

**STRATEGIC PLANNING COMMITTEE MEETING  
OF THE BOARD OF DIRECTORS**

**MAY 13, 2014  
10:30 A.M.  
HHC BOARD ROOM  
125 WORTH STREET**

**AGENDA**

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

**II. ADOPTION OF APRIL 8, 2014  
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**

**III. SENIOR VICE PRESIDENT'S REPORT** **LARAY BROWN**

**IV. INFORMATION ITEM:**

**i. HIV SERVICES UPDATE PRESENTATION**

TERRY HAMILTON, ASSISTANT VICE PRESIDENT  
CORPORATE PLANNING & HIV SERVICES

SIMONA BRATU, MD  
HIV MEDICAL DIRECTOR, KINGS COUNTY HOSPITAL CENTER/  
HIV SERVICES CLINICAL ADVISORY GROUP

**V. OLD BUSINESS**

**VI. NEW BUSINESS**

**VII. ADJOURNMENT**

**JOSEPHINE BOLUS, RN**

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**NEW YORK CITY HEALTH AND HOSPITALS CORPORATION**



## **MINUTES**

### **STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS**

**APRIL 8, 2014**

The meeting of the Strategic Planning Committee of the Board of Directors was held on April 8, 2014 in HHC's Board Room located at 125 Worth Street with Josephine Bolus presiding as Chairperson.

#### **ATTENDEES**

##### **COMMITTEE MEMBERS**

Josephine Bolus, NP-BC, Chairperson of the Committee  
Ram Raju, M.D.  
Robert F. Nolan  
Bernard Rosen

##### **OTHER ATTENDEES**

M. Dolan, Senior Assistant Director, DC 37  
C. Fiorentini, Analyst, New York City Independent Budget Office

##### **HHC STAFF**

M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations  
J. Bender, Assistant Director, Media Relations, Communications and Marketing  
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations  
E. Casey, Assistant Director, Corporate Planning and HIV Services  
D. Cates, Chief of Staff, Office of the Chairman  
J. Chesser, Assistant Vice President, Office of Intergovernmental Relations  
J. DeJesus, Administrator, World Trade Center Environmental Health Center  
M. Dunn, EEO Officer, North Bronx Health Network  
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations  
D. Green, Senior Assistant Vice President, Corporate Planning Services  
T. Hamilton, Assistant Vice President, Corporate Planning Services  
L. Haynes, Assistant Systems Analyst, President's Office

- L. Johnston, Senior Assistant Vice President, Medical and Professional Affairs
- J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations
- S. Kleinbart, Director of Planning, Coney Island Hospital
- Z. Liu, Senior Management Consultant, Corporate Planning Services
- P. Lockhart, Secretary to the Corporation, Office of the Chairman
- A. Marengo, Senior Vice President, Communications and Marketing
- K. McGrath, Senior Director, Communications and Marketing
- H. Mason, Deputy Executive Director, Kings County Hospital Center
- A. Martin, Executive Vice President and Chief Operating Officer, President's Office
- T. Miles, Executive Director, World Trade Center Environmental Health Center
- J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
- K. Park, Associate Executive Director, Finance, Queens Health Network
- S. Penn, Deputy Director, World Trade Center Environmental Health Center
- L. Robinson, Administrator, World Trade Center Environmental Health Center
- S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs
- W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
- R. Solomon, Associate Director, Lincoln Medical and Mental Health Center
- D. Thornhill, Associate Executive Director, Strategic Planning, Harlem Hospital Center
- J. Wale, Senior Assistant Vice President, Behavioral Health
- K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations
- R. Wilson, M.D., Senior Vice President, Corporate Chief Medical Officer, Medical and Professional Affairs

## **CALL TO ORDER**

The meeting of the Strategic Planning Committee was called to order at 10:50 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, NP-BC. The minutes of the March 11, 2014 meeting of the Strategic Planning Committee were adopted.

