Act. The Exchange will be a centralized, consumer-friendly marketplace for individuals and small businesses to purchase affordable health insurance and the goal is to reduce the ranks of the uninsured with a system designed to meet our state's needs.

Commissioner Shah indicated that he serves on the Governor's task force to develop a framework for a Health Insurance Exchange in New York. Based on the task force recommendations, Governor Cuomo introduced a program bill to establish a Health Insurance Exchange that would enhance access to affordable, quality health care for all New Yorkers. The State Assembly approved this legislation prior to the end of this year's legislative session. Although the Senate did not take up the bill, they have indicated they may take up this issue later this year. Dr. Shah will update the members on the status.

ALL PAYER DATA BASE

Commissioner Shah noted the need for solid and comprehensive data. Advancing health care transformation in an effective and accelerated manner requires a broader view of population health and the performance of the health care system than any currently available data resources permit. The data resources reflect the same fragmentation of health and health care that the

Department is trying to eradicate. The problem cannot be solved using the same tools. Commissioner Shah indicated that the Department is now leading an ambitious effort to establish an all payer data base, starting with claims data and considering possible enhancements to link with SPARCS, public health and other data bases. The Department is actively working with a variety of stakeholders to formulate a short- and long-term plan, which Rachel Block would describe in her report.

ORGAN DONATION

Commissioner Shah commented that the Department is working to increase the number of New Yorkers enrolled in the State's Organ and Tissue Donor Registry. The last week in July, Dr. Shah was joined by federal, state and local officials and transplant recipients at a media event in New York City to announce a new partnership to encourage people to "Give the Gift of Life" by signing up to be an organ donor. New Yorkers represent approximately 10 percent of the entire national organ transplant waiting list. Each year, 1,200 New Yorkers receive an organ transplant. However, an additional 9,000 state residents remain on waiting lists. Also alarming is that minority and ethnic groups make up 50 percent of the national waiting lists. DOH conducted a webinar for community-based and faith-based organizations to reach out to diverse racial and ethnic minorities for National Minority Organ Donor Day on August 1. New York is committed to strengthening and improving enrollment efforts, including the development of an online enrollment system that uses a secure, electronic signature.

TOBACCO CONTROL ADS

Commissioner Shah stated, New York continues to address the largest cause of preventable death in our State: smoking. On August 1, 2011, the Department launched a new, statewide campaign to raise awareness about the tremendous, personal toll smoking has taken on New Yorkers. The campaign includes television ads 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 rates of adult and teen smokers to well below the national averages. We anticipate that the message in these new ads will convince smokers to call the Department's Smokers' Quitline and kick the habit for life.

PUBLIC HEALTH ACCREDITATION

Commissioner Shah noted voluntary accreditation of state and local public health agencies by the national Public Health Accreditation Board will start in 2011. The goal of the accreditation process is to improve and protect the health of the public by advancing the quality and performance of state, local, Tribal and territorial public health departments. The Board has established standards for public health services, and the accreditation process will document accountability with those standards to policymakers and the public. The Department is moving forward to begin the application process. He stated that Dr. Birkhead will provide more information on the accreditation process in his remarks today.

COMMISSIONER EVENTS

Commissioner Shah noted at the last Council meeting, he believes it is important for the Department and Commissioner to take a proactive and interactive role to highlight important health issues across New York State. In a little over six months since he was confirmed as Commissioner, he had the opportunity to speak to numerous stakeholder groups, health industry leaders, health care providers, and community partners in a variety of settings.

Dr. Shah mentioned that his travels have taken him from New York City and Long Island to Lake Placid, and from Buffalo to Washington, D.C. He indicated at each stop his message has been that New York can be a national leader in public health and in the transformation of our health care system. To lead, we must move forward to develop new ideas and build stronger collaborations and partnerships to protect and sustain public health and improve health care.

Dr. Shah noted that we all share this goal and the work of the Council will help New York achieve a health system ready to the meet the challenges of the 21st century

Dr. Streck asked if Council members had questions or comments for Dr. Shah. To view the Council member's questions please refer to pages 6 through 14 of the attached transcript.

Dr. Streck thanked the Commissioner and moved to the next item on the agenda and introduced Mr. Helgerson give the report on the Office of Health Insurance Program Activities.

Report of the Office of Health Insurance Program Activities

Mr. Helgerson thanked Council members for the opportunity to give them an update on the Medicaid Resign Team. He spoke about key initiatives and the vision that the Governor laid out, and in terms of his public addresses whether it was a State of the State or the Budget address and mentioned the Governor articulated the need for substantive reform in the state's Medicaid program. New York has the largest Medicaid program in the Country, and when you look at our spending on a per person basis, we spend roughly twice as much as the national average in terms of Medicaid spending. Seeing the growing costs and the trends in costs, the reform efforts of the past and Governor Cuomo's efforts has really been to try to engage the stakeholder community in New York much more aggressively and collaboratively than perhaps has been done in the past. And that really is what led to the Medicaid redesign team. And so far, I would say that collaboration has been a success.

Mr. Helgerson commented, in terms of the M.R.T., that was created back in January through an Executive Order and was given really two tasks. The first meeting 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. At the same time, also asked to travel the state to try to identify strategies 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. He noted, 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.

He explained, there are twenty-seven members to the M.R.T., and they are actually in the final stages, and an announcement of some additional members, and some replacements of members. 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 as well as members of the legislature. The idea was that whatever recommendations ended up coming out of the M.R.T. would have to be approved by the legislature, and so we had the chairs and ranking members of the health committees in both houses of legislature who were very active participants.

PHASE ONE: Mr. Helgerson noted it led to seventy-nine distinct proposals that were recommended by the M.R.T. Those were delivered to the Governor on February 24, 2011. He accepted them as is and then proceeded to move those forward in a thirty day budget amendment that was submitted to the legislature. That bill went through that budget process. Seventy-three of the seventy-eight proposals emerged, which I think that few would have predicted possible. The vast majority of the M.R.T. is now moving into implementation phase.

PHASE TWO: He stated is 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 members are invited. In fact, the first waves of those teams have had several meetings. The topics they address are a wide array, from implementing managed long-term care, to how to encourage the development of more supportive housing, to medical malpractice reform, and payment reform.

