1

2 NEW YORK STATE DEPARTMENT OF HEALTH

3

PUBLIC HEALTH AND HEALTH PLANNING COUNCIL

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5

6 DATE: August 4, 2011

7 CHAIRMAN: DR. WILLIAM STRECK

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10:00 2 (The meeting commenced at

3 a.m.)

4 DR. STRECK: Good morning,

5 everyone. If you could take your seats,
we're

6 about ready to begin the meeting. Thank you.

7 Let's see. Okay.

8 It's ten a.m. and we're
trying to

9 establish precedence for our new Public
Health and

10 Health Planning Council to begin promptly
and

11 operate efficient meetings. So I'm Dr.
William

12 Streck, the chair of the Public Health and
Health

13 Planning Council. I call the meeting to
order, and

14 I remind council members, staff, and
audience that

15 the meeting is subject to the opening
meeting law

16 and is broadcast over the internet. The
webcasts

17 are accessed at the Department of Health's
website.

18 The on-demand webcasts will be available no
later

19 than seven days after the meeting for a
minimum of

20 thirty days, and then a copy will be
retained in

21 the Department for four months.

22 There are certain ground
rules

23 to -- and suggestions to make the meeting

24 successful. We have synchronized captioning,
so it

25 is important for people not to talk over one

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2 another. The first time you speak, please state
3 your name and briefly identify yourself as a
4 council member or Department of Health staff. This
5 will be of assistance to the broadcasting company
6 to record the meeting. Please note that the
7 microphones are hot, meaning they pick up every
8 sound. Therefore, it's best to avoid rustling of
9 papers next to the microphone and to be aware of
10 sidebar conversations.
11 As a reminder to our audience,
12 there's a form that needs to be filled out before
13 you enter the meeting room. It's required by the
14 New York State Commission on Public Integrity in
15 accordance with Executive Law Section 166.
16 It's a pleasure today to welcome back Dr. Theodore
17 Strange as a member of the council, one of the few
18 escapees to return in recent history to the -- to
19 this work. But Dr. Strange, who was a former
20 member of the Public Health Council, now returns as
21 a new appointee to the Public Health and Health
22 Planning Council. Those of us who were able to
23 work with Ted in the past realize we are benefited
24 greatly by his reemergence as a member of our
25 group. So welcome back, Ted.

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2 DR. STRANGE: And just a
3 question, Dr. Streck. Do I have to return the
4 plaque back?
5 DR. STRECK: There will be
6 another one at the end of this term of service.
7 I'd like to provide a brief overview of the
8 activities for today. We'll begin will Department
9 of Health reports. Commissioner Shah will provide
10 his report. Mr. -- is Mr. Helgerson here today?
11 MR. HELGERSON: Yes, sir.
12 DR. STRECK: Oh, Jason, I didn't
13 see you. Good. He will give a report on the
14 Office of Health insurance program activities.
15 Ms. Block will provide an update on the Office of
16 Health insurance technology and transformation.
17 Dr. Birkhead will give a report on the activities
18 of the Office of Public Health.
19 Mr. Cook will give an update on
20 the Office of Health systems management, and then
21 we can probably all adjourn because that will be a
22 pretty comprehensive review of our activities.
23 Under the category of health policy, Ms. Lipson and
24 Mr. Abel will give a report on healthcare finance
25 and restructuring initiatives, including the

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2 multi-state obligated groups and provider

3 integration/collaboration legislation.

4 Following Ms. Lipson and

Mr.

5 Abel's report, under health planning, Dr.

Rugge

6 will give a report on the initiatives of the

health

7 planning committee, and on a request for a

stroke

8 center designation.

9 Subsequently, under public

health

10 services, Dr. Boufford will give a report on

the

11 initiatives of the Committee on Public

Health.

12 And under the category of regulation, Dr.

Gutierrez

13 will present regulations for adoption and

for

14 discussion.

15 Project review

recommendations

16 and establishment actions will be presented

by Mr.

17 Booth, as the vice chair of the committee

that has

18 addressed this. This will occur after a

luncheon

19 break. We will not serve lunch, but we will

20 adjourn the meeting at noon and reconvene at

twelve

21 thirty. At that time, the committee on

22 establishment and project review will begin

its

23 deliberations.

24 Members of the council and

most

25 of our guests who regularly attend are now

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2 with the reorganization of -- of the agenda by
3 topics or categories which capture the roles and
4 responsibilities of council. Included in this
5 format is the batching of certificate of need
6 applications so that those applications that have
7 consensus behind them are moved expeditiously
8 without any extended discussion. And the purpose
9 of this is to allow time for adequate discussion
10 of -- of those applications, either C.O.N. or
11 establishment, where more extended discussion seems
12 necessary and appropriate.
13 I'll pause for a moment to make
14 sure that all members have filled out any recusals
15 or conflicts in terms of the applicants. And with
16 that, I will move to the Department of Health
17 report. Dr. Shah?
18 DR. SHAH: Thank you, Bill. Good
19 morning. I know the council has another busy
20 agenda, so I'll just take a few minutes to give you
21 a brief update on some of the activities of the
22 Department of Health.
23 On June 24th, Governor Cuomo
24 signed the Marriage Equality Act into law. And
25 following the passage of this historic law,

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2 Department of Health actually updated and printed
3 the new state marriage license forms, distributed
4 over a hundred and fifty thousand of them to county
5 clerks before the law became effective. It was a
6 very exciting time.
7 The Department also conducted a
8 series of webinars to provide information to over
9 nine hundred local clerks with information about
10 the new law and answer questions regarding their
11 new responsibilities. I'm pleased to report that
12 this transition went very well, and implementation
13 of the new law was seamless.
14 The -- the work of Governor
15 Cuomo's Medicaid redesign team continues as we
16 implement reforms included in the state budget
17 passed in April. The reforms are aimed at reducing
18 Medicaid costs while improving quality and access
19 for most -- for the most vulnerable New Yorkers.
20 We now have ten work groups focusing on a variety
21 of issues. We're in the process of implementing
22 seventy-three proposals with more to come. And as
23 we work to lower the rate of spending growth while
24 improving quality, some providers face significant
25 challenges. We will work with those

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2 during this transition phase to ensure that the
3 public has continued access to the healthcare they
4 need.
5 Jason Helgerson will be giving
6 you more specifics on several of the working
7 groups, but I wanted to highlight the work of one
8 workgroup in particular as an example of how we are
9 progressing. Last month, I asked Steven Berger,
10 who you all know from his work on hospital
11 evaluations, to chair a workgroup that will assess
12 the strengths and weaknesses of the Brooklyn
13 Healthcare System and its future viability. The
14 group, which includes highly qualified and
15 experienced members, will solicit input and conduct
16 site visits to develop recommendations to ensure a
17 high quality financially secure and sustainable
18 healthcare system for Brooklyn's two and half
19 million residents.
20 Last week, the group hosted its
21 first public meeting at New York City College of
22 Technology in Brooklyn. Hundreds of individuals
23 provided input, and we are continuing to collect
24 information from the public. Another hearing is
25 scheduled for this September. The group

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2 develop its recommendations and present them to the

3 department by November 1st.

4 On the federal healthcare reform

5 front, New York has begun the process of developing

6 and operating a health insurance exchange as

7 required by the Affordable Care Act. The exchange

8 will be a centralized, consumer friendly

9 marketplace for individuals and small businesses to

10 purchase affordable health insurance. The goal is

11 to reduce the ranks of uninsured with a system

12 designed to meet our state's needs.

13 I serve on the governor's task

14 force to develop a framework for health insurance

15 exchange in New York. Based on the recommendations

16 of the task force, Governor Cuomo introduced a

17 program bill to establish a health -- a health

18 insurance exchange, and the state assembly approved

19 the legislation prior to the end of this year's

20 legislative session. Although the Senate did not

21 take up the bill, they have indicated they may take

22 up the issue later this year. I'll keep you

23 updated on the status of that important measure.

24 At the core of all our efforts is the need for

25 solid and comprehensive data. Advancing

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2 transformation in an effective and accelerated

3 manner requires that broader view of population

4 health and the performance of the system as a whole

5 that -- more than any current data resources

6 currently provide. Our data resources currently

7 reflect the same fragmentation of health and

8 healthcare that we are trying to eradicate. We

9 cannot solve new problems using those same old

10 tools.

11 The department is now leading an

12 ambitious effort to establish an all-payer

13 database, starting with claims data and considering

14 possible enhancements to link with SPARCS, public

15 health, and other databases. We are actively

16 working with a variety of stakeholders to formulate

17 a short and long-term plan which Rachel Block will

18 describe in a bit, in more detail.

19 I want to briefly review some of

20 the other health and public health initiatives

21 we're working on. We're working on a -- improving

22 the number of New Yorkers enrolled in the state's

23 organ and tissue donor registry. Last week, Sue

24 Kelly (phonetic spelling) and I were joined by

25 federal, state, and local officials, and

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2 recipients at a media event in New York City to
3 announce a new partnership to encourage people to
4 give the gift of life by signing up to be an organ
5 donor.
6 New Yorkers represent
7 approximately ten percent of the entire nation's
8 waiting list for organ donors -- for organs. Each
9 year, twelve hundred New Yorkers receive an organ
10 transport. However, an additional nine thousand
11 state residents remain on waiting lists, and
12 unfortunately many die while waiting. Also
13 alarming is that minority and ethnic groups make up
14 fifty percent of the national waiting list.
15 This week, we conducted a webinar
16 for community-based and faith-based organizations
17 to reach out to diverse racial and ethnic
18 minorities for National Minority Organ Donor
19 Awareness Day on August 1st. New York is committed
20 to strengthening and improving enrollment efforts,
21 including the development of an online enrollment
22 system that uses a secure electronic signature. We
23 are confident that we can significantly improvement
24 enrollment in organ -- in the organ registry, which
25 will save lives.

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2 New York continues to address the

3 largest cause of preventable death in our state:

4 smoking. On August 1st, the department launched a

5 new statewide campaign to raise awareness about the

6 tremendous personal toll smoking is taking on New

7 Yorkers. The campaign includes television ads,

8 which you may have seen, and radio spots featuring

9 real people talking about how their lives have been

10 adversely affected by severe health problems caused

11 by years of smoking. New York's tobacco control

12 program has achieved significant success in

13 reducing the rate of adult and teen smokers to well

14 below national averages. We anticipate that these

15 new ads will convince smokers to call the

16 department's smokers quit line and kick the habit

17 for life.

18 As a final note on public health,

19 the national Public Health Accreditation Board will

20 begin voluntary accreditation of state and local

21 public health agencies this year. The board has

22 established standards for public health services,

23 and the -- and the accreditation process will

24 document accountability with those standards to

25 policymakers and the public, thereby

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2 quality and performance of public health
3 departments throughout this country. Dr. Gus
4 Birkhead will provide more information on this
5 application process in his remarks today.
6 As I noted in our last council meeting, I believe
7 it is important for the department to take a
8 proactive and interactive role to highlight
9 important health issues across New York State. In
10 a little over six months since I was confirmed as
11 commissioner, I've had the opportunity to speak to
12 numerous advocates, health industry leaders,
13 healthcare providers, and community partners in a
14 variety of settings. My travels have taken me from
15 New York City and Long Island to Lake Placid, and
16 from Buffalo to Washington, D.C. At each stop, my
17 message has been that New York can be a national
18 leader in public health and in the transformation
19 of our healthcare system. To -- to lead, we must
20 move forward to develop those new ideas and build
21 stronger collaborations and partnerships to protect
22 and sustain public health and improve healthcare.
23 I know we all share this goal. Your work today
24 will help New York achieve a health system ready to
25 meet the challenges of the twenty-first

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2 Thank you. This concludes my report.
3 DR. STRECK: Thank you,
4 Commissioner. Are there questions/comments for the
5 Commissioner? All right. Then we will thank the
6 Commissioner and move on to Mr. Helgerson and the
7 report of the Office of Health insurance program
8 activities. Jason?
9 MR. HELGERSON: All right. Well,
10 good morning, and it's a pleasure to be here. It's
11 my first visit to PHHPC, and I'm glad to give -- be
12 given the opportunity to give you an update in
13 terms of where we're at with regards to the
14 Medicaid redesign team and its process.
15 A lot has happened in the last
16 seven months. This is our July update. I won't
17 spend too much of your time going through it; it's
18 available on the website. But I thought I could
19 use today as an opportunity to give you some update
20 on some of the key initiatives and also discuss a
21 little bit where we're at with regards to phase two
22 of the Medicaid redesign team's efforts, which will
23 take us to the end of this calendar year.
24 So first off, in terms of the -- actually, the
25 vision that the governor laid out, and --

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2 think the governor, in -- in -- both in terms of
3 his public addresses, whether it was a state of the
4 state address or the budget address, really, I
5 think, clearly articulated the need for substantive
6 reform in the state's Medicaid program. New York
7 has the largest Medicaid program in the country,
8 and when you look at our spending on a per person
9 basis, we spend roughly twice as much as the
10 national average in terms of Medicaid spending.
11 And so seeing that and seeing the growing costs and
12 the -- and the trends in costs, the -- the governor
13 felt strongly that substantive reform is necessary.
14 But I think the big difference between reform
15 efforts of the past and Governor Cuomo's efforts
16 has really been to try to engage the stakeholder
17 community in New York much more aggressively and
18 collaboratively than perhaps has been done in the
19 past. And that really is what led to the Medicaid
20 redesign team. And so far, I would say that that
21 collaboration has been a success.
22 In terms of the M.R.T., we were
23 created back in January through an executive order
24 and was given really two tasks. Or as people, and
25 Dr. Streck, and the Commissioner, and both