## **INFORMATION ITEMS**

### **2014-15 State Fiscal Year Final Budget Overview**

Wendy Saunders, Assistant Vice President, Intergovernmental Relations

Ms. Brown greeted and informed the Committee that she would not be providing a Senior Vice President's report to allow time for two information item presentations, which included an overview of the finalized 2014-15 State Fiscal Year Budget by Ms. Wendy Saunders, Assistant Vice President of Intergovernmental Relations, and a federal update presentation by Ms. Judy Chesser, Assistant Vice President of Intergovernmental Relations. Ms. Brown further notified the Committee of her early departure from the meeting to meet with Deputy Mayor Paoli to discuss North Central Bronx Hospital.

Ms. Brown invited Ms. Wendy Saunders, Assistant Vice President of the Office of Intergovernmental Relations to present an overview of the finalized 2014-15 State Fiscal Year Budget. Ms. Saunders reported that the New York State Legislature had passed the finalized State budget on March 31, 2014. She emphasized that this was quite an achievement for the Governor in having an on time budget for the fourth consecutive year. She also noted that the last time that this had been accomplished was more than 20 years ago.

Ms. Saunders reported that the total state budget was \$137.9 billion, which represented an increase of \$687 million compared to the Governor's original proposed budget (i.e., \$137.2 billion). Ms. Saunders explained that the finalized budget would only increase overall spending by 0.1% more than the Governor's original proposal, and reflected a 1.8% increase in spending over the previous year's budget. Ms. Saunders also reported that the finalized budget included a \$1.5 billion tax-cut package and a \$1.1 billion spending allocation for education. She highlighted that the spending allocation for education also included the Mayor's Pre-K initiative.

### Medicaid Spending

Ms. Saunders reported that, overall the Legislature had restored \$79.7 million in Medicaid spending. She reminded the Committee that this amount included the two percent across the board rate cut which had already been included as an option in last year's budget. Ms. Saunders noted that the restoration of the two percent rate cut would not translate into increased revenue for HHC (i.e., \$23 million) because it had been already been accounted for in HHC's Financial Plan.

Ms. Saunders informed the Committee that there would be no inflationary increase or trend factor for Medicaid providers this year. However, she reminded the Committee that, when it was eliminated in last year's budget, the trend factor cut to HHC was \$26.4 million.

Ms. Saunders reported that the finalized budget included a provision that would extend the Global Medicaid Cap for one year, along with the State Department of Health (SDOH)'s "superpowers" to make administrative rate cuts that would keep spending under the cap. She referred to the previously held Finance Committee meeting at which, Ms. Zurack, HHC's Senior Vice President and Chief Financial Officer, had discussed transparency relating to spending under the global cap. She added that there would be significant new reporting requirements for SDOH related to the Global Medicaid Cap. SDOH will provide monthly and annual detailed reports to the Legislature and to the public. These reports will describe how the cap is calculated and the various service lines that make up the cap.

Ms. Saunders reported on the "shared savings" provision of the finalized budget. She reminded the Committee that, in the Governor's original proposal, a minimum of half of the "shared savings" resulting from the imposition of the global cap would be distributed proportionately to all providers and health plans. No more than half would go to "financially distressed and critically needed providers," which would be determined by SDOH. Ms. Saunders reported that, unfortunately the State Senate was not comfortable with that proposal. Their one house budget proposal changed that distribution formula to proportionally distribute 70% of any "shared savings" to providers and health plans with the remaining 30% being placed in a reserve fund. In their proposal, none of the "shared savings" would be distributed to "financially distressed and critically needed providers."

Mrs. Bolus, Committee Chairperson asked how much would HHC lose under the "shared savings" initiative. Ms. Brown responded that HHC would not lose but would potentially gain. She explained that HHC would gain if the extra 50% is assigned to "financially distressed and critically needed providers". Ms. Saunders informed the Committee that the Senate had added another requirement that the SDOH must consult with the Legislature, providers, health plans, workers and other interested parties on how the funds would be distributed. Additionally, SDOH must also report how the formula for both a proportional distribution and designation of "financially distress and critically needed providers" will be determined.