He commented that one of the critiques of the M.R.T. was that it was only twenty-seven members, and there were a lot of people who felt that they couldn't be part of the process. Each of these workgroups is made up of usually between five and seventeen different members. Over a hundred and twenty different people will be participating in 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.

MAJOR REFORM ELEMENTS OF PHASE ONE

Implementation of a new global Medicaid cap. It applies to the Department of Health portion of the Medicaid spend, which is the vast majority. It's a two year, state share actual dollar cap, so it's actually a dollar amount of state share that we can spend this year as well as next fiscal year. And then after that, the cap grows. Actually, the cap's life is four years, and it will grow at a ten year rolling average of the medical portion of C.P.I., which has been roughly around four percent. In our view, is a significant change, and it's one of the few such programs I think it is nationally a unique effort to try to introduce a unique level of discipline into the management of the Medicaid program. In particular, the Commissioner of Health actually has what the Governor likes to call superpowers to establish mechanisms for controlling expenditures and ensuring that the program stays within those budgetary caps. It is a cap on spending, but it also gives the state the tools to rein in spending. Those measures could be

changes in provider rates or introductions of new utilization controls

Care management for all. The Department has begun a process and have had what most people call managed care in Medicaid for a couple of decades, but a major segment, particularly some of our highest cost populations, have really been left out in traditional fee for 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. 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 case management services. This is not your traditional insurance company care managed care model. There will be 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.

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

Mr. Helgerson commented 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 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 health, acute care services, and potentially long-term care. And it's a very exciting initiative where we're trying to encourage providers who typically have worked within silos to come together to form a health home, and the state will provide, initially, with ninety percent federal money, a per member per month management fee that will help those entities effectively manage the populations they serve. We anticipate that over the next year, upwards of two hundred thousand people could be enrolled. Over time, as many as seven hundred thousand to a million New York residents could benefit from health homes. We're hopeful that this will get at those high cost populations who are driving most of the costs in the Medicaid program.

Mr. Helgerson noted that not everything has been completely resolved. Many 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 not have unnecessary overlap and confusion.

There are a number of different initiatives, and what I haven't even mentioned were world behavioral health organizations, which is another effort. A lot of these are all sort of different strategies and different ways for making sure we're managing care. We're trying to 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 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. We will have a series of providers who either will be patient-centered medical homes, be part of health home networks, could be potentially integrated delivery systems, accountable care organizations that will work within that managed care environment providing the comprehensive management services that the population needs. Our belief is that fundamentally this is where cost containment in Medicaid should be focused as opposed to ever lower rates to providers.

Medical Malpractice 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 our costs for medical malpractice have grown substantially. The net result of the efforts was the creation of a very unique medical indemnity fund which will fund healthcare costs of children who are negatively impacted by negligence. And that as a result of that, we've actually already seen medical malpractice insurance costs go down by as much as twenty percent, which translates into three hundred and twenty million dollars of costs actually taken out of the healthcare system, and that's even before the medical indemnity fund has actually even been put up and running, which we anticipate on October 1st.

Mr. Helgerson indicated that the bottom line for phase one is two point three billion dollars in savings for the next fiscal year. A lot of work needs to be done to achieve that, seventy-three distinct projects. Many people in the room have been 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 the year before. Anticipated savings gross of three point three billion. The big part of was not just to look for immediate cost reductions, but also plant some seeds of meaningful reform that would help bend the cost curve in the long run. Obviously, capping the growth rate in Medicaid spending, a very important initiative. It's really changed fundamentally how we look at the budget. It's forced us to learn more as we've been publishing. If you go to our website, every month, we publish a new report in terms of tracking our expenditures. But I think the key thing is that a lot of this work really has begun. It's just the beginning, and there's a lot of work both for the M.R.T. itself and then also for the state staff who are responsible for implementation.

PHASE TWO

Mr. Helgerson noted, we have ten workgroups that are most of them, seven of them, have already been established. The final three, we're launching early next week. Those groups are going to be meeting throughout the fall. As I said, it's a unique opportunity for us to engage even more stakeholders. These are the groups, and as you can see, a wide array of topics covered. Benefit 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.

Mr. Helgerson also mentioned, payment reform, which Dr. Streck, along with Dan Sisto, will be leading the opportunity to explore how the state can encourage more fundamental changes 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 fundamentally changed the nature of the incentives in the program? The answer I would say is no, more is needed and a lot of important work there.

Mr. Helgerson stated that in terms of just timeline, as I said, all these groups are up and running. It's a lot of activity, and lots of meetings. We're hopeful beginning in October, the first sets of recommendations from the first wave of committees will start coming through, and the last waves of recommendations will come through to the full M.R.T. in November.

Mr. Helgerson explained that finally, in terms of the public, we've definitely encouraged the public to be involved. We continue to use the websites, Facebook, and Twitter are great ways to follow us online. We also have the e-mail listserv. Workgroups are holding all their meetings in public, so there are ample opportunities. Members are also holding public hearings, as was mentioned for the Brooklyn. So there's definitely more opportunities, even above and beyond the people who are on those workgroups.

Mr. Helgerson asked what does this final product of M.R.T. look like? The Department's goal is to actually take the product of the workgroups, combine that with the product of Phase One, and really put that into a comprehensive reform strategy for New York that will really lead us from a policy standpoint for the next three to five years. That's really what we're trying to accomplish.

Mr. Helgerson noted this final play may require that the state pursue a comprehensive 1115 Waiver to implement some of those changes. In particular, we're very interested in a new relationship with the federal government as it relates to dual eligibles, who are driving both Medicaid costs and Medicare costs, and who historically have not been well served by the disconnect between those two programs. And to get some of what we need about better coordination for that population, a waiver will probably be likely. But we're very excited. We think we've made a lot of progress to date, but that we still have work to do.

Mr. Helgerson advised that finally, it is always something that comes up with any meeting with providers is how we're doing relative to the global spending cap. We have spending

basically through May, so for the first two months of the fiscal year. As you can see, we have a variance overall of where spending is exceeding target by thirty-one million. That's still about only one percent of total. We're currently in the process of finalizing the analysis for June. That report will come out soon, either late this 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 monitor this very, very closely. Mr. Helgerson concluded his report and asked if there were questions.