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2 of the Medicaid redesign team know, that at that
3 first meeting when we went around and gave these
4 new members an opportunity to speak, folks like to
5 think of the M.R.T. as sort of two teams. Team
6 number one was given the unenviable task of trying
7 to find roughly two point three billion dollars in
8 savings for this fiscal year, and basically it's
9 come up with that plan in roughly two months. A
10 huge task, and at the same time, also asked to
11 travel the state to try to identify strategies
12 and -- and tap into the knowledge and expertise of
13 all the residents of New York.
14 Team two was given the task of
15 really looking at some more substantive longer-term
16 reform efforts. And interestingly, or probably not
17 surprisingly, when folks were given an opportunity
18 to speak at that first meeting, they expressed a
19 higher degree of interest in team two than they did
20 in team one. But I can say that despite the
21 challenge, the team really embraced this effort,
22 and the efforts of the group were substantial.
23 There are twenty-seven members to the M.R.T., and
24 we're actually in the final stages, and an
25 announcement probably later today of some

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2 additional members, some replacements of members.
3 But the idea with the M.R.T. was really to bring
4 together a diverse set of stakeholders, including
5 obviously representatives from the healthcare
6 industry, but also consumer representation,
7 representatives from business. Also included were
8 members of the legislature. The idea was that
9 whatever recommendations ended up coming out of the
10 M.R.T. would have to be approved by the
11 legislature, and so we had the chairs and ranking
12 members of the health committees in both houses of
13 legislature who were very active participants.
14 So phase one, which, as I said, began in January,
15 led to seventy-nine distinct proposals that were
16 recommended by the M.R.T. Those were delivered to
17 the governor on February 24th. He accepted them as
18 is and then proceeded to move those forward in a
19 thirty day budget amendment that was submitted to
20 the legislature. That bill went through that
21 budget process. And out on the other end,
22 seventy-three of the seventy-eight proposals
23 emerged, which I think that few would have
24 predicted possible. But we're very excited about
25 the fact that the -- the vast majority of

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2 of the M.R.T. is now moving into implementation
3 phase.
4 Phase two, which, as I mentioned,
5 was more focused on comprehensive reform. We are
6 now divided up into, as Commissioner Shah
7 mentioned, ten workgroups. The final three are
8 going to be launched early next week. The rest are
9 now already beginning to engage, and -- and -- and
10 members are invited. In fact, the first wave of
11 those teams have had several meetings. The topics
12 that they address are a wide array, from
13 implementing managed long-term care, to how to
14 encourage the development of more supportive
15 housing, to medical malpractice reform, to payment
16 reform. A wide array of issues are being
17 addressed.
18 What I think is also exciting,
19 and one of the sort of critiques of the M.R.T. was
20 that it was only twenty-seven members, and there
21 were a lot of people who felt that they couldn't be
22 part of the process. Each of these workgroups are
23 made up of usually between five and seventeen
24 different members. Over a hundred and twenty
25 different people will be participating in

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2 workgroups, so we definitely think that the

3 workgroups have given us a great opportunity
to

4 expand the scope and net of participation by
the

5 stakeholder community.

6 The recommendations of
these

7 workgroups will be delivered in whole to the

8 governor by December of 2011 for his
consideration

9 in the -- in the next budget.

10 So I'll skip ahead to the
major

11 reform elements of phase one. Arguably, the
-- the

12 most significant reform element in phase one
was

13 the implementation of a new global Medicaid
cap.

14 It applies to the Department of Health
portion of

15 the Medicaid spend, which is the vast
majority.

16 It's a two year, state share actual dollar
cap, so

17 it's actually a dollar amount of state share
that

18 we can spend this year as well as next
fiscal year.

19 And then after that, the cap grows. And
actually,

20 the cap's life is four years, and it will
grow at a

21 ten year rolling average of the medical
portion of

22 C.P.I., which has been roughly around four
percent.

23 And so this, in our view, is a significant
change,

24 and it's one of the few such programs -- in
fact, I

25 think it is nationally a unique effort to

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2 try to introduce a unique level of discipline into
3 the management of the Medicaid program. In
4 particular, the Commissioner of Health actually has
5 what the governor likes to call superpowers to
6 establish mechanisms for controlling expenditures
7 and ensuring that the program stays within those
8 budgetary caps. So it is a -- it is a cap on
9 spending, but it also gives the -- the state the
10 tools to rein in spending. Those measures could be
11 changes in provider rates or introductions of new
12 utilization controls. And so we've been monitoring
13 expenditures very closely, and I'll talk a little
14 bit about later.
15 Next is moving to care management
16 for all. We've begun a process. We've had what
17 most people call managed care in Medicaid for a
18 couple of decades, but a major segment,
19 particularly some of our highest cost populations,
20 have really been left out in traditional fee for
21 service Medicaid where they have to navigate
22 between a disparate set of really unconnected
23 providers with little support from the state or
24 anyone else in terms of making sure they're
25 accessing the services they need.

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2 The M.R.T. set the state on a
3 three year progression towards getting the state
4 out of the fee for service business. And what that
5 will mean is that the state will contract with a
6 variety of different entities to provide case
7 management services. I want to emphasize, this is
8 not your traditional insurance company care --
9 managed care model. We will have some insurance
10 companies participating, as we do today, but we
11 also look to other unique groupings of providers
12 who come together to form care management
13 organizations.
14 We also know that, as we move,
15 some of the special populations, whether it's brain
16 injury waiver populations or people who are
17 currently in self-directed waiver populations for
18 long-term care services, that we need to look at
19 the benefit package and the care management
20 strategies, the contracts, and make sure that those
21 contracts and -- and strategies reflect the unique
22 needs of these special populations.
23 Also contained in the M.R.T. is a significant
24 expansion on the state's efforts in patients that
25 are in medical homes and the launching of a

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2 concept called "health homes." Almost a
million
3 New York Medicaid residents already benefit
from
4 having access to primary care through
5 patient-centered medical homes as recognized
by
6 N.C.Q.A. We want to expend that number even
7 further, potentially by another million. In
8 addition, there's a new concept called "
health
9 homes," which is an even more comprehensive
effort
10 around effectively coordinating care between
11 providers that includes social supports,
behavioral
12 health, you know, obviously acute care
services,
13 potentially long-term care. And it's a very
14 exciting initiative where we're trying to
encourage
15 providers who typically have worked within
silos to
16 come together to form a health home, and the
state
17 will provide, initially, with ninety percent
18 federal money, a per member per month
management
19 fee that will help those entities
effectively
20 manage the populations they serve. We
anticipate
21 that over the next year, upwards of two
hundred
22 thousand people could be enrolled. Over
time, as
23 many as seven hundred thousand to a million
New
24 York residents could benefit from health
homes.
25 And really, we're hopeful that this will

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2 get at those high cost populations who really are

3 driving most of the costs in the Medicaid program.

4 So just to -- and this just to give you a sense

5 that not everything has been completely resolved.

6 A lot of these strategies that have been launched,

7 either in the past or more recently, we are working

8 with stakeholders through the M.R.T. to come up

9 with ways to ensure that these coordination

10 strategies are, basically, integrated into a

11 comprehensive plan that will ensure that our

12 members are getting the services, but we do not

13 have unnecessary overlap and confusion.

14 As you can see, there's a number of different

15 initiatives, and what I haven't even mentioned were

16 word behavioral health organizations, which is

17 another effort. A lot of these are all sort of

18 different strategies and different ways for making

19 sure we're managing care. And so what we're trying

20 to do is come up with a strategy like this where we

21 actually attempt to make sure that we have a

22 coherent strategy.

23 This is still a draft. It will

24 continue to evolve. I think it's important to say

25 that our vision is that within say three to

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2 years, all Medicaid recipients will be enrolled in

3 some kind of care management organization that has

4 basically a fully integrated capacity to manage the

5 overall health and long-term care as well as

6 behavior health needs of that population. That we

7 will have a series of providers who either will be

8 patient-centered medical homes, be part of health

9 home networks, could be potentially integrated

10 delivery systems, accountable care organizations

11 that will work within that managed care environment

12 providing the comprehensive management services

13 that the population needs.

14 Our belief is that fundamentally

15 this is where cost containment in Medicaid should

16 be focused as opposed to ever lower rates to

17 providers.

18 And then, finally, in terms of

19 major initiatives, medical malpractice reform.

20 This is something that came up through the process,

21 probably one of the more controversial elements of

22 the M.R.T. in terms of its discussions. But

23 there's a strong belief that particularly in New

24 York City that our costs for medical malpractice

25 have grown substantially. The net result of

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2 the efforts was the creation of a very unique

3 medical indemnity fund which will fund healthcare

4 costs of -- of children who are negatively impacted

5 by negligence. And that as a result of that, we've

6 actually already seen medical malpractice insurance

7 costs go down by as much as twenty percent, which

8 translates into three hundred and twenty million

9 dollars of costs actually taken out of the

10 healthcare system, and that's even before the

11 medical indemnity fund has actually even been put

12 up and running, which we anticipate on October 1st.

13 So I will skip ahead to -- the bottom line for

14 phase one is two point three billion dollars in

15 savings for the next fiscal year. A lot of work

16 needs to be done to achieve that, seventy-three

17 distinct projects. And many people in the room

18 have been very involved in this in terms of trying

19 to get all those projects implemented in a timely

20 fashion. It's really keeping us all extremely busy

21 this summer.

22 Also, a number of these reforms

23 actually will save more money next year and the

24 year before. Anticipated savings gross of three

25 point three billion. And the big part of

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2 was not just to look for immediate cost reductions,

3 but also plant some seeds of meaningful reform that

4 would help bend the cost curve in the long run.

5 Also, obviously, capping the growth rate in -- in

6 Medicaid spending, a very important initiative.

7 It's really changed fundamentally how we look at

8 the budget. It's forced us to learn a lot more as

9 we've been publishing. If you go to our website,

10 every month, we publish a new report in terms of

11 tracking our expenditures.

12 But I think the key thing is is

13 that a lot of this work really has begun. It's

14 just the beginning, and there's a lot of work both

15 for the M.R.T. itself and then also for the state

16 staff who are responsible for implementation.

17 So just a quick update in terms of phase two. As I

18 think I mentioned, we do have ten workgroups that

19 are -- most of them -- seven of them have already

20 been established. The final three, we're launching

21 early next week. Those groups are going to be

22 meeting throughout the fall. As I said, it's a

23 unique opportunity for us to engage even more

24 stakeholders. These are the groups, and as you can

25 see, a wide array of topics covered. Dr.

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2 instance, is going to be leading the basic

benefit

3 review, which is really an effort by us to

4 comprehensively look at the Medicaid benefit,

which

5 hasn't been looked at in many, many years to

6 whether or not we're encouraging the most

cost

7 effective healthcare by the things that we

covered,

8 the cost sharing policies we have in place.

9 Also mentioned, payment reform, which Dr.

Streck,

10 along with Dan Sisto, will be leading. I

think

11 opportunity to explore how the state can

encourage

12 more fundamental changes in -- in the way we

pay

13 for healthcare. As we said before, even if

we move

14 everybody in the Medicaid program to care

15 management strategies, if all that happens

is those

16 same managed care organizations just use fee

for

17 service as their methodology, have we realty

18 fundamentally changed the nature of the

incentives

19 in the program? The answer I would say is -

- is --

20 is no, and that more is needed and a lot of

21 important work there.

22 So in terms of just

timeline, as

23 I said, we're -- we've got -- all these

groups are

24 up and running. It's a lot of -- lot of

activity,

25 lots of meetings. But we're really hopeful

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2 beginning in October, the first sets of
3 recommendations from the first wave of committees
4 will start coming through, and the last waves of
5 recommendations will come through to the full
6 M.R.T. in November.
7 So just, finally, in terms of the
8 public, we've definitely encouraged the public to
9 be involved. We continue to use the websites.
10 Facebook, Twitter are great ways to follow us
11 online. We also have the e-mail listserv.
12 Workgroups are holding all their meetings in
13 public, so there's ample opportunities. Member
14 workers are also holding public hearings, as was
15 mentioned for the Brooklyn. So I think there's
16 definitely more opportunities, even above and
17 beyond the people who are on those workgroups.
18 So what does this final product of M.R.T. look
19 like? Our goal is to actually take the product of
20 the workgroups, combine that with the product of
21 phase one, and really put that into a comprehensive
22 reform strategy for New York that will really lead
23 us from a policy standpoint for the next three to
24 five years. That's really what we're trying to
25 accomplish.

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

15 And then, finally, it's
always
16 something that comes up with any meeting
with
17 providers is how we're doing relative to the
global
18 spending cap. We have spending basically
through
19 May, so the -- for the first two months of
the
20 fiscal year. As you can see, we have a
variance
21 overall of where spending is exceeding
target by
22 thirty-one million. That's still about only
one
23 percent of total. We're currently in the
process
24 of finalizing the analysis for June, which
will
25 give us the quarter of the fiscal year's

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2 That report will come out soon, either late this
3 week or early next. But generally speaking, we
4 feel like we're staying within striking distance of
5 the target, but that we need to continue to monitor
6 this very, very closely.
7 So with that, I can answer your
8 questions.
9 DR. STRECK: Thank you, Jason.
10 Questions for Mr. Helgerson? Mr. Robinson?
11 MR. ROBINSON: Thanks. That was
12 a great report. One of the things that you're
13 working on is obviously coordination of care. One
14 thing that doesn't seem to be up there -- it may be
15 beyond the scope of M.R.T. -- is structural
16 reorganization within the state. I'm talking
17 specifically about the Office of Mental Health and
18 O.M.R.D.D., and maybe Commissioner Shah is the
19 right person to answer that. But it strikes me
20 that if you want to do the right kind of
21 coordination and eliminate silos, one thing to put
22 on the table for consideration, whether the M.R.T.
23 is the forum or not, is a look at how we're
24 structuring government oversight of -- of the
25 healthcare delivery system in totality.

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2 DR. SHAH: Sure. So I can answer

3 that. So Paul Francis has reconstituted SAGE. And

4 at the state level, we're looking across all the

5 agencies to figure out how to move that process

6 forward over the next few months. So you know,

7 we -- several steps forward, we took a pause,

8 and -- and we had our first meeting just a few days

9 ago. And we're -- we're beginning that work

10 exactly along those lines to look at those

11 efficiencies across all state government. But

12 specifically in health is where I'm involved.