#### Medicaid 1115 Waiver

Ms. Saunders reported that both houses of the Legislature were very interested in the Medicaid 1115 Waiver. They are interested in ensuring transparency, legislative and public involvement in how the Delivery System Incentive Payment Program (DSRIP) funds would be spent. Ms. Saunders commented that, although the state had not yet finalized the waiver, it had received significant attention during the budget discussions. She added that, as part of budget process, SDOH provided the Legislature with regular detailed reporting on waiver programs and projects. Ms. Saunders informed the Committee that a DSRIP Advisory Panel would be formed and tasked with reviewing the funding recommendations made by the SDOH contractor that would be charged with assessing applications. She explained that the DSRIP Advisory Panel would make non-binding recommendations to the Health Commissioner. Moreover, the Advisory Panel cannot include members of the Legislature. It will include experts in health care systems who are not providers or otherwise conflicted. Ms. Saunders added that the finalized budget included a provision requiring that there be statewide spending to the extent practicable and allowed in the final waiver.

Mrs. Bolus asked if the DSRIP Advisory Panel would be a voluntary or paid panel. Ms. Brown responded that it would be a non-paid advisory panel.

At the request of Mr. Rosen, Ms. Brown explained that the Medicaid 1115 Waiver had many components and that the Delivery System Reform Incentive Payment (DSRIP) program was one of the waiver's biggest components. She reminded the Committee that DSRIP funds would be available to two groups: public hospitals, and safety net providers, which includes voluntary hospitals, nursing homes, community health centers and home care agencies. She also reminded the Committee that the DSRIP overarching goal is to reduce preventable hospitalizations and avoidable emergency room utilization. Ms. Saunders added that, just like the Global Medicaid Cap, the Legislature had added significant new reporting requirements for spending under the waiver, DSRIP programs and implementation.

### Capital Funding

Ms. Saunders reported on the capital funding provision that was included in the finalized budget. This provision allocates \$1.2 billion for a state funded initiative for capital funding over seven years for hospitals, nursing homes, diagnostic and treatment centers, licensed clinics and assisted living programs. Ms. Saunders explained that this state funding for a new capital program was meant to compliment the 1115 Waiver. Ms. Saunders informed the Committee that, while the proposal had been included in the original waiver request, the federal government would not agree to fund it. Ms. Saunders reminded the Committee that the \$1.2 billion would be distributed over seven years. As such, \$200 million would be available in each of the first 5 years, and \$100 million for the program's last two years. Ms. Saunders noted that the finalized provision differed from the Governor's original proposal as the funding had been separated into two distinct pools: one for DSRIP providers and one for non-DSRIP providers. She also noted that, because HHC would be classified as a DSRIP provider, HHC would expect to be in the DSRIP pool. Ms. Saunders also informed the Committee that DSRIP providers would need to include a request for these funds as part of their DSRIP application. Ms. Saunders further explained that the DSRIP Advisory Panel that was created under the Medicaid 1115 Waiver would also be charged with assessing applications for capital funding for the non-DSRIP providers. Ms. Saunders added that these funds were intended to improve financial stability and improve collaboration. As proposed by the Governor, these funds can be used for closures, mergers, restructuring, infrastructure improvements, expanding primary care capacity, promoting integrated delivery systems and providing continued access to essential health services. Ms. Saunders noted that the Legislature had also added Telehealth to the list of options.

Mrs. Bolus recalled that HHC had applied for Federally Qualified Health Center Look-Alike (FQHC-LAL) status for all its diagnostic and treatment centers (D&TCs). She asked if these HHC facilities would still be eligible for capital funding. Ms. Brown responded and explained that D&TCs referred to a category of providers from the state's perspective. She explained that, notwithstanding that HHC was seeking FQHC Look-Alike status all of its D&TCs that would form the FQHC, these facilities would still be considered D&TCs by the state.

Mr. Robert Nolan, Board Member asked if the \$1.2 billion capital funding over the seven-year period had to be approved each year by the Legislature. Ms. Saunders responded that it should be included in the budget each year for seven years.