Dr. Streck asked if Council members had questions or comments for Mr. Helgerson. To view the Council member's questions please refer to pages 30 through 54 of the attached transcript

Dr. Streck moved to the next item on the agenda and introduced Ms. Block to give the report on the Office of Health Information Technology Transformation Activities.

Report of the Office of of Health Information Technology Transformation Activities

Ms. Block began her report by updating the Council on key activities. The Department is actively pursuing the development of an all-payer database. This is pursuant to the authority given as part of the budget and in the context of M.R.T. to enhance data capability significantly so the Department can look not only at the Medicaid program, but at the totality of the healthcare system in a much more comprehensive way.

Ms. Block noted that in terms of process and timeline, the Department has convened a small stakeholder advisory council that is representative of a broad range of interests who need to be very much involved in and have a stake in the development of the all-payer database. There have been two meetings of that group, and another will be held by the end of August in order to make recommendations to the Commissioner in September.

Ms. Block advised that the Department has been actively reaching out to a number of individual organizations who have particular capacity to offer or a particular expertise. The Department is also talking to organizations that are involved in other states who have already established these all-payer databases so the Department can gain from their experience

Ms. Block explained that on July 31, 2011 the HEAL Five program was completed. The Department is now in the process of finalizing and collecting all the documentation from those projects as to the successful implementation that has been achieved by all the projects in terms of meeting project goals that they set out. Having the health information technology infrastructure available is really going to provide the necessary tools to assist clinicians, consumers, and the Department figure out how to further advance the healthcare transformation that the Commissioner described.

Ms. Block outlined next steps, the Department with the New York eHealth Collaborative and the stakeholders that they have pulled together to continue the implementation of the HEAL Ten and Seventeen programs, which have focused on supporting patient centered medical homes, connecting them to other providers in their communities who are involved in providing care for patients with chronic diseases. HEAL Seventeen, includes a focus on integrating patient centered medical homes and behavior health. The development of this infrastructure and the care coordination models that are resulting from these HEAL funded activities represent a good jumping off point in terms health homes, patient-centered medical homes, and eventually A.C.O.'s as the Department moves forward with those initiatives.

Ms. Block noted that the Department is actively outreaching to the 7 RHIOs to ensure that they are 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 advance work to make sure that those health homes can take advantage of the health information infrastructure that is available in their communities to support those care management plans that the health homes will be responsible for developing. The OHITT has worked very closely with OHIP in terms of integrating health information technology requirements into the various programs which they are moving forward with.

Ms. Block advised that the New York eHealth Collaborative and the New York City REACH program both received contracts from the federal government to implement the regional extension center program in New York State. This program is geared to primary care physicians in particular to get the certified E.H.R.'s to get them to meet the meaningful use requirements which are necessary in order for those physicians to get Medicare and Medicaid payment incentives, which are available for the next few years for that particular purpose. She expressed that she is proud to announce that there are over five thousand physicians between the two programs signed on.

Ms. Block concluded her report. To view the various members's questions and comments refer to pages 54 through 66 of the attached transcript.

Dr. Streck thanked Ms. Block for her report and moved to the next item on the agenda and introduced Dr. Birkhead to give the Report on the Activities of the Office of Public Health.

Report of the Office of Public Health Activities

Dr. Birkhead began his report by updating the Council on the work the Department has been undertaking regarding accreditation. A national group has formed called the Public Health Accreditation Board (PHAB). This is a nonprofit accrediting agency that has been put together through a combination of efforts by CDC, Robert Wood Johnson Foundation, Association of State and Territorial Health Officials, and others. This past July the PHAB issued guidance for state and local health departments to become accredited which is a measurement of health department performance against a set of nationally recognized practices and evidence-based standards. There is recognition that comes along with this of achievement of accreditation by national entity. The accreditation process is very heavily endorsed by CDC.

Dr. Birkhead explained the process and benefits of the accreditation and layed out a draft timeline. The Department at the end of year is looking into the readiness checklist to see where there are gaps that the Department needs to work on, and then begin to take an online orientation and begin to complete the prerequisites with a goal of about a year from now of having those prerequisites in place, and then the application being submitted, and the site visits occurring towards the end of 2012 or beginning of 2013.

Dr. Birkhead noted that the next steps for the Department is to work with the Public Health Committee of this Council to review the prerequisites, the prevention agenda, the state health assessment, and then the completion of this five year phase of the prevention agenda and into the next phase, which will overlap with the Department's accreditation process. Dr. Birkhead also explained other areas where the Council can assist the Department.

Dr. Birkhead stated that the accreditation will help us the Department to really develop into a higher functioning quality improvement focused organization that will hopefully result, in the end, in the improved health in the state.

Dr. Birkhead completed his report and Dr. Streck inquired if there were questions from members. Please refer to pages 67 through 80 of the attached transcript to view Dr. Birkhead's complete report and comments from Council members.

Dr. Streck thanked Dr. Birkhead for his report and moved to the next item on the agenda and Mr. Cook to give the Report on the Activities of the Office of Health Systems Management

Report of the Office of Health Systems Management

Mr. Cook began his report by bringing the Council up to date on a few issues. Mr. Cook noted one major success story is the submission of electronic CONs. The system went live in the beginning of December, and May of this year we now allow for entities that have not been established to submit applications. Since May of this year, the Department have seen almost eighty percent of the applications being submitted electronically. Before the members was a chart that shows, in the first three or four months, the overwhelming numbers of applications were actually not coming in electronically. So we are approximately at eighty percent. 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.

Mr. Cook noted there's been tremendous value internally for us in having these submitted electronically. As well as everything we've heard from the industry, it has made their lives much easier. But one of the things that we're seeing is we've already been able to document a twenty percent reduction in the number of days to go through a full C.O.N., and the Department have also been able to understand where there are opportunities for improvement. If you looked at some our data, then what you find is a significant percentage of what is sent is when the C.O.N. comes in, it is sent back to the applicant for additional information. One of the things that we're working on now is how can the Department begin to correct that back and forth in order to further expedite and make the process easier? That represents about twenty-eight percent of the

time that's necessary for a full review.