13 DR. STRECK: Mr. Fassler?

14 MR. FASSLER: At a prior meeting,

15 the Commissioner presented a vision of hospitals

16 being O.R.'s, E.R.'s, and you know, basically

17 having patients as they get -- soon being

18 transferred to nursing homes in hospitals. With

19 the M.R.T.'s process how will this be accomplished?

20 MR. HELGERSON: You mean in terms

21 of like fundamentally restructuring the -- the

22 nature of hospitals and how they -- and the

23 services that they perform?

24 MR. FASSLER: So that a more

25 sick -- more acute patient goes to a nursing

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

5 MR. HELGERSON: Sure. And

6 Commissioner, you want to --?

7 DR. SHAH: Yeah. I mean,
I -- I
8 think the -- the -- the -- the vision I was

9 painting is that people get the level of
care in
10 the least intensive setting possible for
their
11 needs. So it -- it's not about pushing
patients
12 out of the hospital. It's about getting the

13 appropriate care, whether you're in the
hospital or
14 in the nursing home or in primary care, both

15 upstream and downstream. And -- and -- and
that's
16 the vision of the future. Not only my
vision, I
17 think it's the federal vision of -- in terms
of how
18 do realign the healthcare system to meet
those
19 needs.

20 M.R.T. is working very
strongly
21 in many of its efforts. You talked -- we
talked a
22 little bit about medical homes and
strengthening
23 the primary care upstream capacity. Maybe
more
24 patients with better coordinated care will
stay
25 there as opposed to going to emergency rooms,

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2 may be too high a level of care for many of those
3 patients. And downstream as well, with the whole
4 subcommittee entirely looking at long-term care.
5 So M.R.T. is front and center in all of these
6 efforts to redesign the healthcare system.
7 MR. HELGERSON: Right. I would
8 say -- I want -- just adding to that is that the
9 care management for all strategy, I think that the
10 more integrated that care management is and -- in
11 creating financial incentives within a capitation
12 or near capitation environment to -- not only to
13 get people to most appropriate environment for care
14 and -- and basically hopefully relying less on the
15 institutions and more upstream provision of
16 services, but also, for instance, moving nursing
17 home residents into care management organizations.
18 We're convinced that there are thousands of -- of
19 people in nursing homes today that frankly would
20 prefer not to be there, their families would prefer
21 not to be there, that there are opportunities. But
22 historically the state, because of lack of
23 resources, hasn't really had the -- the -- the
24 boots on the ground, so to speak, to really
25 effectively help those families move to

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2 and -- and -- and more appropriate settings.
3 And so I think that care management
4 organizations will be far more effective at -- at doing that.
5 And I think those are the -- once you put those
6 things all within capitation, you create the right
7 set of financial incentives for that kind of
8 creativity and work.
9 DR. STRECK: Dr. Gutierrez?
10 DR. GUTIERREZ: In your
11 slide number twenty-seven, "How the public can get
12 involved," I notice that everything is web
13 related. And I don't think the Medicaid recipients
14 are truly able to avail themselves to that. I think
15 that some other way of -- should be created to
16 facilitate the clientele to reach these
17 groups. MR. HELGERSON: Understood.
18 And then I think that's what -- one -- one of
19 the things we're trying to do with regards to
20 the workgroups are that the workgroup meetings
21 are public, and they are being held across the
22 state in various locations. So in the case of the --
23 obviously, the people of Brooklyn have a
24 high degree of interest in what recommendations
25 are about changes to or improvement in the

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2 delivery system in Brooklyn. And that's why it's
3 very important that a public hearing was held in
4 Brooklyn at -- at a place that was, in our view,
5 fairly accessible. But we'll continue to hold
6 those public hearings and -- and try to make it
7 as -- as available to the -- to the public as -- as
8 we possibly can.
9 DR. STRECK: Dr. Rugge?
10 DR. RUGGE: Thanks for the
11 presentation. Could you comment on -- for -- with
12 regard to health homes, the enrollment process, and
13 also payment methodology and payment levels that
14 are to be anticipated?
15 MR. HELGERSON: Sure. In terms
16 of health homes, we are working on a very fast
17 track. The application for health homes is
18 actually now available on the website, and so I
19 know there's a lot of activity and interest around
20 this.
21 The -- in terms of enrollment
22 process, we are identifying populations that meet
23 the current federal requirements in terms of
24 eligibility. So it's people with multiple chronic
25 conditions or who have a diagnosis of AIDS

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2 H.I.V. who will be eligible for health home
3 enrollment. We're going to be sort of phasing that
4 enrollment in over time, but the idea is that we're
5 hoping that we will have health homes certified.
6 We'll have -- applications are actually due to us,
7 I believe, September 1st, and we're going to be
8 enrolling the first individuals into health homes
9 on October 1st.
10 But I think what's important to
11 point out is that what does enrollment mean? That
12 means that health homes will be assigned members
13 and given information about those members, but the
14 health homes themselves will be responsible for
15 actually reaching out to that -- those members and
16 actually getting them to document that they're
17 willing to participate in health home. And
18 basically, health homes will have three months to
19 accomplish that. So that's one of the reasons
20 we're encouraging health homes to tap into
21 community based organizations, because those
22 community based organizations will often be really
23 effective partners in identifying some of these
24 people, particularly those who are the ones we
25 really need to get our arms around the most,

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2 are the folks who are intermittent users of
3 healthcare, folks who bounce in and out of
4 emergency rooms with significant behavioral
health
5 needs. So it's -- there's a lot of work
being done
6 on it.
7 DR. RUGGE: And the money?
8 MR. HELGERSON: Oh, yes,
the
9 money. Everyone asks about the money. So
the --
10 we'll be posting very shortly what the
actual
11 P.M.P.M. amounts will be. It's just there's
a
12 little bit of tweaking, I think, being done
there.
13 But the idea is that it's a per member per
month
14 management fee. We're benchmarking it to
existing
15 care management programs and looking at some
other
16 states. But that amount will vary depending
on the
17 level of acuity of the patient. So a
patient with
18 higher levels of acuity, higher levels of
need,
19 the -- the health home would receive a
higher level
20 of payment. So there will be some -- some
21 variation.
22 DR. RUGGE: Just to say it,
23 it's -- it's difficult to plan a program
until one
24 knows, number one, how many enrollees and
what
25 level of acuity they have, and then in --

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2 turn, what resources are available to care for
3 population. So I gather the initial applications
4 just indicate there would be some capacity and some
5 ability to reach out without any specifics with
6 regard to what's to be done on the ground?
7 MR. HELGERSON: That's correct.
8 So in -- in the early phases of this, there's sort
9 of two things going on. One is enrolling people
10 who are currently sort of out there in the fee for
11 service world or out there in sort of unconnected
12 care who have high acuity and we want to connect to
13 care, really, some -- some of those cases for the
14 first time. We're also proposing to convert people
15 who are in existing care management programs,
16 including targeted case management, over to
17 becoming health homes. Those are people who we do
18 know of who are connected to a provider of care
19 management services. There's a little bit of both
20 going on.
21 But yes, I mean, I -- one of the
22 challenges we have is that these are people who
23 haven't had a lot of connection. We'll -- we will
24 be providing health homes with information about
25 them to the extent we have it. But I think

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2 the challenges that the health homes are going to
3 have -- and then also, I should -- should mention
4 from the payment side that there's also gain
5 sharing on the back end with health homes, that up
6 to fifteen percent of the savings, state savings,
7 that's generated from better care management will
8 go back to the health home. So our hope is that
9 the health homes will effectively identify these
10 people, reach out to them, sign them up, get them
11 into better care coordination, and then as a
12 result, both the state and the health home will see
13 savings from it.
14 DR. STRECK: Dr. Bhat, then --
15 then Ms. Hines.
16 DR. BHAT: Thank you. You
17 mentioned about the dually eligible,
18 Medicare/Medicaid. I think the proposal is to take
19 away the twenty percent that's going to pay as the
20 co-payment. An analysis in this fee is one where
21 sixty to seventy percent of the patients are dually
22 eligible. Taking off the twenty percent off the
23 table, the whole industry is going to have severe
24 consequences because they cannot just function.
25 The industry as a whole has approached the

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2 people and won't be looking at it because that's
3 probably one of the quirks of just across the board
4 making a move to just take the twenty percent off
5 the table. That's something that already being
6 addressed, and I'm pretty sure that Department of
7 Health will probably come up with some kind of a
8 solution for that.
9 And the question that I have for
10 Dr. Shah is saying that there's increasing evidence
11 that -- especially in the downstate area where I'm
12 practicing, a lot -- lot of people do not have
13 where -- I think their knowledge about healthcare
14 is very little, that literally health illiteracy is
15 probably about eighty percent in Brooklyn and parts
16 of Queens. In all the reforms that we are doing
17 here, is anybody looking at the health literacy as
18 well -- addressing that issue?
19 DR. SHAH: Yes. Actually, we
20 have a working group as part of M.R.T. looking at
21 disparities. And as part of the disparities
22 working group, that's a forum where issues such as
23 health literacy can be addressed and specific
24 policies, certainly -- not only health, but
25 language, there are many other barriers that

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2 these disparities. That's the forum where

any

3 potential reform ideas can be introduced.

So we

4 have a specific committee that will look at

that.

5 And Dr. Birkhead, who will speak a little

later, is

6 supporting that committee.

7 DR. STRECK: Ms. Hines?

8 MS. HINES: Good morning.

So

9 clearly, change is happening at an

impressively

10 rapid pace, and it will have both intended

and

11 unintended consequences. And since it's

driven

12 largely by financial targets, I wonder is

there a

13 framework or a process around which we will

assess

14 the impact on access and quality?

15 MR. HELGERSON: Very good

16 question. So one of the things that the

payment

17 reform committee, not that it doesn't have a

broad

18 enough scope as it is, is also going to be

looking

19 at -- we -- we, as a state, have used a

variety of

20 measures to measure the overall

effectiveness of

21 the Medicaid program. To be honest, those

measures

22 have really been focused primarily on those

23 populations currently enrolled in managed

care

24 where we have a paper form and strategy and

25 measures that are published on an annual

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2 But whole swaths of our population, long-term care
3 for instance, we have not had a very effective
4 assessment mechanism of quality and access. And so
5 what we're going to be also doing is looking at
6 making sure we come together with a comprehensive
7 set of measures that really look across the entire
8 roughly five million people who are enrolled in the
9 Medicaid program and the full scope of services
10 that are provided. And then within those measures
11 that we identify as the ones that are most relevant
12 and important, the ones we really need to track
13 against, is really just that short-term, mid-term,
14 and long-term goals for those measures. And then
15 track that very closely because, as you mentioned,
16 there are unintended consequences to any type of
17 reform. And you have to be watching for those very
18 closely, especially when you're proceeding at a
19 pace that we are in terms of how -- how much we
20 have to save in such a short time.
21 So our hope is that by
22 identifying those key measures, setting those
23 goals, and then monitoring that and being very
24 transparent about the monitoring of that, that we
25 collectively, not just the state health

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2 but the entire stakeholder community who care about
3 these individuals as well as the services, that we
4 collectively can see how we're doing, and then, if
5 necessary, change path, make modifications to
6 proposals, do different things to help us minimize
7 and mitigate those impacts.
8 The last thing I'd say about that
9 is that one of the things we tried very hard to do
10 throughout the implementation phase of the Medicaid
11 redesign team has been to try to work with
12 particularly effective providers as closely as
13 possible to -- we've given ourselves flexibility in
14 terms of implementation to try to minimize some of
15 those unintended consequences. And we've tried
16 very hard to listen, and I -- I'll give you -- a
17 more perfect example of this would be the nursing
18 home industry in the state, which traditionally has
19 not had the most positive of relationships with
20 the -- with the department. I -- I think somebody
21 told me that in the last ten years, the state has
22 been sued a hundred times by the nursing --
23 elements of the nursing home industry. But what
24 we've tried to do with -- with them is to really
25 engage them. And I -- I give them a

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2 amount of credit.

3 I think one of the sort of
untold

4 success stories of the -- of -- of the
M.R.T. was

5 that -- what was called a rebasing, which
was a --

6 basically adoption of a -- of a new
methodology for

7 payments to nursing homes, which had sort of
been

8 left unimplemented for a couple of years.
And the

9 home administration sort of inherited this
problem

10 and was sort of given a Hobson's choice
which was

11 if we implement, we redistributed hundreds
of

12 millions of dollars between homes,
retroactively,

13 that we were told basically would put about
a

14 hundred homes at risk of closure. If we
didn't

15 implement, we have homes out there who had
made

16 financial decisions based on the assumption
of a

17 new rate -- those are the -- these are
winners

18 under the implementation -- who now would be
at

19 financial distress because they'd made those

20 financial decisions. So basically, we were
in a

21 situation where we thought we'd lose either
way

22 with the implementation.

23 We took -- we went to the

24 industry, which you know is somewhat
disparate, and

25 basically the industry itself came up with a

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2 implement rebasing that minimized the negative
3 impacts to a great extent and ensured that the most
4 vulnerable homes saw no reductions. And so -- and
5 we really feel that that level of unanimity that
6 was reached by them is a good example of what we're
7 trying to do, which is -- we understand that this
8 exercise is trying to take about -- gross
9 dollars -- four billion dollars out of the
10 healthcare sector in New York, and we're trying to
11 do it as -- you know, as smartly as we can, and I
12 think that's been one of the challenges. But I
13 think that as I had said, there's example in
14 nursing home, there's other examples out there, is
15 that, I think if you engage stakeholders in -- in
16 meaningful ways and are willing to listen, I think
17 you can -- you can do these things in -- in a less
18 destructive fashion.
19 DR. STRECK: I think we'll allow
20 about two more questions, and I -- these two hands
21 over here were up first. I think, Dr. Grant, you
22 were prior to Ms. Hautenburg, and then we'll have
23 her.
24 MS. HAUTENBURG: This is about
25 the basic benefit package with D.H.H.S.

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2 accepted the I.O.M. recommendations for preventive

3 care for women. Will New York State be willing to

4 go above and beyond with their own money to expand

5 that list? And I'm particularly interested in the

6 issue of abortion, which has always been covered by

7 the Medicaid program in New York State with its

8 state-only dollars.