### Health Information Technology

Ms. Saunders reported that the final budget included a provision to reserve up to a total of \$95 million for Health Information Technology (HIT). She added that \$55 million of that allocation would be for the State Health Information Network of New York or SHIN-NY, which she described in her previous presentation on the proposed budget as the health information "superhighway" that would provide statewide interoperability between the various Regional Health Information Organizations (RHIOs). Ms. Saunders stated that this funding would be generated partly from the Health Care Reform Act (HCRA) covered lives assessment, which is paid by New York State's health insurers. Ms. Saunders explained that, because of the increase in the number of people with health insurance, made possible through the implementation of the Affordable Care Act and Health Exchange, these surcharges or covered live assessments were expected to increase. Ms. Saunders noted that the Legislature accepted this proposal with a caveat that a reserve fund would be created rather than a direct allocation of the funding for HIT initiatives. In addition, \$10 million in funding would be allocated to create an All Payer Claims Database (APD) for health insurance claims to be used by researchers and others who are working to improve population health. Along with the reserve fund, the Legislature called for the creation of a New State HIT Infrastructure Workgroup that would be charged with evaluating the State's HIT infrastructure and systems and to make recommendations on the SHIN-NY, Electronic Medical Records (EMRs), APD, the State Planning and Research Cooperative System (SPARCS) and the Medicaid Eligibility Systems.

Mr. Salvatore Russo, HHC's General Counsel, asked if any appointments had been made to the HIT Infrastructure Workgroup. Ms. Saunders responded no.

### Hospitals

Ms. Saunders reported on the hospital focused provisions that were included in the final budget. She stated that there was a provision to restore Medicaid presumptive eligibility for certain populations, which had been eliminated as a by-product of federal health care reform. She informed the Committee that HHC advocated for restoring this program, which the Senate had rejected in their budget proposal. Ms. Saunders noted that Medicaid presumptive eligibility would be restored by January 1, 2015 or earlier.

Ms. Saunders reported that the final budget included the Governor's proposal to delay hospital inpatient rebasing by three to six months (from January 1, 2014 to sometime between April 1, 2014 and July 1, 2014); and a provision which would also allow for periodic updates to the base year of inpatient psychiatric, specialty and detoxification facilities, by no later than April 1, 2015. Ms. Saunders explained that the Legislature had delayed the rebasing for the special facilities and created a workgroup to review the new methodologies. Under these proposals, rates could be adjusted to prevent a net aggregate increase in Medicaid spending.

Ms. Saunders reported that the final budget included a provision to adjust both inpatient and outpatient rates related to the implementation of the International Classification of Diseases Version 10 (ICD-10) coding system.

Ms. Saunders informed the Committee that HHC was pleased that funding for the Excess Medical Malpractice Program was extended through June 30, 2015. She added that the Senate had proposed to add an additional 1,000 slots but the Senate's proposal was not included in the final budget.



Ms. Saunders reported that the Governor's final budget included \$40 million for Vital Access Providers (VAP). The Vital Access Program (VAP) provides grants to essential health care providers that were affected by system transformations like closures. She noted that this increase would bring the total funding to \$194 million. Ms. Saunders informed the Committee that, to date, Lincoln Medical Center, Woodhull Medical and Mental Health Center and Kings County Hospital had received more than \$5 million in VAP funding. Ms. Saunders added that VAP was a popular program and that the State Department of Health had received more than 150 applications totaling \$1.2 billion. Ms. Saunders noted that the VAP program was one of the programs that had been included for funding in the Medicaid MRT Waiver. While it is not certain that it will be included in the final waiver, if not included, the finalized state budget included VAP funding using state only funds.

### Long Term Care

Ms. Saunders reported on the long term care provisions of the final budget. She reported that the Nursing Home Upper Payment Limit for non-state public nursing homes had been increased, which was previously capped at \$300 million statewide. Ms. Saunders stated that HHC had advocated for an increase or the elimination of the cap. She informed the Committee that HHC was successful in getting an increase in the cap to \$350 million for non-state public nursing homes. It is estimated that this increase would result in an additional \$4.2 million annually for HHC.

Ms. Saunders reported that HHC advocated strongly against a proposal that would have prevented nursing homes from getting Medicaid rate increases when the number of high acuity patients that they cared for increased. This proposal would have resulted in a loss of more than \$2 million annually for HHC. She explained that the proposal would have prevented rate increases for case mix index increases of greater than two percent, over a six month period. Ms. Saunders noted that the total statewide impact would have been \$42.9 million.