So we're learning more about ourselves, how to be more efficient. We're learning a great deal more about how we can work with the industry to try and eliminate this back and forth that exists. One of the things that we will have for the council in the fall is a performance report card that will lay this all out, and you'll be able to look at time that is required for full administrative and limited reviews, because obviously one of the things the Dr. Shah has reminded me of, and that we often hear, is the amount of time that it takes to review applications. But I think this electronic submission system has really begun to develop data for us to assess. It also has already seen pretty significant results. So I really want to compliment Charlie Abel in the Division of Health Facility 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.

Mr. Cook then discussed Brooklyn MRT and reiterated a couple of issues relating to the process that is going on led by Steve Berger. There has been one public hearing and had over sixty-eight people there who testified. We've gotten significant submissions of data, but I think the importance of this process is really two things. Number one, the Department has emphasized over and over that this is not Berger Two. This is not an effort to go in and close hospitals. This is really a regional planning effort to try and understand and assess, how do you improve the healthcare delivery system in a part of Brooklyn that right now is undergoing fiscal stress, but also faces significant poverty issues and significant inefficiencies? If you looked at Brooklyn as we have begun to look at, what you will find is a significant percentage of admissions, preventive quality indicators that are represented in Brooklyn hospitals that could be avoided with better community and preventive care. And it's about thirty-four thousand admissions that we've been able to identify. We're not criticizing the hospitals for not doing their job. If anything, the hospitals are admitting these patients because they need care. We can find ways to avoid those admissions, we will improve the health of individuals, and we will improve the cost effectiveness of the system.

Mr. Cook commented that Dr. Shah met with a group of about twenty hospitals from the northern Adirondacks who are beginning to ask the same questions that we're 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 this will lay the foundation for a series of ongoing discussions across the state of how do we assess communities? How do we then try and encourage and build community health related systems?

In closing, Mr. Cook commented that the Department received a closure plan from Peninsula Hospital. The administration of Peninsula has submitted warn notices, which are ninety day notices to employees that layoffs are imminent within those ninety days, and the closure plan is now being reviewed. The Department is working with the union, Peninsula Hospital, St. John's, and the surrounding hospitals, particularly South Nassau, and Franklin, and Jamaica, who are likely to see the impact of that closure. And right now that process is ongoing.

Mr. Cook completed his report and Dr. Streck inquired if there were questions from members. Please refer to pages 80 through 86 of the attached transcript to view Mr. Cook's complete report and comments from Council members.

Dr. Streck thanked Mr. Cook for his report and moved to the next item on the agenda Health Policy and introduced Mr. Abel and Ms. Lipson to give the Report on the Healthcare Finance and Restructuring Initiatives: Multi-State Obligation Groups and Provider Integration/Collaboration Legislation

HEALTH POLICY

Report on the Healthcare Finance and Restructuring Initiatives: Multi-State Obligation Groups and Provider Integration/Collaboration Legislation

Mr. Abel began his report by summarizing the high points of his policy paper that was distributed to Council members via email.

- MRT initiative to expand access to healthcare facilities through the formation of multi-state obligated groups. Mr. Abel then gave a definition of an obligated group applications for establishment. (See pages 87-89 for the definition). Through this initiative, M.R.T. initiative, we were asked to look at multi-state obligated groups. What would be the challenges for us to be able to co-establish through some model the Article 28 facilities with these multi-state obligated groups? They exist throughout the nation and there are very large multi-state obligated groups, and we have had discussions in the past with a couple of large obligated groups that were seeking to bring in New York State healthcare facilities.

Mr. Abel noted, the Department's obligated group establishment applications, the Department reviews the character and competence of all the members that are forming the obligated group. We examine the financial aspects of all the members. We want to make sure that the formation of this obligated group is not going to hurt any one facility, and then the aggregate will improve the financial position of the group. So we'll look at it from specifically, from the character and competence perspective, and from the financial perspective.

Multi-state obligated groups may have dozens, and there are those that have well over a hundred entities, maybe all maybe a mix of healthcare and non-healthcare in all the states. That presents, obviously, a challenge not only from the character and competence perspective, but also from the financial perspective, understanding the regulatory environment of all the states involved for all the healthcare facilities. For the non-healthcare facilities, even a greater dimension of complexity. Where does that healthcare reside in its market for its products? How can it impact on the New York State facility?

Mr. Abel stated those were the challenges that presented themselves. On the flip side, there seemed to be great benefits because many of these multi-state obligated groups already are rated and are rated very highly in the A and double A category. The prospect 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 borrowing that of an A

rated obligated group and being able to achieve a lower interest rate for a major modernization project, for example, the financial benefits are extraordinary. A project that may be a hundred and fifty million dollar project, we're talking tens of millions of dollars over the life of a loan that could be saved as a result of a New York State facility borrowing through an A rated obligated group.

Mr. Abel referred to the policy paper and how the Department handled obligated groups in the past through the establishment process. He referred to page four, it begins to lay out the proposed policy that we would like to begin to implement and to enable us to achieve those that lower cost of capital for New York State facilities who apply, who wish to join a multi-state obligated group. It facilitates 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 also more creative financing vehicles than what is currently existing in New York State.

Also, 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 we have seen from the obligated groups that have approached us. We believe it's very beneficial to not only to achieve efficiency with respect to borrowing, but efficiency with respect to best practices in operating healthcare facilities. So how would we be doing that? We are essentially proposing that we limit our character and competence review to the active parent entity. In New York State, historically, we've been able to approve and well, you folks have also approved, two different models of obligated groups. Multiple healthcare facilities with an active parent co-established operator to oversee that group. That active parent may have any one or all of the Section 405 powers that to assist 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.

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 with respect to joint borrowing. The M.T.I., the master trust indenture, is really the only entity that dictates the degree of integration of those facilities. The M.T.I. dictates what the financial conditions necessary for withdrawal. In addition to the entities to the obligated group, it dictates the conditions when a draw on assets from one or more of the entities 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 multi-state obligated group structure that would include New York State facilities, we would want to have an active parent model so that active parent model needs to demonstrate to us the ability, the capability to operate healthcare facilities with adequate character and competence and in a financially feasible manner. So our review for establishment purposes would be limited to character and competence on the board or whatever the critical decision makers are at the active parent entity, and the current compliance review for the healthcare facilities within New York State.

We are proposing that we not view the character and competence of all the board members or all the proprietary entities or whatever exists outside of New York State.