9 MR. HELGERSON: That's -- that's

10 correct. It is covered. I think the state will

11 have to have a -- I think once the benefit package

12 is completely finalized and we get the complete

13 guidance, an analysis is going to have to be made

14 that looks at all of the mandated levels of

15 benefits that exist in New York. Chances are that,

16 in aggregate, our mandates will be greater than the

17 basic benefit package.

18 For those of you who may not be

19 familiar, that if -- if the benefit package is

20 greater, and the state maintains those greater

21 mandates, that individuals coming through the

22 health insurance exchange with -- looking for tax

23 credits, that the state on its own would have to,

24 in essence, finance the difference between what the

25 tax credits would -- would make up and what

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2 basically the targets of affordability are. And --
3 well, I think that the state will have a very
4 interesting set of decisions to make, given the
5 potential financial implications of that.
6 DR. STRECK: Dr. Grant?
7 DR. GRANT: Two quick questions
8 and comments for you, Mr. Helgerson, or you, Dr.
9 Shah, Commissioner.
10 On the M.R.T., the whole issue of
11 prevention and wellness, I would hope that that is
12 being underscored. That's a big effort with
13 N.C.Q.A., C.M.S., et cetera, and we've got make
14 sure that we're looking at getting the client
15 educated about how to be -- be self-empowering to
16 take care of this so that you can keep those costs
17 down.
18 And secondly, I would hope that
19 the insurer would like to hear what the role is
20 with the department in getting the insurers at
21 the -- at the table right from the beginning so
22 that you can make sure that they're part of the
23 process for reducing costs, too.
24 DR. SHAH: Let me -- let me
25 answer the first part first. Certainly,

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2 many opportunities for insuring that
3 wellness and prevention gets incorporated into the
4 benefit -- you know, a benefit redesign subcommittee.
5 We can look at the payment reform committee. We
6 can look at the disparities committee. I think there
7 are multiple avenues where these important ideas
8 get incorporated from different perspectives
9 into the future of Medicaid for New York State. So
10 I'm confident that we have the right folks
11 around the table and the process is such that it will
12 allow us to -- to do this well.
13 And -- and I -- I'd like
14 to just also suggest, maybe I'm going out on a limb
15 here, you know, the governor set a real strong
16 vision for what he wanted for the Medicaid program, and
17 Jason's been fantastic at implementing it.
18 At -- when we started, we didn't know what phase
19 two would look like. I would suggest that
20 there's probably going to be a continual phase three,
21 four, who knows, through this administration. And
22 this is not a one stop, one chance to fix
23 everything. We will continue this process in some form
24 going forward.
25 DR. STRECK: Though I'm

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2 to give Mr. Fensterman the last word, he did raise

3 his hand, so -- but I have one more question here.

4 MR. FENSTERMAN: Thank you,

5 Doctor. I appreciate that.

6 You opened the door, so I -- I

7 have to ask the question on the issue of nursing

8 homes and rebasing. I personally -- I -- my law

9 firm represents approximately a hundred and fifty

10 nursing homes. I personally know many nursing

11 homes who, as a result of the implementation of

12 what was a very difficult decision, as you

13 described it, who are literally losing now in

14 excess of a hundred thousand dollars per month.

15 Many of them say that they have been told that

16 there is going to be regional pricing that is being

17 considered. And many say that the department -- or

18 they've heard -- I'm not sure how they have

19 ascertained this knowledge that that is being

20 contemplated being implemented sometime in, on or

21 about October of this year. My concern, of course,

22 is besides the fact that there is a -- that is a

23 gargantuan sum of money for a nursing home operator

24 to lose, that also ultimately can impact quality of

25 care in those facilities because it would

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2 very difficult to render the appropriate quality of
3 care while concomitantly losing that amount of
4 money. And it was done in one fell swoop.
5 And unfortunately, there are literally some nursing
6 homes who were earning a good deal of money who are
7 now earning twice as much as they were earning
8 before as a result of the implementation of that.
9 And I understand, and I -- and I agree that you
10 were faced with an extraordinarily difficult
11 decision, but there are inherent inequalities and
12 inequities in what occurred. And the unintended
13 effects that you alluded to are now -- are now
14 actually in the process of occurring. Are we
15 moving forward towards regional pricing in -- in an
16 effort to remediate these inequalities?
17 MR. HELGERSON: The answer is
18 that -- just so be clear, that rebasing, to a great
19 extent, as I said, was a policy that sort of
20 evolved over multiple years. It has a much -- a
21 very complex history to it. And -- but the --
22 and -- and we were able to, at least across the
23 various associations, achieve some degree of
24 unanimity in terms of how to address what you
25 mentioned was an extremely difficult

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2 That said, clearly there are homes who are
worse
3 off by the implementation of the -- of the
4 initiative.
5 So the -- the issue is now
moving
6 forward, what's going to be done? And what
we've
7 said is that the current system of paying
nursing
8 homes, which is based -- historically been
9 cost-based, is not really a system that is
10 sustainable or creates the right set of
financial
11 incentives, in our view, moving forward.
And so
12 the idea is -- and this is -- we've thrown
this
13 back to the industry again to see if they
could
14 reach consensus -- we'll see if they can
reach a
15 consensus -- was to adopt a pricing system,
meaning
16 that it would be less about cost and more
based on
17 specific factors that contribute to -- and
so we
18 had greater uniformity, I guess, in payments.
19 What the current system has and has had for
quite a
20 while, is a -- sort of an interesting myriad
of
21 different rates that nursing homes were paid.
22 Oftentimes, it was very hard to explain the
23 differences between what one nursing home
was
24 getting paid and what another nursing home
was
25 getting paid.

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2 Now in terms of the details of
3 the pricing system, we've really left that up to
4 the industry to see if they could reach another
5 consensus. There's the issues around regional
6 pricing. Is there a statewide price? Do you use a
7 facility specific WEF or wage adjustment? Is a
8 regional WEF, a statewide WEF? There's a wide
9 array of details that go into it, but I think the
10 key thing is is that we've also stated is that you
11 can't just go to a brand new system overnight.
12 That was part of the problem we were in, and we are
13 in with regard to rebasing, which was with no
14 additional money on the table, how do we implement
15 a two year plus swing of dollars between these
16 homes? And we tried to mitigate it, and the
17 industry came up with a plan to mitigate to the
18 best they could.
19 Now moving forward, I think we've
20 got a little bit more flexibility. And the idea is
21 actually to adopt a four year phase-in strategy so
22 that homes will know what their rates are going to
23 be at full phase in, but are not necessarily going
24 to be, you know, fully implemented on day one,
25 which hopefully gives everyone a little bit

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2 time to adopt -- adapt to the -- the new rate
3 structure.
4 The other confounding factor, as
5 I mentioned, we're moving to care management for
6 all, and we're trying to get out of the fee for
7 service business within the next three years, which
8 means that nursing homes will no longer be paid
9 with -- at the end of that three year period, by
10 the state Medicaid program directly, but rather by
11 plans. And so the question will be, will plans use
12 the state's same rate methodology? It could very
13 well be. And I suspect it'll be initially the
14 standard. But I do think particularly for homes
15 that are of vital importance who are serving a
16 population in a community where a shortage exists,
17 they will have some potential to negotiate
18 potentially rate add-ons, which is kind of what
19 happens today in other sectors within managed care.
20 So I think there'll be some greater flexibility,
21 especially when the state gets out of the direct
22 payment business.
23 DR. STRECK: Thank you, Mr.
24 Helgerson. And obviously Medicaid and the Medicaid
25 redesign team and all the work that is

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2 has a wide-ranging impact on this state and its

3 budget, so we will continue to allow time here for

4 that discussion and monitor that process as best we

5 can. And certainly there will be participants

6 within this group over the course of those

7 deliberations.

8 We're going to move now to the

9 report of the Office of Health Information

10 Technology, and Ms. Block's going to provide that

11 report.

12 MS. BLOCK: Thank you very much.

13 Uncharacteristically, I do not have slides, but

14 that's because I'm going to be giving a very brief

15 update on some of our key activities.

16 The Commissioner mentioned that we are actively

17 pursuing the development of an all-payer database.

18 This is pursuant to the authority that we were

19 given as part of the budget and in the context of

20 M.R.T. to really enhance our data capability

21 significantly so we can look not only at the

22 Medicaid program, but really at the totality of our

23 healthcare system in a -- in a much more

24 comprehensive way. So we're very excited at the

25 opportunity to be moving forward with this.

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2 Briefly, in terms of process and timeline, we have
3 convened a small stakeholder advisory council that
4 is representative of a broad range of interests who
5 need to be very much involved in and -- and have a
6 stake in the development of the all-payer database.
7 We've had two meetings of that group, and we'll
8 have another by the end of August. So as you can
9 see, we're really pushing through the summer to try
10 to come up with the preliminary framework of
11 recommendations that we would like to be making to
12 the Commissioner sometime in September.
13 In addition to that stakeholder group, we've been
14 actively reaching out to a number of individual
15 organizations who have particular capacity to offer
16 or a particular expertise that we need to tap into.
17 And we're also talking to organizations that are
18 also involved in other states who have already
19 established these all-payer databases so we can
20 gain from the learnings of their experience in this
21 field.
22 So as I said, hopefully by the
23 end of September, we'll be in a position to make a
24 formal proposal to the Commissioner that will have
25 been pretty thoroughly vetted with a wide

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2 of groups. And if there is anyone on the council
3 who has specific subject matter expertise or
4 interest in this who would like to be involved or
5 would like to talk to us about this, please let the
6 council staff know, and they can give you my
7 contact information.
8 With regard to the Statewide
9 Health Information Network of New York, many of you
10 are familiar with this. Really, the first
11 investment that we made in developing a statewide
12 health information infrastructure was through the
13 HEAL Five program. And I'm very pleased to
14 announce that actually on July 31st, the HEAL Five
15 program was completed. And we have -- now are in
16 the process of finalizing/collecting all the
17 documentation from those projects as to the
18 successful implementation which we believe has been
19 achieved by all the projects in terms of meeting
20 their project goals that they set out with for that
21 particular program.
22 So what this really translates
23 into in practical terms is we now have statewide
24 availability of health information exchange
25 services that any provider who joins a RHIO

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2 able to access. And obviously, this is
really just
3 in time if we look at whether it's M.R.T. or
4 federal health reform or any of the other
things
5 that we need to support, having this health
6 information technology infrastructure
available is
7 really going to provide the necessary tools
to
8 really help clinicians, consumers, and the
9 department figure out how we can further
advance
10 the healthcare transformation that the
Commissioner
11 described.
12 In terms of next steps,
we're
13 currently with the New York eHealth
Collaborative
14 and the stakeholders that they have pulled
together
15 to continue the implementation of the HEAL
Ten and
16 Seventeen programs, which, as many of you
know,
17 have focused on supporting patient centered
medical
18 homes, connecting them to other providers in
their
19 communities who are involved in providing
care for
20 patients with chronic diseases. In HEAL
Seventeen,
21 we expanded that to include a focus on
integrating
22 patient centered medical homes and behavior
health.
23 So again, the development of this
infrastructure
24 and the care coordination models that are
resulting
25 from these HEAL funded activities obviously

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2 represent a good jumping off point in terms of

3 health homes, patient-centered medical homes, and

4 eventually A.C.O.'s as we move forward with those

5 initiatives as well.

6 We're actively outreaching to the

7 RHIOs right now to ensure that they're fully aware

8 of the health home requirements and to try to tie

9 them into potential health home applicants in their

10 communities so that they can do some of the advance

11 work to make sure that those health homes can take

12 advantage of the health information infrastructure

13 that's available in their communities to support

14 those care management plans that the health homes

15 will be responsible for developing. And we've

16 worked very closely with Jason's staff in terms of

17 integrating health information technology

18 requirements into the various programs which

19 they're moving forward with.

20 Finally, I'd like to give a brief

21 report of the New York eHealth Collaborative and

22 the New York City REACH program. Both received

23 contracts from the federal government to implement

24 the regional extension center program in New York

25 State. This program is really geared to

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2 primary care physicians in particular to get
the
3 certified E.H.R.'s to get them to meet the
4 meaningful use requirements which are
necessary in
5 order for those physicians to get Medicare
and
6 Medicaid payment incentives, which are
available
7 for the next few years for that particular
purpose.
8 And we're extremely proud to announce that
we have
9 over five thousand physicians between the
two
10 programs signed on and -- and in flight, in
terms
11 of moving forward with those efforts. And
as a
12 result of -- of the incredible work that
both NICE
13 (phonetic spelling) and New York City have
done, we
14 are now respectively number two and number
three in
15 the county in terms of performance among the
16 regional extension centers. So we're very
pleased
17 at that progress and -- and it seems as
though each
18 month, a really much greater interest is
being
19 expressed by physicians across the state to
20 participate in this program.
21 I think all of this really
22 translates into a tipping point in terms of
a
23 health information technology adoption over
the
24 next couple of years in New York State. And
as I
25 said, clearly that will only benefit the

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2 and public health goals which the

Commissioner

3 expressed.

4 That is the end of my

report.

5 Thank you.

6 DR. STRECK: Questions or

7 comments for Ms. Block? Dr. Martin?

8 DR. MARTIN: Hi. One of

the

9 challenges that RHIOs and physicians and

virtually

10 everyone who is participating in the state

faces is

11 the regulatory/legal situation where the

state's

12 laws, the state's regs, the state's

practices, the

13 federal laws, regs, and practices are not --

they

14 overlap, but they're not necessarily in

15 synchronicity. Right now, as you know,

through

16 NICE, the RHIOs and all stakeholders are

17 participating in looking over the policies

and

18 procedures that sort of govern the health

19 information exchange, because they were

governed,

20 basically, as I understood it, through the

HEAL

21 Five contracting process to a large extent,

as you

22 point out. And thankfully, for somebody who

had

23 one of those HEAL Fives, we're pretty much

done

24 with that.