Ms. Saunders reported that the final budget included the Governor's proposal to create a Medicaid Nursing Home Default Rate for managed care plans. She added that, in the absence of any negotiated rate, managed care plans would be required to pay nursing homes the current fee-for-service Medicaid rate. This would not apply to rehabilitation services.

Ms. Saunders reported that the final budget included a provision to allocate \$380 million for Home Health Care Workers' living wage programs that were being implemented around the state. She added that the Governor had originally proposed \$300 million, which he later increased to \$350 million. Ultimately, the Legislature added another \$30 million to this proposal for a total of \$380 million that was approved in the final budget. Ms. Saunders noted that more discussions and information about this proposal would be forthcoming.

Mr. Rosen asked about the impact for long term care patients who were members of the health plan. Ms. Saunders responded that, instead of receiving fee-for-service-payments, nursing homes were increasingly being paid by managed care plans for patients who were enrolled in managed long term care. This will continue to increase as the state transitions long term care patients into managed care. Ms. Saunders added that there had been a great deal of concern that the plans would pay less than the Medicaid fee-for-service rate.

Mr. Rosen asked if the managed care organizations were not paying enough would the default rate prevail. Ms. Saunders responded affirmatively.

### Behavioral Health

Ms. Saunders reported on the Behavioral Health proposals that had been approved in the final budget. These proposals include:

1. A proposal to create a Community-Based Behavioral Health Services Reinvestment Program. The program would be funded by State General Fund savings that would be generated by transitioning this population to managed care. It would be designed by the State Department of Health (SDOH) and the State Department of Mental Health to increase funding for community based services.
2. A proposal to advance co-location of behavioral health and physical health services. The budget reallocates \$15 million from last year's budget for programs that support the co-location of services. It also allows the State to issue emergency regulations to implement the integration of co-located behavioral health and physical health services that were authorized as part of last year's budget.
3. A proposal to provide funding for the transition to managed care. The budget includes \$20 million for training, HIT and transition costs related to the transition of behavioral health into managed care. The State is authorized to provide the funding to health homes, plans, providers and others pursuant to a plan that will be developed. The transition is scheduled to begin with adults in New York City next January.
4. A budget provision to increase rates for ambulatory behavioral health services. The budget provides authority to the State Office for Mental Health (OMH) and the State Office of Alcohol and Substance Abuse Services (OASAS) to transfer funds to SDOH to pay for rate increases for ambulatory behavioral health services. The increase would be effective through 2016 for New York City providers, except for patients under 21 where the increases would remain in place for an additional year. The proposal does allow managed care plans to negotiate different rates with providers.
5. The Governor's proposal to create a Collaborative Care Clinical Delivery Model was rejected. The Legislature rejected the Governor's proposal to establish a new model for clinics to treat depression and other mental or substance abuse disorders.

### Other Important Health Care Related Proposals in the Governor's Final Budget

Ms. Saunders reported on other healthcare related initiatives that were approved in the finalized state budget. These initiatives include:

1. Nurse Practitioner Modernization Act. The final budget includes a provision that would allow experienced nurse practitioners to establish collaborative relationships with a hospital or a physician in their specialty rather than the current requirement for a written practice agreement.

2. Safe Patient Handling Program. The final budget includes new Safe Patient Handling Program that requires every hospital and nursing home to establish an internal committee charged with developing a program for their facility. The facility would have to implement the program by January 1, 2017.
3. Out-of-Network Proposal. The final budget includes extensive new requirements for health plans and hospitals for services that are provided out-of-network by approved providers covered under the patient's health plan. The patient cannot be billed more than what they would have paid in-network for emergency services. Providers can attempt to recover additional charges from the health plan. There also are new notice and disclosure requirements for health plans and providers and a new dispute resolution process.
4. HIV Testing Requirements. The final budget includes the Governor's proposal to overhaul the requirement governing HIV testing. As of April 1, 2014, this proposal would eliminate the requirement for written informed consent, except for patients in correctional facilities.
5. Basic Health Plan. The final budget includes a provision that would authorize the State to take advantage of an option under the Affordable Care Act (ACA) to implement a Basic Health Plan, if it is in the financial interest of the State. The State would receive any subsidies that would otherwise be available for participants to purchase coverage under the Health Exchange. The plan would cover individuals with incomes between 138-200% of the federal poverty level (about \$16,000 - \$23,000 for an individual or \$27,000-\$39,000 for a family of three.) The plan would be available for many legal immigrants who cannot qualify for Medicaid due to their immigration status (but not for the undocumented).
6. New State requirements for Bronx health care facility construction projects. The final budget includes a new requirement for the SDOH to hold community forums in consultation with local Community Boards for any proposed freestanding clinic, outpatient health care facility or center, or ambulatory care facility affiliated with a hospital. It would only apply to construction projects that would exceed three stories in height or 30,000 square feet that are being proposed to be built in the Bronx. After hearing from the community, SDOH would approve, deny or modify the proposal.