From a financial perspective, we would view look at the financial performance of the New York State entities and financial performance of the obligated group to which the New York State entities seek to join and determine that it would be beneficial for the New York State entities to join that obligated group. Where an obligated group that has a borrowing history, these entities again are generally rated by the major credit agencies, and we are proposing that the major credit agencies, at least one of the major credit agencies, has a rating that obligated group at an investment credit level, which is for our purposes a triple B level or higher. We want to make sure that there is an established track record of sound financial performance. Those credit agencies do their due diligence with respect to providing ratings for those facilities. There's extensive documentation that is available to the Department to view the financial performance history of that obligated group. Also that documentation contains any serious issues relative to the performance of the facilities that are within the obligated group. We would use those documents for character and competence purposes as well.

(Please refer to pages 87 through 121 of the attached transcript for member's comments and questions)

Dr. Streck thanked Mr. Abel for his report and moved to the next item on the agenda and introduced Dr. Rugge to give his Report on the Committee on Health Care Planning

Report of the Committee on Health Planning

Dr. Rugge reported to the Council members the first project the Health Planning Committee is looking to take on is C.O.N. review and reform. With the state having already addressed the mechanics of the process of application, we're now looking to tackle the content of the C.O.N. program. Whether this turns out to be a sandpapering exercise or more fundamental reframing is to be determined. We hope to avoid President Obama's metaphor, that being "a shellacking." It only took about five minutes of the committee's discussion to become rather feisty about what it is that drives improvement and that creates energy in the healthcare system. Is this really coming from the providers, and the C.O.N. process can only dampen that? I would observe that what drives providers, what drives change, is opportunity is driven by the combination of need and reimbursement. So certainly, in some clear way, the C.O.N. process does address our understanding of what need is.

Dr. Rugge commented that the materials we've had and the discussion we just had raised two very interesting aspects to the discussion that I think the committee will be undertaking. For one is what kind of revision of the C.O.N. is necessary with regard to establishment of new kinds of organizations, new kinds of financing arrangements? The other paper that we've all received was the proposal to establish a possible certificate of public advantage, a very interesting twist on understanding how to certify or recognize new forms of organizations and whether a certificate of public advantage might fold into C.O.N. where there might be a parallel process or whether, perhaps, the certificate of public advantage could replace the C.O.N., I think, are the kind of open questions that we as a council and as a committee might choose to address. A couple of days ago, we were to circulate a broad overview of the process by staff. There will be more information coming forward regarding the profile of the activities we've been undertaking over the last number of years to have a better handle on how we may shape the future.

In addition, we've come to understand that all of our meetings are subject to the open meetings law. Council is working very hard to find a way to have a bulletproof secure mechanism for us to do webcast meetings. And I suspect we will have such a meeting prior to the next meeting of the committee and the council face to face. I should also say that a letter has been drafted to a long list of stakeholders in the healthcare system asking for their perspectives and their recommendations regarding C.O.N. That letter is now being reviewed by the executive clearance process, I always expected existed, but had never exactly heard of before.

As we do this look at C.O.N., the committee is also expecting to have a concurrent review of current activities going on at the regional level by health planning. Clearly, any work that we do here as the PHHPC needs to dovetail with work done at a more local level and at the regional level. In addition, I would see this as preparatory for the council and the committee itself to take a look at what kind of structure of healthcare planning statewide should there be in the future. So I really see this as preparatory to another agenda item which will come forward later in our work.

Dr. Rugge noted the two strong presentations at our committee meeting, one by Jeff Kraut describing that new forms of collaboration among community leaders and providers on Long Island, America's oldest suburb, with a particular attention to disparities in healthcare and health services within the island and how to match new delivery spots and services to those populations. Also, Fran Weisberg described her efforts at hosting a community table, at bringing providers together, and really determining the nature of expansion plans institution by institution within Rochester while also more broadly at the region in terms of more rural outlying areas and what kind of health services are necessary and appropriate given the competition and the resources available in Monroe County.

In addition, another topic which will come our way, and that is how to address through the regulatory process these new kinds of institutions, be they medical homes, health homes, or accountable care organizations. To that end, in collaboration with D.O.H. and at the behest of the Commissioner, the United Hospital Fund and the primary care development corporation are sponsoring a statewide conference on medical homes in October. A conference which I expect will tee up the kinds of issues that we will then be taking on as a committee during 2012.

In closing, Dr. Rugge made a motion for approval, which was seconded by Dr. Berliner to establish a designated stoke center at Auburn Hospital. The motion to approve the applications passed.

Please refer to pages 121 through 126 of the attached transcript for member’s comments and questions.

Dr. Streck thanked Dr. Rugge for his report and moved to the next item on the agenda and introduced Dr. Boufford to give her Report on the Committee on Public Health

Report of the Committee of Public Health

Dr. Boufford reported to Council members the whitepaper that was prepared. She commented that it has been revised between the last meeting and this meeting as a result of the comments.

Dr. Boufford indicated that staff conducted a poll to members to prioritize the areas they wanted to work in. The group is very concerned, wants to concern itself with the organization capacity of the health department and all of the areas that Dr. Birkhead touched on in terms of accreditation. Especially, looking at ways in which the pretty dramatic changes in the healthcare delivery system in New York State and also New York State's application of accountable care organization activities can be used a vehicle for improving population health results.

Dr. Boufford commented that is where the funding and policy energy is and we're very keen to try to align the incentives so that providers can be even more of a force for population health in their communities. In the re-edit, we came up with a set of sort of givens, expected activities that really relate to the accreditation process and the strategic planning for the Department of Health. We hope to plan to involve in those. Similarly, if the community transformation grant comes through, to be very active as part of the prevention agenda leadership group in overseeing that. I believe there's a commitment to that group. Perhaps expanding its membership to include multiple stakeholders regardless of whether the community transformation grant comes through because there's a big role for that.

Dr. Boufford noted three other kinds of activities. One is that we wanted to stay familiar with the context in which New York State will making its changes, meaning things like the national prevention strategy, the national quality improvement strategy, and the HHS disparities plans, the national disparities plan. A number of oversight and advisory activities, some of which we hope will link very closed to what Dr. Rugge has just talked about. We would like very much like to link the work with the Health Planning Committee to the review or reinvention process to really look at the potential for a greater impact on population health in that effort and then also link it to the local health department planning activities, which was linked a couple of years ago when they were the phasing of the hospital community plans and the local health department plans was in sync. We thought that was a good idea. The idea of trying to build on those relationships that were developed during that process and see how the CON process can also motivate local planning and local stakeholder engagement.