25 But -- so the -- the --

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2 guess the legal landscape still remains really a
3 bit of a mix. It's unclear what we're now held to
4 as well as what we're doing going forward. I
5 understand the Commissioner has statutory authority
6 to make a fair amount of changes, but it's unclear
7 to me what sort of timeline we're thinking of and
8 how the NICE process is fitting into this. And if
9 you could just clear that up a little bit, that
10 might be helpful.
11 MS. BLOCK: Sure. So as Dr.
12 Martin indicates, we've undertaken a comprehensive
13 review of federal and state privacy policies,
14 and -- and we're going to align that with the
15 existing privacy and security policies which have
16 governed the programs to date.
17 And in terms of timing, as I
18 understand it, the -- the plan is to have that
19 review completed by the end of the year. And we
20 have begun the process of -- of some initial
21 development of the regulations governing the
22 statewide health information network internally at
23 this point just to create a bit of a framework
24 and -- and -- and decide with legal counsel how we
25 should approach the level of specificity and

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2 the unique relationship that we have with the

3 eHealth Collaborative in a regulatory context.

4 So we've begun sorting through some of those

5 issues, and I think that -- that we have an

6 opportunity to align the timing of the completion

7 of that review, the result of the committee's

8 discussion of the results of that review, and blend

9 that into the regulation. And that would suggest

10 that we would be advancing the -- the regulation

11 early next year, which should dovetail pretty well

12 with the end of the remaining HEAL contracts, which

13 is really what continues to bind everybody to the

14 statewide policy guidance as it currently exists.

15 So fingers crossed, we should be able to have a

16 pretty good alignment and -- and not drop the ball

17 at the point that the HEAL program formally ends as

18 it relates to health information technology.

19 DR. STRECK: I have a question

20 regarding the all-payer database. About ten years

21 ago, I chaired a group for the state that was

22 looking at oncology services in the Medicaid

23 population, and I remember quite distinctly a

24 distinguished president of a large insurance

25 company testifying at one of our hearings

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2 pointing out -- pointedly pointing out -- that all

3 of his company's data was proprietary and not

4 available for any comparative analysis to give us

5 any parameters on the Medicaid population versus

6 the insured population.

7 So my question is, how are the

8 insurers responding to this opportunity that has

9 been presented to them?

10 MS. BLOCK: Well, I'm very

11 pleased to tell you that times have changed, I

12 think, in part because there are already twelve

13 states that are implementing their own laws to

14 implement these all-payer databases, and as a

15 result, particularly the national plans have had to

16 develop policies and procedures to work with those

17 states to provide their data in the context of

18 those particular state programs. So that's one

19 thing that has changed.

20 I think that there is a growing

21 recognition that the value of this data for them as

22 well as for us in terms of being able to advance

23 more effective policies and procedures in terms of

24 payment reform, responding to A.C.O.'s, all of the

25 other things that we know are coming down

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2 We had a meeting with the Health Plan Association
3 Board, and just yesterday, I had an opportunity to
4 meet with probably forty staff from health plans
5 representing a variety of health plans from across
6 the state. They're extremely enthusiastic about
7 participating in this opportunity and -- and
8 have -- have really already started to proactively
9 conduct assessments of their own capabilities to
10 determine what would be the quickest and easiest
11 way that they could provide the data that we're
12 likely to be requesting from them.
13 So I think that at this point, we
14 have a pretty strong commitment from both the
15 Health Plan Association as an association and most
16 of the individual insurers across the state to --
17 to be proactive participants in the development of
18 this database. And we've indicated to them that we
19 really do see this as a partnership with them as
20 well as with all of the other healthcare
21 stakeholders who will be participating in this.
22 DR. STRECK: Other questions or
23 comments? Dr. Rugge?
24 DR. RUGGE: I'd just make a
25 comment about this in light of the

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2 experience that we've had an agreement, in
3 principle, and I think true willingness on the part
4 of the payers to participate in a regional
5 database, you know, highlights the -- the necessity
6 of better defining what is particular and what is
7 public, and that despite that, it has taken many,
8 many months of working through nine different legal
9 departments, nine different privacy departments to
10 determine what standards and to come up with a
11 simple data use agreement. So there's a tremendous
12 need for imposition of -- of public expectations in
13 terms of what kind of agreements are -- are
14 appropriate and needed by all concerned, be they
15 providers or -- or insurers. Without that, we will
16 be enmeshed for decades in the process of -- of
17 combining data.
18 DR. STRECK: Thank you for
19 pointing out that complexity can strangle
20 enthusiasm, but we will nonetheless trust in Ms.
21 Block and the work ahead here. It -- it is
22 encouraging from the payer perspective, I think.
23 Other questions? Peter?
24 MR. ROBINSON: It's -- it's
25 actually more of a comment. I think that

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2 you'll find is a distinction between the for profit
3 and not for profit insurers in the state. And from
4 our way of seeing it, the not for profit insurers
5 seem to be much more willing participants in these
6 processes. The Rochester region has its nonprofit
7 payers on the governing body of the RHIO, and there
8 is a good exchange of information and good
9 participation. I think that in areas where you
10 have the for profit companies, you have a different
11 situation. I think it mainly raises the issue of,
12 let's hope the state doesn't actually encourage
13 more transition of not for profit payers to for
14 profit in order to get onetime financial benefits
15 out of it and -- and perhaps give up some of the
16 local accountability that comes from their not for
17 profit status.
18 So I think it's a policy question
19 that we have to be mindful of, and maybe as the
20 M.R.T.'s look at issues of financing, that this is
21 off the table.
22 DR. STRECK: Other comments or
23 questions for Ms. Block? Thank you very much.
24 We'll now move to a report of the Office of Public
25 Health Activities. Dr. Birkhead?

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2 DR. BIRKHEAD: Thanks very much,
3 Dr. Streck. I'm going to speak to the council
4 today about a new activity that we're undertaking
5 at the State Health Department, which is
6 accreditation, actually, of the State Health
7 Department. And you may -- may ask, "What is
8 public health accreditation?"
9 Over the past several years, a
10 new national group has formed called the Public
11 Health Accreditation Board. This is a nonprofit
12 accrediting agency that has been put together
13 through a combination of efforts by C.D.C., the
14 Robert Wood Johnson Foundation, the Association of
15 State and Territorial Health Officials, and others.
16 And just this July, it issued its -- it -- guidance
17 for state and local health departments to become
18 accredited.
19 So what is public health
20 accreditation? It's a measurement of health
21 department performance against a set of nationally
22 recognized practices and -- and evidence-based
23 standards. There is recognition that comes along
24 with this of achievement of accreditation by a
25 national entity. So this is -- this is

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2 first time, as I mentioned, that there is a
3 national entity accrediting state and local health
4 departments, And this body will also continually
5 develop. This is the first pass, the first set
6 of -- of guidance. There was a beta test, but
7 really we are -- all the states are all going to be
8 guinea pigs in this process of working through the
9 accreditation. And so this is -- is -- may -- may
10 be modified or change or over time.
11 This is very heavily endorsed by
12 C.D.C. Here are statements by Tom Frieden, the
13 director of C.D.C., that accreditation is a major
14 accomplishment for health departments to help
15 addressing key community health problems. And just
16 as the public expects hospitals, law enforcement
17 agencies, and schools to be accredited, so should
18 they come to expect public health departments to be
19 accredited.
20 At this point in time,
21 accreditation is a voluntary thing, a voluntary
22 goal for states and locals. It's possible in the
23 future, although not certain, that some federal
24 funding might be -- or other funding might be
25 conditioned on being an accredited agency.

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2 probably in the -- in the -- in the distant
future.
3 For the time being, it's voluntary. But I
think
4 for a number of reasons, it's -- it's
important for
5 us in New York to look at -- at doing this.
6 This really fits in with our focus on
improvement
7 at the -- at the -- at the State Health
Department
8 as well. One goal of the national
accreditation
9 program is to improve and protect the -- the
health
10 of the public by improving the quality and
11 performance of public health departments.
And
12 basically, this is a process if you've been
13 through -- in an academic or other kind of
14 accreditation -- a process of evaluating and
15 continuously improving the processes and
programs
16 and interventions within the department.
And we do
17 have -- C.D.C. has simultaneously issued
grants to
18 health departments. We have a performance
19 improvement grant that will help support our
20 efforts in developing this.
21 The Public Health
Accreditation
22 Board has -- has set up the accreditation
over
23 twelve domains. These are the ten essential
public
24 health services, which I think I've talked
to the
25 council before about, plus an -- an

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2 domain and a governance domain, and I'll talk a
3 little bit more about these.
4 Within each domain, they will --
5 they've established a set of standards and measures
6 for those standards, and then finally, the
7 documentation that the health department would need
8 to produce to show evidence that they are meeting
9 the measures and -- and have the standards in
10 place.
11 So again, the standards address
12 the core public health programs and activities the
13 ten essential public health services relate to.
14 For example, environment health, health education,
15 chronic disease, communicable disease, et cetera.
16 This accreditation process, since different states'
17 health -- health departments are different in terms
18 of their scope, this does not include accreditation
19 of, for example, the Medicaid and health insurance
20 programs, hospital nursing service or
21 surveillance -- healthcare surveillance programs,
22 or the health information technology piece, which,
23 in New York, are part of the state health
24 department. In other states, they may not be.
25 However, I think because this process of

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2 accreditation draws in stakeholders and -- and

3 looks for the health department to have links with

4 these other areas, insurance, hospital sector,

5 health information technology, I think the fact

6 that they are in with the department is going to

7 benefit our approach, because we already have very

8 strong links with these other -- with these other

9 entities. So that will benefit our application.

10 The three prerequisites that we need that are part

11 of the accreditation: First, we need to produce a

12 state health assessment. This is an assessment of

13 the -- of the health of the population, and along

14 with that, a state health improvement plan, and at

15 this point, the prevention agenda which we've

16 spoken, I think, many times to the council about,

17 constitute a state health assessment. We have a

18 series laid out over ten goal areas of -- of

19 measures and health -- health elements that we are

20 tracking as well as the improvement plan that's

21 encompassed within the prevention agenda. That --

22 that agenda will end its five years in 2012. And

23 as I talked at the last meeting, I think we will

24 then look -- work with the Public Health Committee

25 of the council to renew it. But that is

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2 essentially, with -- with tweaks, what we will use

3 to meet the requirements for accreditation of the

4 assessment and -- and the state health improvement

5 plan.

6 And then the third aspect is a --

7 is a D.O.H. strategic plan. And we will begin the

8 process this summer under Dr. Shah's direction, to

9 bring together the executive staff to begin to

10 develop a -- an updated and more formal strategic

11 plan for the state health department. We've had

12 strategic plans in the past, but I think this is an

13 opportunity to really look afresh with a new

14 executive staff and develop a comprehensive plan

15 going forward that will meet our needs with the

16 department, but also help with this accreditation

17 process.

18 So there -- there are seven steps

19 in the process, which is, just very quickly, a

20 pre-application phase, then the application, the

21 document submission. There will be a site visit by

22 an accreditation body, and then if all goes well, a

23 five year accreditation. And this sets up then a

24 cycle of reaccreditation, as you may be familiar

25 with from academic or other settings, where

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2 where it's a process of continual improvement.

3 Here's roughly the timeline that we've laid out for

4 this: We're in the process now of -- in the -- the

5 end of this year, into looking at the readiness

6 checklist to see what -- where we may have gaps

7 that we need to -- to work, and then begin to

8 develop the online -- there's an online orientation

9 that we need to take, and begin to complete the

10 prerequisites with a goal of about a year from now

11 of having those prerequisites in place, and then

12 the application being submitted, and the site

13 visits occurring towards the end of 2012, the

14 beginning of 2013. So we have some time to work

15 through this process in -- in a thoughtful manner

16 and hopefully in a way that will not just be an

17 exercise in putting together documentation, but

18 actually improve the processes in our functioning

19 as a department.

20 There are key participants and

21 roles that I just wanted to highlight. The

22 Commissioner, obviously, as the lead of the agency,

23 provides support for the process and -- involved in

24 the -- in the site visit. There's what's called an

25 appointing authority, which, in New York, we

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2 believe is -- represents the governor, and we will

3 get the governor's support for the application that

4 goes in. And then a governing authority, which

5 probably is a combination in New York. We're still

6 trying to sort of figure out the language of the

7 accreditation board and how it fits with our

8 particular state, but the governing authority is

9 probably a combination of the Commissioner and

10 potentially this council, the Public Health and

11 Health Planning Council, which has some regulatory

12 authorities over, for example, the State Sanitary

13 Code. So we'll still work that out.

14 In any event, we would certainly

15 want to use this council and the Public Health

16 Committee as -- as a key, both stakeholder group,

17 and as a key group to -- to bounce our ideas and

18 our -- our strategic plan off of for -- for a

19 reality check. And then I -- I -- I think the way

20 it's laid out, there may be some formal role as

21 well for the council in supporting our application

22 for accreditation.

23 And then the -- the health

24 department and the stakeholders -- and part of this

25 process of accreditation will involve a

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2 input, public comment process that we still have to
3 work out what the details of. But that -- that is
4 one of the requirements that we will -- we will
5 need to work on.
6 So really, the next steps -- so
7 we will work with the Public Health Committee of
8 this council to review our -- the -- the
9 prerequisites that I mentioned, the -- the
10 prevention agenda, the state health assessment, and
11 as we -- as we then come to the completion of this
12 five year phase of the prevention agenda and into
13 the next phase, which will overlap with our
14 accreditation process, I think we would certainly
15 bring the strategic plan to the group as well when
16 that's completed after this summer's work and ask
17 also to -- the council's assistance in reviewing
18 some of the standards and documentation that we
19 need to put together for -- for this process.
20 So it's -- it's an exciting process. I think
21 really the -- the -- the -- the benefit will be
22 in -- in improving our ability to function as a
23 department. We have very good interactions and
24 cross-functional activities going on now. But in
25 some cases, it's not -- it could be -- use

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2 increased formality. It's a -- it's a process

3 to -- to work through. And so I think this

4 accreditation will help us to really develop into a

5 higher functioning quality improvement focused

6 organization that will hopefully result, in the

7 end, in the improved health in the state, and

8 that's our ultimate goal.