Dr. Boufford noted they would like to follow the redesign closely, national health reform impact on the state, and I.T., however, I believe our committee ranked that lower, but I think it's in good hands with the Dr. Shah and Rachel Block, however we'll have some comments on that. The third category is leadership activities. We've had pretty good statewide representation of other sectors. Identify a couple of priority areas on the prevention agenda that are particularly linked to the most dramatic health disparities in the state and trying to see, I think, as one of our members said, how we could move the needle on one or two of those during the course of the next year or so.

Dr. Boufford explained that the Committee is very interested in promoting health in al policy approach in New York, that the decisions of multiple sectors like transportation, agriculture, and economic development all have health implications. We want to begin thinking about how those health impacts could be avoided as decision are made on the development of plans in those sectors. So our voting came out of the sort of top five and I think we realized from the vote that we do need too maybe drill down a little bit more and I think hopefully use some techniques that Dr. Rugge mentioned to get a little bit more meat on those bones before we jump on which priorities we'll take on. I think partnering on the health planning effort was everyone's first priority. I hope we can really do that.

Finally, Dr. Boufford noted a concern that was expressed at the last meeting that we really need to create some structure that allows for public access to the meetings, but also allows the committees to identify a little more closely with one another as they do their work, and also have some time where they be in a smaller space or more directly related to each other, but still giving appropriate access. We know there are going to be challenges in doing that, but we like to move in that direction.

Please refer to pages 126 through 134 of the attached transcript for member's comments and questions.

Dr. Streck thanked Dr. Boufford for her report and moved to the next item on the agenda and introduced Dr. Gutierrez to give his Report on the Committee on Codes, Regulations and Legislation

Committee on Codes, Regulations and Legislation

Dr. Gutierrez introduced regulation Amendment of Subpart 5-1 of the Title 10 NYCRR (Public Water System) and made a motion for adoption, which was seconded by Dr. Bhat. The motion to approve the regulation passed. He then introduced regulation Section 405.8 and 751.10 (New York Patient Occurrence Reporting and Tracking System (NYPORTS) for discussion.

Please refer to pages 134 through 137 of the attached transcript for member's comments and questions.

Dr. Streck then moved onto the next agenda item, the Report of the Committee on Establishment of Health Care Facilities and recognized Mr. Booth.

REPORT OF THE COMMITTEE ON ESTABLISHMENT OF HEALTH CARE FACILITIES

A. APPLICATIONS FOR CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 1: Applications Recommended for Approval – No Issues or Recusals, Abstentions/Interests

CON Applications

NO APPLICATIONS

CATEGORY 2: Applications Recommended for Approval with the Following:

- ❖ PHHPC Member Recusals
- ❖ Without Dissent by HSA
- ❖ Without Dissent by Establishment and Project Review Committee

CON Applications

Cardiac Services – Construction **Exhibit #4**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	102412 C	Buffalo General Hospital – Kaleida Health (Cattaraugus County) Interest – Mr. Booth Interest – Ms. Regan	Conditional Approval
2.	102404 C	Olean General Hospital (Cattaraugus County) Interest – Mr. Booth	Contingent Approval

Mr. Booth introduced Category Two under Applications for Construction and batched the first two Cardiac Services applications. Mr. Booth motioned for approval which was seconded by Dr. Berliner. The motion to approve the applications passed with the noted interest from Mr. Booth and Ms. Regan on application 102412 C Buffalo General Hospital – Kaleida Health and an interest was noted from Mr. Booth on 102404 C Olean General Hospital. To review the discussion, please refer to pages 140-141 the attached transcript.

Ambulatory Surgery Centers – Construction **Exhibit #5**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	111109 C	Eastern Niagara Hospital – Lockport Division d/b/a Eastern Niagara Ambulatory Surgery Center (Niagara County) Interest – Mr. Booth	Contingent Approval

Mr. Booth then introduced an application for Ambulatory Surgery Center – Construction 111109-C. He motioned for approval which was seconded by Dr. Berliner. The motion to approve the application passed with the noted interest from Mr. Booth. To review the discussion, please refer to pages 140-141 of the attached transcript.

Transitional Care Units - Construction **Exhibit #6**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	102368 T	Rome Memorial Hospital, Inc. (Oneida County) Interest – Mr. Booth	Contingent Approval
2.	102369 T	New York Hospital Medical Center of Queens (Queens County) Interest – Mr. Fassler Interest – Dr. Martin Interest – Dr. Sullivan	Contingent Approval
3.	102370 T	Good Samaritan Hospital of Suffern (Rockland County) Recusal – Dr. Torres Interest – Dr. Martin Interest – Dr. Sullivan	Contingent Approval

Mr. Booth introduced applications for Transitional Care Units – Construction 102363 T Rome Memorial Hospital, Inc. with a noted interest from Dr. Booth, 102369 T New York Hospital Medical Center of Queens, with noted interests from Mr. Fassler, Dr. Martin and Mr. Sullivan, and 102370T Good Samaritan Hospital of Suffern with noted interests from Dr. Martin, Dr. Sullivan and a recusal from Dr. Torres. Dr. Torres exited the room and Mr. Booth motioned for approval which was seconded by Dr. Berliner. The motion to approve the applications carried with the noted recusals from Dr. Torres. Dr. Torres re-entered the meeting room. See pages 142-144 of the attached transcript.