9 So thanks, and I'll be happy to

10 answer any questions.

11 DR. STRECK: Questions or

12 comments? Dr. Boufford?

13 DR. BOUFFORD: Yeah, I -- I think

14 this is very exciting, and it's great to see New

15 York early -- early out of the -- out of the -- the

16 gate. I -- I wonder if you could comment on the --

17 the implications of the accreditation process for

18 local health departments -- in local health

19 departments, your relationship with them? And then

20 the other thing is the New York City exceptionalism

21 question. How -- how does that fit into all of

22 this conversation?

23 DR. BIRKHEAD: Well, this

24 accreditation process is set up for both state and

25 local health departments. In fact, just

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2 this week, NYSACHO, the Association of State -- the
3 New York State Association of County Health
4 Officials, had a day-long session on accreditation.
5 So this is very much, I think, on the minds of the
6 counties in New York, and New York City is a part
7 of that group. We had one county, upstate, who was
8 a beta test site for the accreditation, so that --
9 that -- that -- there have been reports coming from
10 that county for the past year or two to NYSACHO on
11 the process, and we are committed to working to
12 support the counties in -- in their developing of
13 accreditation.
14 As you know, in New York, we have
15 the Article 6 program, which funds -- partially
16 funds local public health services. As part of
17 that process, counties need to have a community
18 health assessment. They need to have a municipal
19 health services plan. So some of the elements of
20 the accreditation may already be placed through our
21 processes under Article 6. What we need to do is
22 sort of look -- do a side by side with the Article
23 6 and the accreditation requirements. We don't
24 want to create a duplicate process for the
25 counties, so we may need to be flexible in -

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2 how we work with them.
3 But this is certainly
something
4 that we would ultimately hope all counties
in the
5 state would also -- also become accredited.
6 DR. STRECK: Gus, on a one
to ten
7 scale, we have a new accreditation process,
but if
8 you look across the country, what's the --
two
9 questions -- what's the range on a one to
ten scale
10 of public health competence against these
11 capabilities at the state level? And where
would
12 be if ten were full accreditation, just for
a sense
13 of the country?
14 DR. BIRKHEAD: Well, it's
a good
15 question. The country is very diverse in
terms of
16 how public health services are -- are
organized.
17 In some states, there really aren't local
health
18 departments. They are only entities of the
state
19 that are -- provide those services. I think
20 there's probably a wide range. I -- I think
in New
21 York, a couple of years ago, we went through
the
22 National Public Health Performance Standards
23 process, which was sort of a self-evaluation
24 process, but we -- we came up pretty strong
in --
25 in many areas, disease surveillance, for

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2 So I think -- I think as state

3 health departments go, we are a very strong health

4 department laboratory. I think we are probably

5 exceptionally strong in that area. So -- so I

6 think we're -- we're in good shape. You know, we

7 are in the process of trying to do more to

8 incorporate quality improvement, and there probably

9 are a few other states that may be ahead of us

10 in -- in sort of being formal about quality

11 improvement in every -- in every program.

12 Washington State comes to mind as one that's been

13 quite well organized in this area for a while and

14 has pretty well developed plans on their website,

15 probably more than -- more than we have at this

16 point.

17 So we certainly have something to

18 learn from -- from other states, but I -- I think

19 we're pretty well positioned. And -- and

20 certainly, our -- our process of funding local

21 health departments has maintained capacity here.

22 That's a kind of a unique system. Not a lot of

23 states have a system of funding as we do with

24 Article 6. So I -- I think the hope is even though

25 it's tough times at all levels of government,

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2 we are able to maintain the core of our public

3 health, state and local, and we'll be able to go

4 through this process.

5 DR. STRECK: Well, thank you for

6 that report. We'll move now to Ms. Lipson and Mr.

7 Abel on the multi-state obligated groups. Karen,

8 Charlie, who's going to lead?

9 MR. ABEL: We -- I just drew --.

10 DR. STRECK: I skipped Mr. Cook;

11 I apologize. So we have the report of the Office

12 of Health Systems Management.

13 MR. COOK: Thank you, Bill. I'm

14 happy to be --.

15 DR. STRECK: I apologize.

16 MR. COOK: I'm going to be very

17 brief because of that. I got the message.

18 I just wanted to bring the group up to date on a

19 couple of issues. I think one of the great success

20 stories that we have had in the department is the

21 move to electronic submission of C.O.N.'s. As

22 those of you know -- who have been here before, you

23 know that beginning in December, that system went

24 live. And in May of this year, we now allow for

25 entities that have not been established to

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2 submit applications.
3 Since May of this year, we
have
4 seen almost eighty percent of the
applications
5 being submitted electronically. You have a
chart
6 before you that shows, in the first three or
four
7 months, the overwhelming number of
applications
8 were actually not coming in electronically.
So we
9 are approximately at eighty percent. And I
think,
10 Mr. Chairman, one of the things we could
like this
11 council to help us on -- we would like to
set a
12 date at which at that point, all
applications would
13 need to be submitted electronically unless
there
14 was some unique circumstance.
15 There's been tremendous
value
16 internally for us in -- in having these
submitted
17 electronically. As well as everything we've
heard
18 from the industry, it has made their lives
much
19 more easy. But one of the things that we're
seeing
20 is we've already been able to document a
twenty
21 percent reduction in the number of days to
go
22 through a full C.O.N., and we've also been
able to
23 understand where there are opportunities for
24 improvement. If you looked at some our data,
then
25 what you find is a significant percentage of

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2 is sent -- is when the C.O.N. comes in, it is sent

3 back to the applicant for additional information.

4 And one of the things that we're working on now is

5 how can we begin to correct that back and forth in

6 order to further expedite and -- and make the

7 process easier? And that represents about

8 twenty-eight percent of the time that's necessary

9 for a full review.

10 So we're learning more about

11 ourselves, how to be more efficient. We're

12 learning a great deal more about how we can work

13 with the industry to try and eliminate this back

14 and forth that exists. One of the things that we

15 will have for the council in the fall is a

16 performance report card that will lay this all out,

17 and you'll be able to look at time that is required

18 for full administrative and limited reviews,

19 because obviously one of the things the

20 Commissioner has reminded me of, and that we often

21 hear, is the amount of time that it takes to review

22 applications. But I think this electronic

23 submission system has really begun to develop data

24 for us to assess. It also has already seen pretty

25 significant results.

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2 So I really want to compliment
3 Charlie Abel in the Division of Health facility
4 planning. They've done just an extraordinary job
5 in implementing this. This has not been an easy
6 thing to go forward at a time of reduced resources.
7 They have just simply done an extraordinary job.
8 So Charlie, thank you.
9 A couple other small issues.
10 There was a brief discussion in the Commissioner's
11 remark -- remarks and in Jason's discussion on the
12 Brooklyn M.R.T., and I want to just reiterate a
13 couple of issues relating to the process that is
14 going on led by Steve Berger. We've had one public
15 hearing. We had over sixty-eight people there who
16 testified. We've gotten significant submissions of
17 data, but I think the importance of this process
18 are really two things. Number one, we have
19 emphasized over and over that this is not Berger
20 Two. This is not an effort to go in and close
21 hospitals. This is really a regional planning
22 effort to try and understand and assess, how do you
23 improve the healthcare delivery system in a part of
24 Brooklyn that right now is undergoing fiscal
25 stress, but also faces significant poverty

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2 issues and significant inefficiencies?

3 If you looked at Brooklyn

as we

4 have begun to -- to look at, what you will

find is

5 a significant percentage of admissions,

preventive

6 quality indicators that are represented in

Brooklyn

7 hospitals that could be avoided with better

8 community and preventive care. And it's

about

9 thirty-four thousand admissions that we've

been

10 able to identify. Now we're not grazing or

11 criticizing the hospitals for not doing

their job.

12 If anything, the hospitals are admitting

these

13 patients because they need care. But we've

14 highlighted indices, like --.

15 (Off the record)

16 MR. COOK: -- understand

that

17 that is an opportunity for efficiency. That

if we

18 can find ways to avoid those admissions, we

will

19 improve the health of individuals, and we

will

20 improve the cost effectiveness of the system.

21 We have also seen, across the state, more

and more

22 interest in trying to understand how do we

do --

23 excuse me -- regional planning. And the

24 Commissioner met with a group of about

twenty

25 hospitals from the northern Adirondacks who

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2 beginning to ask the same questions that we're
3 asking in Brooklyn. What are the efficiencies that
4 we can come up with so that we're prepared for the
5 changes down the road? How do we do a better job
6 of recruiting and retaining primary care
7 physicians? How do we avoid admissions that are
8 not necessary? How do we begin to link with each
9 other so that we're doing a better job in
10 collaborating? So this first effort in Brooklyn, I
11 think, is -- really will lay the foundation for a
12 series of ongoing discussions across the state of
13 how do we assess communities? How do we then try
14 and encourage and build community health related
15 systems?
16 Finally, I just very briefly want
17 to talk -- as -- as you may know from the news
18 reports, we've received a closure plan from
19 Peninsula Hospital on the Rockaways. The
20 administration of Peninsula has submitted warn
21 notices, which are ninety day notices to employees
22 that layoffs are imminent within those ninety days,
23 and the closure plan is now being reviewed. We're
24 working with both the union, Peninsula Hospital,
25 St. John's, and the surrounding hospitals,

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2 particularly South Nassau, and Franklin, and

3 Jamaica, who are likely to see the impact of that

4 closure. And right now that process is -- is

5 ongoing.

6 So I'm happy to answer any

7 questions.

8 DR. STRECK: Questions for Mr.

9 Cook? Mr. Berliner?

10 DR. BERLINER: Rick, are the

11 Brooklyn hospitals strong enough to stay alive

12 during the M.R.T. process until --.

13 MR. COOK: Yeah. I mean, I -- I

14 think, you know, our recommendations are due

15 November 1st. There obviously are several

16 hospitals that are fiscally challenged, but

17 the one thing that is already occurring I think quietly are

18 discussions among the hospitals of what -- what

19 kind of relationships might be built in the

20 interim. So I -- I think they'll get through this

21 process, but we're obviously engaged in ongoing

22 discussions with several who are having some

23 particular problems.

24 DR. STRECK: Other questions or

25 comments? Thank you. I've already

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2 Karen. And Charlie, you may now begin.

3 MR. ABEL: Thank you. I was

4 asked to -- to put together a little presentation

5 for PHHPC members, and we distributed a draft

6 policy paper to members last week. Hopefully, you

7 folks have had an opportunity to -- to review that.

8 I'll summarize some of the high points, and I would

9 like to engage you folks on a -- on a discussion

10 on -- on our proposed policy revisions.

11 Now this is part of the M.R.T. --

12 an M.R.T. initiative to expand access to healthcare

13 facilities to -- to capital through the formation

14 of multi-state obligated groups. Now obligated

15 groups, as -- as you folks know, you -- you -- many

16 of you have seen in -- through Public Health

17 Council, obligated group applications come through

18 for establishment. And obligated groups are -- are

19 composed of a number of entities. It could be

20 healthcare. Obviously, most of the projects that

21 you've seen before you have been healthcare

22 institutions. It could be other

23 institutions/entities brought together to cross

24 collateralize one another's debt. And entering

25 in -- entering into what is called the

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2 indenture, which basically binds those
facilities
3 together to guarantee one another's debt in
-- in
4 an effort to raise the credit rating of that
group
5 and be able to then access a -- capital
through
6 borrowing at -- at lower rates than an
individual
7 facility might otherwise be expected to
achieve.
8 So -- and -- and we've done -- in New York
State,
9 the -- the regulations require that any
facility,
10 any Article 28 facility, in order to have a
-- that
11 facility guarantee another entity's debt
must
12 receive the -- the Department of Health

13 Commissioner's approval. Now on an
individual
14 basis when there is an individual instrument,
loan
15 instrument, we -- we do that internally,

16 administratively. But for an obligated
group
17 formation, because that obligated group is
bound by
18 the M.T.I., it has an ongoing need to -- to
-- to
19 borrow and make decisions among the -- the
entities
20 as to -- as to how to make payments on loans,
et
21 cetera, that's an ongoing basis. And as a -
- as
22 a -- as a way to grant authorization on
behalf of
23 the Commissioner, we've established the
process of
24 going through an establishment action
through
25 submitting an establishment C.O.N. and

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2 forward through the -- now, this council for

3 approval to form that obligated group, and
enable

4 then the Article 28 facilities to, if need
be,

5 support the debt payments of other
institutions

6 within that obligated group.

7 Historically, over the
last

8 twelve years, the -- those obligated groups
that

9 have been formed have been intrastate
obligated

10 groups, facilities within -- all the
facilities

11 within that obligated group has -- have been
within

12 New York State. Not all of them healthcare

13 facilities. We actually had a couple of --
couple

14 of obligated groups form that were formed
with

15 healthcare facilities, but also other --
other

16 related facilities in an effort to, again,
achieve

17 a better rating for the agencies and -- and
-- and

18 for banks, and be able to achieve lower
interest

19 rate going forward.

20 So through this initiative,
this

21 M.R.T. initiative, we were asked to -- to
look at

22 multi-state obligated groups. What would be
the

23 challenges for us to be able to -- to
co-establish

24 through some model the Article 28 facilities
with

25 these multi-state obligated groups? Now

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2 large -- obligated groups is a -- it's a -- it's a

3 term of art in -- in the -- the financial industry.

4 They exist throughout the -- the nation. And there

5 are very large multi-state obligated groups, and we

6 have had discussions in the past with a couple of

7 large obligated groups that are -- that were

8 seeking to bring in New York State healthcare

9 facilities.

10 In our obligated group

11 establishment applications, as you know, we look at

12 the character and competence of all the -- the

13 members that are forming the obligated group. We

14 examine the financial aspects of all the -- the

15 members. We -- we want to make sure that the --

16 the -- the formation of this obligated group is not

17 going to hurt any one facility, and then the

18 aggregate will improve the -- the financial

19 position of -- of the group. So -- so we'll look

20 at it from -- specifically, from the character and

21 competence perspective, from the financial

22 perspective.