CATEGORY 3: Applications Recommended for Approval with the Following:

- ❖ No PHHPC Member Recusals
- ❖ Establishment and Project Review Committee Dissent, or
- ❖ Contrary Recommendations by HSA

NO APPLICATIONS

CATEGORY 4: Applications Recommended for Approval with the Following:

- ❖ PHHPC Member Recusals
- ❖ Establishment and Project Review Committee Dissent, or
- ❖ Contrary Recommendation by HSA

NO APPLICATIONS

CATEGORY 5: Applications Recommended for Disapproval by OHSM or Establishment and Project Review Committee - with or without Recusals

NO APPLICATIONS

CATEGORY 6: Applications for Individual Consideration/Discussion

CON Applications

NO APPLICATIONS

B. APPLICATIONS FOR ESTABLISHMENT AND CONSTRUCTION OF HEALTH CARE FACILITIES

CATEGORY 1: Applications Recommended for Approval – No Issues or Recusals, Abstentions/Interests

CON Applications

Acute Care Services – Establish/Construct **Exhibit #7**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	111388 E	Riverside Health Care System, Inc. (Westchester County)	Approval

Diagnostic and Treatment Centers – Establish/Construct **Exhibit #8**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	102147 B	Premium Health (Kings County)	Contingent Approval
2.	111183 E	Airport Imaging, LLC d/b/a Hudson Valley Imaging (Orange County)	Contingent Approval
3.	111220 B	Healthcare Partners of Saratoga, LTD (Saratoga County)	Contingent Approval

Residential Health Care Facilities – Establish/Construct **Exhibit #9**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	111347 E	CPRNC, LLC d/b/a Central Park Rehabilitation and Nursing Center (Onondaga County)	Contingent Approval

Certified Home Health Agencies – Establish/Construct **Exhibit #10**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	071074 E	***DEFERRED AT THE APPLICANT'S REQUEST** Excellent Home Care Services, LLC (Kings County)	

HOME HEALTH AGENCY LICENSURES **Exhibit #11**

Number	Applicant/Facility	COUNCIL Recommendation
1990 L	Meadowbrook Terrace, Inc. (Jefferson County)	Contingent Approval
1966 L	Chautauqua County Department of Health (Chautauqua County)	Contingent Approval

2024 L	Schuyler County Public Health Department (Schuyler County)	Contingent Approval
2025 L	Lewis County Public Health Licensed Home Care Service Agency (Lewis County)	Contingent Approval
1884 L	Crestwood Health Care Center, Inc. d/b/a Elderwood Assisted Living at Crestwood (Niagara County)	Contingent Approval
1910 L	Heathwood Health Care Center, Inc. d/b/a Elderwood Assisted Living at Heathwood (Erie County)	Contingent Approval
1981 L	Elderwood Assisted Living at Riverwood, Inc. (Erie County)	Contingent Approval

Mr. Booth introduced Category #1 application seeking approval for establishment and construction. Dr. Berliner seconded the motion to approve applications in Category #1. The motion to approve carried. To review please refer to pages 144 through 147 of the attached transcript to review Council member's comments.

CATEGORY 2: Applications Recommended for Approval with the Following:

- ❖ PHHPC Member Recusals
- ❖ Without Dissent by HSA
- ❖ Without Dissent by Establishment and Project Review Committee

CON Applications

Ambulatory Surgery Center – Establish/Construct **Exhibit #12**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	111076 B	QEASC, LLC (Queens County) Interest – Dr. Martin Interest – Dr. Sullivan	Contingent Approval

Mr. Booth introduced Category #2 applications seeking approval for establishment and construction. Mr. Booth motioned for approval on the first application for Ambulatory Surgery Center 111076-C which was seconded by Dr. Berliner. The motion to approve the application passed with the noted interests from Dr. Martin and Dr. Sullivan. To review the discussion, please refer to page 147 the attached transcript.

2.	111165 B	Queens Boulevard GI, LLC (Queens County) Interest – Dr. Martin Interest – Dr. Sullivan	Contingent Approval

Mr. Booth briefly introduced the next application 111165 and motioned for approval which was seconded by Dr. Berliner. The motion to approve the application passed with the noted interests from Dr. Martin and Dr. Sullivan. To review the discussion, please refer to pages 147-148 the attached transcript.

3.	111196 B	Syracuse Surgery Center, LLC (Onondaga County) Interest – Mr. Booth	Contingent Approval

Mr. Booth introduced the final application under Ambulatory Surgery Center heading, 111196. He motioned for approval which was seconded by Dr. Gutierrez. The motion to approve the application passed with the noted interest from Mr. Booth. Please refer to pages 148-149 of the attached transcript.

Diagnostic and Treatment Centers – Establish/Construct **Exhibit #13**

	Number	**Applicant/Facility**	**COUNCIL Recommendation**
1.	081059 B	Menorah Campus Health Services, Inc. (Erie County) Interest – Mr. Fassler	Contingent Approval

Mr. Booth then moved to Diagnostic and Treatment Center section. He briefly introduced application 081059 and motioned for approval which was seconded by Dr. Gutierrez. The application passed with the noted interest from Mr. Fassler. Please refer to page 149 of the attached transcript.

Hospice – Establish/Construct **Exhibit #14**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	102454 E	Compassionate Care Hospice of New York, Inc. (Bronx County) Interest – Ms. Regan	Contingent Approval

Mr. Booth moved to an application for Hospice. He introduced application 102454 and motioned for approval with which seconded by Dr. Berliner. Ms. Hines had concerns relative to the applicant's capabilities to fulfill multiple roles as described in the application. A vote to approval failed. Dr. Berliner made a motion to defer for one cycle so the Council can question the applicant. Dr. Grant seconded the motion. The motion to defer the application one cycle was approved. Please refer to pages 149-164 of the attached transcript for discussion on this application.

Residential Health Care Facilities – Establish/Construct **Exhibit #15**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	092035 E	Park Avenue Operating Co., LLC d/b/a Park Avenue Extended Care Facility (Nassau County) Recusal – Mr. Fensterman	Approval
2.	092037 E	Nassau Operating Co., LLC d/b/a Nassau Extended Care Facility (Nassau County) Recusal – Mr. Fensterman	Approval
3.	092038 E	Townhouse Operating Co., LLC d/b/a Townhouse Center for Rehabilitation and Nursing (Nassau County) Recusal – Mr. Fensterman	Contingent Approval
4.	092041 E	Throgs Neck Operating Co., LLC d/b/a Throgs Neck Extended Care Facility (Bronx County) Recusal – Mr. Fensterman	Approval

5.	092077 E	Bayview Nursing and Rehabilitation Center (Nassau County) Recusal – Mr. Fensterman	Contingent Approval
6.	111132 E	Amerifalls, LLC d/b/a Niagara Rehabilitation and Nursing Center (Niagara County) Recusal – Mr. Fensterman	Contingent Approval
7.	111170 E	JOPAL, Bronx, LLC (Bronx County) Recusal – Mr. Fensterman	Contingent Approval

Mr. Booth batched the following applications 092025, 092037, 092038, 092041, 092077, 111132, and 111170, for Residential Health Care Facilities and noted Mr. Fensterman's recusal. Mr. Fensterman exited the room and Mr. Booth made a motion for approval which was seconded by Dr. Berliner. Motion for approval passed and Mr. Fensterman returned to the room. Please refer to page 165 of the attached transcript.