23 Multi-state obligated groups that

24 may have dozens, and there are those that have well

25 over a hundred entities, maybe all

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2 maybe a mix of healthcare and non-healthcare in all
3 the states. That presents, obviously, a challenge
4 not only from the character and competence
5 perspective, but also from the financial
6 perspective, understanding the regulatory
7 environment of all the states involved for all the
8 healthcare facilities. For the non-healthcare
9 facilities, even a greater dimension of complexity.
10 Where does that healthcare -- where -- where does
11 that entity reside in its market for its products?
12 How can it impact on the New York State facility?
13 Obviously, we want to protect the New York State
14 facilities from the potential of having resources
15 siphoned from that -- from that New York State
16 facility to support a problem facility in some of
17 other state, or a problem entity in some other
18 state.
19 So those -- those were the
20 challenges that presented themselves. On the -- on
21 the flip side, there seemed to be great benefits
22 because many of these multi-state obligated groups
23 already are rated and are rated very highly in --
24 in the -- in the A and double A category. And so
25 the -- the -- the -- the -- the prospect of

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2 enabling a New York State healthcare facility -- by
3 the way, we have very few A rated healthcare
4 facilities in New York State. Many of our
5 healthcare facilities are not rated. The -- the
6 vast majority, in fact, are not. So the benefit of
7 having a New York State healthcare facility
8 participate in a -- in a borrowing that -- of an A
9 rated obligated group and being able to achieve a
10 lower interest rate for a major modernization
11 project, for example, the -- the financial benefits
12 are extraordinary. We -- we -- you know, for a
13 project that may be a hundred and fifty million
14 dollar project, we're talking tens of millions of
15 dollars over the life of a loan that could be saved
16 as a result of -- of a New York State facility
17 borrowing through an A rated obligated group. So
18 clear advantages.
19 What -- what this paper did was
20 lay out some of that background for you, lay out
21 how we have handled obligated groups in -- in the
22 past through the establishment process, and -- and
23 then on page four, it begins to lay out the
24 proposed policy that we would like to -- to begin
25 to implement to -- to enable us to -- to --

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2 to achieve those -- that lower cost of capital for
3 New York State facilities who apply, who wish to
4 join a multi-state obligated group. See -- you see
5 the benefits there. It facilitates the -- the
6 introduction to new sources of capital investment.
7 Clearly, that gives New York State facilities the
8 ability to access new markets, not only through --
9 with lower interest potentially for its debt,
10 but -- but also more creative financing vehicles
11 than what is currently existing in New York State.
12 And -- and through the obligated group structure
13 that we are recommending, which includes an active
14 parent entity over the entire obligated group, it
15 introduces an expertise that exists in that active
16 parent entity that -- that we have seen from the --
17 from the obligated groups that have approached us
18 that we believe is very beneficial to not only
19 achieving efficiency with respect to borrowing, but
20 efficiency with respect to best practices in
21 operating healthcare facilities. At -- at a -- at
22 a multi-state level, bring that expertise to the
23 New York State healthcare facility. So -- and --
24 and of course, leveraging that -- that larger
25 facility's borrowing potential of -- and --

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2 using that for the benefit of the New York State

3 facility.

4 So how -- how would be doing

5 that? Excuse me. It would -- it -- we -- we are

6 essentially proposing that we limit our character

7 and competence review to the active parent entity.

8 Now I -- I -- I probably should back up just a bit.

9 In New York State, historically, we've been able to

10 approve and -- well, you folks have also approved,

11 two different models of obligated groups. One,

12 multiple healthcare facilities with an active

13 parent co-established operator to oversee that

14 group. That active parent may have any one or all

15 of the Section 405 powers that -- that -- to assist

16 in the operation of that Article 28 facility.

17 We've also approved a model where, without an

18 active parent, but each of the facilities involved

19 are jointly and separately liable for that debt.

20 And so there's no central decision-making body, but

21 the -- and in -- and in fact, there -- there's no

22 ability for some entity to make decisions with

23 respect to how to operate individual facilities.

24 Those facilities are really simply coming together

25 to leverage, you know, their financial

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2 with respect to joint borrowing. So the -- the --
3 the M.T.I., the master trust indenture, is really
4 the only entity that dictates the -- the -- the
5 degree of integration of those facilities. The
6 M.T.I. dictates what the financial conditions
7 necessary to -- for withdrawal. In addition to --
8 of -- of entities to the obligated group, it -- it
9 dictates the -- the conditions when a draw on
10 assets from one or more of the -- of the entities
11 to support one of the entity's debt service
12 payments if those sort of conditions exist.
13 Clearly, for us to be able to embrace a multi-state
14 obligated group structure that would include
15 state -- New York State facilities, we would want
16 to have an active parent model so that that active
17 parent model -- that active parent needs to
18 demonstrate to us the ability -- the capability to
19 operate healthcare facilities with adequate
20 character and competence and in a financially --
21 financially feasible manner. So our review for
22 establishment purposes would be limited to
23 character and competence on the board or whatever
24 the -- the critical decision makers are at the --
25 at the active parent entity, the -- the

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2 was applying to the active parent, and the
current

3 compliance review for the healthcare
facilities

4 within New York State.

5 We are proposing that we -
- that

6 we not view the character and competence of
all the

7 board members or all the proprietary
entities or

8 whatever exists outside of New York State.
From a

9 financial perspective, we would view -- we
would

10 look at the financial performance of the New
York

11 State entities and the -- and -- and the --
the

12 financial performance of the obligated group
to

13 which the New York State entities seek to --
seek

14 to join and determine that it would be
beneficial

15 for the New York State entities to join that

16 obligated group. Where -- where there is an
--

17 where there is an obligated group that has a

18 borrowing history, these entities again are

19 generally rated by the major credit agencies,

20 and -- and we are proposing that the major
credit

21 agencies -- at least one of the major credit

22 agencies has -- is rating that obligated
group at

23 an investment credit level, which is for our

24 purposes a triple B level or -- or higher.

25 So we want to make sure that there is an

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2 established track record of sound financial

3 performance. Those credit agencies do their due

4 diligence with respect to providing ratings for

5 those facilities. There's extensive documentation

6 that is available to the Department to view the --

7 the performance -- the financial performance

8 history of that obligated group. And -- and also

9 that -- that documentation contains any -- any

10 serious issues relative to the performance of the

11 facilities that are within the obligated group. So

12 we would use those documents for character and

13 competence purposes as well.

14 DR. STRECK: So Charlie,

15 basically, are you asking for the endorsement of

16 this concept today from the council?

17 MR. ABEL: We -- we -- we --

18 first of all, we don't believe that we -- that we

19 need to have an approval here. We wanted to

20 present this because we believe we can do this

21 within the existing statute and regulations.

22 DR. STRECK: Okay.

23 MR. ABEL: But we wanted to have

24 a discussion. We wanted to seek your input into --

25 into this proposal so that -- so that we

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2 that into consideration.
3 DR. STRECK: So it's a very clear
4 presentation, and the question really revolves
5 around due diligence or character and competence on
6 the parents of the obligated group, but not -- not
7 committing the department to review every
8 subsidiary trail for the -- for the parents, other
9 than those in the New York State component, the
10 institutions in New York State, which would be
11 reviewed for character and competence. That's
12 really the question that has been presented, and
13 we're open for discussion. Mr. Berliner?
14 DR. BERLINER: Charlie, is this a
15 strategy in search of a mission? I mean, has
16 anyone actually been interested in this?
17 MR. ABEL: Yes, yes.
18 DR. BERLINER: And is it clear
19 that the benefits of -- of -- of the out-of-state
20 obligated group would be better, financially, than
21 anything they can get from financial institutions
22 inside New York?
23 MR. ABEL: We -- we have -- we
24 went through extensive discussions with one major
25 obligated group approximately four years ago.

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2 we were, at that time, not able to get our hands
3 around embracing this healthcare facility joining
4 that obligated group. That healthcare facility
5 sought and obtained financing for a major capital
6 project through, at the time, the local I.D.A.,
7 industrial development agency, which as -- as you
8 see in the paper, the I.D.A.'s don't exist anymore
9 for healthcare financing. They -- their
10 legislation subset it.
11 We took a look, and we -- we --
12 we have since worked with -- at the time that
13 multi-state obligated group entity made the point
14 that they could lend the -- absorb that facility's
15 debt into its debt structure and provide a lower
16 aggregate interest rate for that facility, it was a
17 saving on the order of thirty million dollars over
18 the life of the project. And we've -- in -- in the
19 interim years, we've taken a look at the
20 performance of that obligated group and its rate
21 structure that it extends to the facilities
22 relative to what this healthcare facility achieved
23 through the I.D.A. It -- it -- it provides
24 substantial savings -- it would have provided
25 substantial savings along the lines of what

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2 obligated group has projected.

3 DR. STRECK: So again,

you're

4 proposing this because you see that it has

an

5 advantage. From the council's perspective,

any

6 such commitment would have to come here for

a

7 character and competence review of the

obligated

8 debt?

9 MR. ABEL: That's correct.

We

10 would continue to bring obligated group --

11 DR. STRECK: Group.

12 MR. ABEL: -- proposals

through

13 for establishment approval. It's just that

the --

14 the -- our review associated with that

15 establishment action would be limited to the

16 character and competence of the active

parent and

17 current compliance for the New York State

18 facilities.

19 DR. STRECK: Other

comments or

20 questions? Mr. Fensterman?

21 MR. FENSTERMAN: Thank you,

Mr.

22 Chairman. Charlie, I think this is a great

concept

23 and necessary, particularly given the

reimbursement

24 issues that various facilities are facing

and how

25 lenders are going to look upon that in terms

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2 their ability to service debt. I just want
to be
3 clear, and the chairman mentioned it. Your
4 proposal suggesting that the character and
5 competence of the active parent outside the
state
6 would be reviewed. And does it also include
the --
7 in -- in New York State, activities of any
of the
8 possible boards in New York?
9 MR. ABEL: It -- it -- it
10 absolutely would be a character and
competence
11 review of the -- of the board, assuming it's
a not
12 for profit active parent entity that may
exist
13 outside of New York State and -- having --
doing a
14 limited co-establishment of that entity with
the
15 New York State facilities. The New York
State
16 facilities -- at this point, we are
proposing a
17 current compliance review. Not a full
character
18 and competence review of all the board
members with
19 a ten year look-back as we do with full
character
20 and competence, but current compliance of
those New
21 York State entities with respect to any --
any
22 problems that the facilities is encountering.
And
23 the -- and the reason for that, obviously,
is that
24 the -- the New York State facilities are
already
25 established Article 28 facilities.

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2 DR. STRECK: So you mean the
3 subsidiaries of the parent, not the applicants,
4 would -- would go through that process, right?
5 In-state subsidiaries of the active parent, but not
6 necessarily applicants for the -- the joint
7 financing.
8 MR. ABEL: That's -- that's
9 correct.
10 DR. STRECK: Okay.
11 MR. ABEL: The New York State
12 entities.
13 DR. STRECK: Right. Okay.
14 MR. FENSTERMAN: Mr. Chairman,
15 could I just follow up with one more question?
16 DR. STRECK: Yes.
17 MR. FENSTERMAN: When you utilize
18 the term "active parent," are you describing a
19 wholly owned subsidiary by this active parent? Is
20 the New York State facility contemplated to be
21 wholly owned by the active parent?
22 MR. ABEL: We are -- we are
23 proposing that there be an active parent entity.
24 And -- and in the -- and in the -- the obligated
25 groups that have approached us, they have an

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2 that is established to function, and

functions

3 already, as an active parent over all of the

4 out-of-state entities. It -- that -- that's

a

5 structure that already exists. We're --

we're

6 proposing to -- not to have that active

parent set

7 up a New York State entity that we will

establish,

8 but rather to -- to establish -- take --

take --

9 take through the establishment process that

board

10 for that current active parent entity.

11 MR. FENSTERMAN: And have

you

12 contemplated analyzing the out-of-state

Department

13 of Health -- their respective Department of

Health

14 rules and regulations as it relates to

borrowing,

15 which differ from state to state? My

concern being

16 that we would not want an out-of-state

entity to be

17 subject to default which would affect our

in-state

18 facilities. So are we analyzing -- you know,

it's

19 very -- for example, in a -- in banking

documents,

20 there are things called "covenants," and you

have

21 to remain within your covenants or else

you're in

22 default. In our own statute, as it relates,

for

23 example, to nursing homes, there's certain

24 financial requirements that you have here

and under

25 the Public Health Law and under Department

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2 regulations. And if you go what I'll call "
out of

3 covenant" for purposes of this discussion,
it could

4 bring about certain consequences from the

5 Department of Health. Are we analyzing what
those

6 rules and regulations are of the
out-of-state

7 Department of Health?

8 MR. ABEL: I'm -- I'm not
sure

9 we're -- we're reviewing all of the things
that

10 you're proposing. We would be reviewing the

11 M.T.I., which would dictate the -- the --
the

12 transactions -- the financial transactions
and the

13 entry and departure of individual members.
We

14 would -- we would not be looking at the
individual

15 loan instruments that exist for the
out-of-state

16 facilities. And -- and also, this is
important, we

17 are -- we are saying that for any entry and
exit to

18 the obligated group by non-New York State
entities,

19 that would be dictated by the M.T.I. and
would not

20 be subject to review -- prior review and
approval

21 by the Department.

22 MS. LEFEBVRE: I -- maybe
I can

23 jump in here. I -- I -- I -- Mr. Fensterman,
I --

24 I think -- I think that the things that
you're

25 concerned about, and what -- what -- that

2 raising, really do get embodied in the -- the --
3 the master trust indenture that Charlie's referring
4 to. Because what we expect is this out-of-state
5 obligated group that's interested in bringing a New
6 York State entity in, will come in as a -- you
7 know, a rated credit that will, in that course,
8 demonstrate, and be able to demonstrate, all the
9 legal, you know, requirements having been met in
10 any state that they -- that they operate in --
11 MR. FENSTERMAN: My --.
12 MS. LEFEBVRE: -- particularly
13 covenant-wise.
14 MR. FENSTERMAN: My suggestion,
15 just for your consideration, is to perhaps obtain
16 estoppel certificates from their various lenders so
17 the onus is not on the Department, but it becomes
18 on the out-of-state facility to go to their lender
19 or credit agency. And by getting an estoppel
20 certificate, that's a certification to the
21 department that they're within covenants, and
22 that's my suggestion.
23 MS. LEFEBVRE: And they would
24 have to do that --
25 MR. FENSTERMAN: Right.

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2 MS. LEFEBVRE: -- in any

3 financing --

4 MR. FENSTERMAN: Right.

5 MS. LEFEBVRE: -- I would suspect

6 anyway.

7 MR. FENSTERMAN: Uh-huh.

8 MS. LEFEBVRE: Thank you.

9 DR. STRECK: So I think we've

10 have a presentation -- Sue? I'm sorry.

11 MS. REGAN: Charlie, I have a

12 concern about the -- the affiliated entities in the

13 group that are not in state, the out-of-state ones.

14 And I -- I think I have somewhat less confidence in

15 the rating agencies than you may have. But I would

16 want to know -- and I'm not proposing the character

17 and competence review because I think that process

18 has been very imperfect, but I'm proposing more

19 along the lines of a -- the kind of due diligence a

20 bond counsel would go through before writing a

21 letter to assure us and you that none of these

22 affiliated entities represent significant

23 liabilities, even -- either financial liabilities

24 or compliance liabilities. I -- I think the

25 character and competence process has -- has

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2 not been elegant in doing that. But we, the state,

3 need some way of doing that, not only for the ones

4 inside the state -- now -- now I don't think the

5 rating agencies do that effectively, but maybe you

6 can come up with some way of doing it. DASNY would

7 have ideas about how they do that.

8 I -- I do think we need to look

9 at these out of state, otherwise, we become, you

10 know, sort of a honey pot for large groups out

11 there who might be -- I'm not speaking about the

12 current one, but, you know, we may be presenting an

13 opportunity that is not best for the state.

14 MR. ABEL: That's -- that's a

15 good point, and certainly we can take a look at

16 bond counsel letters for the most recent bond

17 offerings that -- that were done for the obligated

18 group. That shouldn't be a problem.

19 MS. LEFEBVRE: And Sue, I would

20 also anticipate -- as we were reviewing these, you

21 know, certainly, rating agencies do a certain set

22 of jobs, but we -- I don't think we would hesitate

23 to pick up the phone and ask questions about what

24 we were seeing in their credit reports or any of

25 the financial statements because all of that

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2 rolls up into this parent's financial statement.
3 So I mean, I think that, you know, we would doing
4 our due diligence on those. And if we had
5 questions, we would certainly ask. And we will
6 certainly be working with DASNY also if -- if they
7 are the financer in these instances.
8 DR. STRECK: Dr. Bhat?
9 DR. BHAT: One of the questions
10 that I have, all the hospitals in New York State
11 are not for profit. And outside New York State,
12 there are a lot of hospital chains that are for
13 profit. Can a not for profit could be a part of an
14 obligated group which is for profit outside the
15 state? And what are the implications of that?
16 MR. ABEL: Just a couple of
17 things. First of all, while all the hospitals
18 currently in New York State are not for profit,
19 there is no restriction for for profit hospitals.
20 The last for profit hospital we had closed, I
21 think, about six or seven years ago. But this
22 policy that we're proposing is specifically for not
23 for profit hospitals for -- within New York State.
24 There are -- I -- I -- I believe there can be
25 structured such an arrangement where there

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2 profit subsidiaries of not for profit hospitals,
3 and those things could exist in New York State as
4 well as other states. So you know, as a practical
5 matter, could there be a for profit entity in an
6 obligated group that contained a not for profit New
7 York State facility? I suspect there very well
8 could be.
9 MS. LEFEBVRE: I would go a
10 little further also, and as -- as Charlie
11 referenced, this is part of the -- you know, our --
12 our response to M.R.T. recommendations that really
13 were asking us to explore and push on enabling
14 capital access for the healthcare industry. In
15 addition to this idea, which is limited to not for
16 profits, it's clear that the group, the -- the
17 M.R.T. group is -- has been asked to look at other
18 forms of for profit financing. We haven't really
19 touched that here in this, but I think that that's
20 something that the M.R.T. group was interested in
21 exploring at some point in time.
22 DR. BHAT: Would -- would that
23 allow these for profits outside the state to get
24 their foot in -- to the -- to have for profit
25 hospitals in New York State?

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2 MS. LEFEBVRE: This action does

3 not. I think that the M.R.T. asked that that idea

4 be looked at. And I think there's a lot of

5 research and certainly a lot of feelings on -- on

6 both sides about -- about the issue. But I think

7 that, you know, just doing the data -- data

8 gathering is what the M.R.T. was looking for.

9 DR. STRECK: Mr. Booth?

10 DR. BOOTH: I believe a for

11 profit can be the member of a not for profit, so

12 it's possible that the -- the parent -- active

13 parent could be for profit here.

14 I -- regardless of how that came

15 up and whether you cut that off at the pass, I

16 would tell you my biggest concern about what I'm

17 hearing here is we are giving up our own control of

18 our own community assets to potentially

19 out-of-state entities in order to get financing,

20 and that's essentially what we're doing. And I'm

21 not sure -- I understand the short-term needs. I'm

22 not sure that's in the long-term needs of -- of our

23 communities.

24 MR. ABEL: Just a point of

25 clarification. While I think we're all

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2 there's no reason why a for profit couldn't be in

3 an -- an obligated group, that we are talking about

4 potentially -- a multi-state obligated group, that

5 we're potentially just talking about an

6 establishment action with a New York State entity.

7 We -- for the purposes of this policy, we are only

8 considering obligated groups with not for profit

9 active parents.

10 DR. STRECK: So the -- oh, Mr.

11 Robinson?

12 MR. ROBINSON: A follow up.

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

14 FROM THE FLOOR: Talk into the

15 microphone, please.

16 MR. ROBINSON: I will try. Thank

17 you. Are we actually, through this process of

18 gaining financing, yielding governance authority of

19 New York State Article 28 facilities -- I mean,

20 total governance authority to these -- to these

21 obligated groups? Is that a consequence of this

22 mechanism that you're putting into place?

23 MR. ABEL: There certainly is the

24 potential for -- and -- and -- and -- and currently

25 what happens when we set up an active parent

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2 through -- through an establishment process, in

3 fact, they become a limited cooperator of the

4 Article 28 hospital. In this -- in this example,

5 that would -- that philosophy is consistent. It

6 would apply to the not for profit entity that could

7 be out-of-state active parent over an obligated

8 group.

9 MR. ROBINSON: I'm amazed that

10 New York State would not have sufficient financial

11 entities within its boundaries to be able to

12 provide this mechanism without needing to go to

13 multi-state operators.

14 MS. LEFEBVRE: It -- it --

15 it's -- it's just a fact that in -- inside of New

16 York State, there are very few healthcare entities

17 that could come together and leverage as much

18 interest rate benefit as, for example, some of the

19 larger multi-state not for profit obligated groups.

20 It's -- it's -- it's just -- it -- it's -- it's an

21 interest rate, you know, plan. When you have --

22 when you have stronger entities, you know,

23 through -- throughout the country, it -- it allows

24 for a significant benefit to a stand-alone

25 facility.

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2 MR. ROBINSON: I -- I just think
3 this runs the risk of getting into the corporate
4 practice of medicine. I -- it -- it -- I
5 understand the benefits, but I think that there are
6 perhaps, as Vick said earlier, unintended
7 consequences sometimes for some of these decisions.
8 So I -- I think this is not a very advisable
9 strategy if we want to maintain the kind of
10 primarily not for profit healthcare environment in
11 New York State that we currently have.
12 MS. LEFEBVRE: Mr. Robinson, even
13 if it's limit -- I mean, this has been, I think,
14 hopefully, really clear that this is limited to not
15 for profit practice.
16 MR. ROBINSON: Yes, but we've
17 actually seen conversions of not for profits to for
18 profit in New York State alone. And even -- and --
19 and that has at least had a governance kind of
20 oversight to it. I -- I think that when we sort of
21 yield this authority to out-of-state entities, we
22 actually ultimately lose significant control over
23 the operation of healthcare services in the state.
24 DR. STRECK: Dr. Rugge?
25 DR. RUGGE: Just as --

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2 two considerations. In several areas around the
3 state, on the boundaries of the state, there are
4 natural medical service areas that overlap from one
5 state to another, which has implications for how a
6 New York State institution may choose to connect to
7 and affiliate with an out-of-state organization.
8 As another observation, clearly any move on this
9 part with regard to obligated groups has
10 implications for how we regard restructuring among
11 healthcare organizations in new fashions to create
12 accountable care organizations, super groups, and
13 regional entities. So we need to be mindful of
14 precedent that we may be setting through these
15 changes, in terms of even more profound changes in
16 the delivery system coming forward.
17 DR. STRECK: Ms. Regan?
18 MS. REGAN: I -- I have to
19 disagree with -- with one fear here because I think
20 this -- this has been around. If you ever read the
21 covenants in something like a HUD document, a
22 guarantee document, it's, you know, bloodcurdling.
23 You give away all your budgeting authority. They
24 can come in at any moment and audit. I mean, these
25 things are already there, the -- these --

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2 giving away of this authority.

3 I think what -- what is scary

4 about this is not so much that we're giving away

5 theoretical budgeting authority. I think that's

6 largely theoretical. But the fear is that we're

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

8 were all invited to become members of the Ford

9 system or the Mayo Clinic, we might feel this was a

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

11 Adirondacks and we were going to do an A.C.O. with

12 Fletcher Allen, I mean, we would think this was a

13 great thing. And what -- what we need to get to is

14 to avoid the sort of knee jerk theoretical fears

15 and look at the substance of these deals, and

16 that's hard to do. But that's what we've got --

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

18 of course, this not -- this for profit thing has

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

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

21 need to be able to go into business with the good

22 guys.

23 DR. STRECK: Mr. Cook?

24 MR. COOK: I just -- I -- I just

25 want to kind of emphasize a couple of points.

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2 mean, number one, I don't see how we're ceding any
3 authority. I mean, once established, we still have
4 the authority with that active parent to apply all
5 the rules and all the regs and all the pressures
6 that we can apply as a department.
7 I think, secondly, it's important
8 to understand the context. Part of the issue that
9 we have heard over and over again is how -- the
10 difficulty of hospitals and others throughout this
11 state to get access to capital. And I think, to
12 Sue's point, what this allows us to do is to begin
13 to understand, what are some of the opportunities
14 that are out there that we need to look at that may
15 be beneficial to many of the hospitals across the
16 state? We don't know everything that we're going
17 to see, but it's certainly worth an opportunity to
18 have a process where we can begin to understand,
19 what are those proposals?
20 DR. STRECK: Thank you. Mr.
21 Berliner?
22 DR. BERLINER: Just -- just a
23 comment on -- on -- on what Rick just said. I
24 mean, it seems to me we confronted this issue when
25 we were dealing with dialysis centers. And

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2 we found that, in fact, we had no control over the

3 active parent. That if the active parent wanted to

4 withdraw its funding or change its policies, there

5 wasn't much we could do because we really -- and

6 that was one of the reasons we allowed the for

7 profits to come in directly because we didn't have

8 that control. But I think it's still an issue of,

9 you know, what can we do once we cede the

10 authority?

11 MR. COOK: It -- it -- it's

12 always going to be an issue. I mean, I -- I think,

13 you know, we learned -- right now, we know that the

14 world is changing significantly. And we know

15 clearly that there are hospitals that are really

16 struggling to upgrade their physical plant, to do

17 simple things like improve their O.R.'s, to be able

18 to even buy hospital beds in some small

19 communities. And some of them do have

20 opportunities through, perhaps, Catholic Healthcare

21 East or others that are concrete examples that

22 really can make a difference. I mean, I think, in

23 some respect, we have to begin to -- and it sounds

24 odd for the director of O.H.S.M. perhaps saying

25 this -- to be more flexible in inviting the

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2 of proposals that may have a benefit to those

3 hospitals.

4 And that's really what this

5 debate -- this is -- that was the debate that led

6 to this. This has been a debate that's been

7 ongoing within the Department over the last year

8 and a half where we interviewed bond counsel, we

9 interviewed Wall Street firms, we've interviewed

10 the entities that might be interested, and have

11 come up with this proposal.

12 DR. STRECK: So to -- to bring

13 this particular discussion to its first conclusion,

14 I suspect we may have more to say about this. It

15 was a very well, very clearly presented proposal.

16 I think that the concerns in terms of governance

17 for the out-of-state active parent model carries

18 some concern. And the potential benefits, or at

19 least the exploration of benefits is what the

20 department is advocating with this policy.

21 MR. ABEL: Now I -- I can tell

22 you that the concerns that I've heard have been our

23 internal concerns that we've had to struggle with

24 and try to balance a policy that will hopefully

25 enable New York State facilities to access

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2 cost capital resulting in lower cost of
healthcare,
3 lower cost to the Medicaid system and the
state's
4 insurers. That -- that's the -- that's the
goal
5 here. We clearly understand the concerns
that have
6 been expressed, and -- and we think through
this
7 policy, we've -- we've -- we've addressed
inherent
8 in the operational structure that we -- the
9 procedures that we envision moving forward
with,
10 hopefully, we will eliminate those kinds of
11 concerns along the way. Did pick up a few
good
12 tidbits and -- and comments that we will
consider
13 in -- in our next internal meeting on this
and move
14 forward. Thank you.
15 DR. STRECK: So we will
view this
16 as you're moving ahead with cautious
concurrence
17 from the Public Health and Health Planning
Council.
18 There will be opportunity for this group to
discuss
19 this if members of the council wish to do so.
And
20 certainly, with the first proposal that
should ever
21 come before this group, we will have the
most
22 active opportunity to discuss active parents.
So
23 thank you for that presentation.
24 We'll now move to report
of the
25 Committee on Health Planning. Dr. Rugge?