Certificates

Certificate of Dissolution **Exhibit #16**

	Applicant	**COUNCIL Recommendation**
1.	MTC Senior Housing, Inc. Recusal – Mr. Fassler	Approval

Mr. Fassler exited the room as Mr. Booth introduced the Certificate of Dissolution and noted the recusal for Mr. Fassler. Mr. Booth motioned for approval which was seconded by Dr. Berliner. The motion for approval passed and Mr. Fassler returned to the room. Please refer to page 165 of the attached transcript.

HOME HEALTH AGENCY LICENSURES **Exhibit #17**

Number	**Applicant/Facility**	**COUNCIL Recommendation**
1708 L	Jules Home HealthCare, Inc. Interest - Ms. Regan	Contingent Approval
1731 L	Tradition, LLC Interest - Mr. Fassler Interest - Ms. Regan	Contingent Approval

1849 L	Caring Hands Home Care Services, Inc. Interest - Ms. Regan	Contingent Approval
1892 L	1st Aide Home Care, Inc. Interest - Ms. Regan	Contingent Approval
1918 L	Caring Touch Homecare, Inc. Interest - Ms. Regan	Contingent Approval
1931 L	JARME Home and Healthcare Services Corporation Interest - Ms. Regan	Contingent Approval
1924 L	Signature Care, LLC Interest - Ms. Regan	Contingent Approval
1580 L	Direct Home Care, Inc. Interest - Ms. Regan	Contingent Approval
1737 L	Reliable Choice Home Health Care, Inc. Interest - Ms. Regan	Contingent Approval
1806 L	Elite Home Services, LLC Interest - Ms. Regan	Contingent Approval
1916 L	ADJ Wisdom Home Care, Inc. Interest - Ms. Regan	Contingent Approval

Mr. Booth batched the following licensures together 1708, 1731, 1849, 1892, 1918, 1931, 1924, 1580, 1737, 1806, and 1916 with noted interests from Ms. Regan on all the applications and an interest from Mr. Fassler on 1731. He made a motion for approval which was seconded by Dr. Gutierrez. The motion for approval passed.

1930 L	Maplewood Home Care, LLC d/b/a Maplewood Home Care Recusal - Ms. Hines Interest - Mr. Booth Interest - Ms. Regan	Contingent Approval

Ms. Hines exited the room as Mr. Booth introduced licensure 1930 and noted Ms. Hines recusal and an interest from Mr. Booth and Ms. Regan. He asked for a motion of approval which was seconded by Dr. Berliner. The motion to approval passed. Ms. Hines re-entered the room.

1942 L	Glorious Home Care Agency Interest - Ms. Regan	Contingent Approval
1948 L	Liberty Resources, Inc. Interest - Ms. Regan	Contingent Approval
1908 L	Greater Harlem Nursing Home and Rehabilitation Center, Inc., d/b/a Greater Harlem Licensed Home Care Services Agency Interest - Mr. Fassler Interest - Dr. Palmer Interest - Ms. Regan	Contingent Approval
1722 L	AZA Home Health Care, LLC Interest - Ms. Regan	Contingent Approval
1974 L	Light 101, Inc. Interest - Ms. Regan	Contingent Approval
1926 L	Doral Investor's Group, LLC d/b/a House Calls Home Care Interest - Ms. Regan	Contingent Approval

Mr. Booth batched the following licensures together 1942, 1948, 1908, 1722, 1974, and 1926 with noted interests from Ms. Regan on all the applications and an interest from Mr. Fassler and Dr. Palmer on 1908. He made a motion for approval which was seconded by Dr. Gutierrez. The motion for approval passed.

CATEGORY 3: Applications Recommended for Approval with the Following:

- ❖ No PHHPC Member Recusals
- ❖ Establishment and Project Review Committee Dissent, or
- ❖ Contrary Recommendations by or HSA

NO APPLICATIONS

CATEGORY 4: Applications Recommended for Approval with the Following:

- ❖ PHHPC Member Recusals
- ❖ Establishment an Project Review Committee Dissent, or
- ❖ Contrary Recommendation by HSA

NO APPLICATIONS

CATEGORY 5: Applications Recommended for Disapproval by OHSM or Establishment and Project Review Committee - with or without Recusals

NO APPLICATIONS

CATEGORY 6: Applications for Individual Consideration/Discussion

Diagnostic and Treatment Centers – Establish/Construct **Exhibit #18**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	102159 B	Parcare Community Health Network (Kings County) Recusal – Mr. Fensterman	No Recommendation

Mr. Fensterman exited the room and Mr. Booth introduced application 102159 and noted Mr. Fensterman's recusal and the application was moving forward without a recommendation. After introducing the application, Mr. Booth turned to the Mr. Abel for some comments. Mr. Abel talked about the opposition's letter which listed 19 points upon which they based their opposition ie., need, budget and physical plant were some issues. After Mr. Abel's comments, Dr. Streck opened up for a lengthy discussion. A motion to defer was noted by Mr. Robinson and a seconded by Dr. Grant and Mr. Levin. The motion to defer failed. After discussion, a motion to approval was noted by Ms. Regan and seconded. The motion to approval passed. Mr. Fensterman re-entered the room. Please refer to pages 168-194 of the transcript.

Dialysis Services – Establish/Construct **Exhibit #19**

	Number	Applicant/Facility	COUNCIL Recommendation
1.	092072 B	Mohawk Valley Dialysis Center, Inc. (Montgomery County)	Contingent Approval

Mr. Booth introduced the final project 092072. He noted for the record that the motion to approve failed at the June 10 E/PRC meeting. After brief statement from the Department Mr. Booth made a motion for approval which was seconded by Dr. Gutierrez. The motion for approval passed. Please refer to pages 197 of the attached transcript.

ADJOURNMENT:

Dr. Streck adjourned the public portion have the meeting and moved into executive session.