Mr. Nolan commented that these new requirements had been intended to kill one specific project, which was a high-rise building that was proposed by Montefiore Hospital in Riverdale. This project was strongly opposed by Riverdale community residents.

Ms. Saunders agreed with Mr. Nolan but also clarified that any freestanding healthcare project affiliated with a hospital in the Bronx, over three stories and over 30,000 square feet, would have to go through this new process.

#### Other Health Care Related Proposals Not Included in State Finalized Budget:

1. Regional Health Planning Collaborative. The Governor's proposal to create 11 Regional Health Planning Collaboratives was not included in the final budget. The two houses approached the issue from opposite directions. The Assembly sought to re-establish health systems agencies while the Senate wanted assurances that the new entities would not have input in the CON process.

2. Private equity pilot proposal. The Assembly rejected the Governor's proposal to allow business corporations to provide capital investment in health care facilities. The Governor originally proposed this last year. Although he had changed the proposal to prohibit publicly traded corporation from participating, it was not enough to sway the Assembly.
3. Limited services "retail" health clinics, urgent care and office based surgery. The final budget did not include the changes that were recently recommended by the Public Health and Health Planning Council (PHHPC) to license limited service clinics, require full accreditation of urgent care providers and impose more stringent requirements office-based surgery practices (beyond the current registration requirements).
4. Certificate of Need (CON) changes. For the second year, the Senate rejected changes to streamline the CON process. It is anticipated that this may be taken up later in the Legislative session.
5. Requirement for nursing homes to pay standard wage and benefits to direct care workers. A proposal to require nursing homes to pay their direct care workers a statewide standard wage and benefits was rejected for the second time. HHC had advocated that regional differences should be taken into consideration. The original Governor's proposal created only one statewide rate, which HHC was concerned, could negatively affect HHC's workers. While the Assembly addressed those concerns, the Senate rejected the full proposal.

The Committee thanked Ms. Saunders for her detailed presentation.

### **The View in Washington – Federal Advocacy Update Presentation**

Judy Chesser, Assistant Vice President, Intergovernmental Relations

Ms. Chesser greeted Committee members and invited guests. Ms. Chesser began her presentation by providing an overview of key activities in Washington. She reported that all the House Members and one-third of the Senate were up for re-election. She informed the Committee that, of the 26 Senate seats that were up for re-election, 21 were Democrat seats. She added that there were rumors that the Senate would not remain Democrat controlled next year. This is because seven of the 21 seats are within states that were won by Mitt Romney; and of those seats, six are in states that were won by Mitt Romney by double digits.

Ms. Chesser reported on a poll concerning the Affordable Care Act (ACA). The findings were that Republican leaning voters responded positively to a call to repeal the ACA. On the other hand, Democrat leaning voters responded to a description of the ACA as being transformative.

Ms. Chesser informed the Committee that the following federal policy issues were important to HHC:

- Medicaid DSH
- Medicare DSH
- Sustainable Growth Rate (SGR) aka "Doc Fix"
- Long Term Care
- Two Midnight Rule

- President’s Budget
- 340B Regulations
- World Trade Center (WTC) Health Program

Medicaid Disproportionate Hospital Share (DSH) Funding – National Cuts

Ms. Chesser reported that the national Medicaid DSH cuts had been readjusted several times. She stated that the good news was that the cuts were being delayed. She reported that originally the DSH reductions were to start in 2014; however, a provision in the Sustainable Growth Rate (SGR) or “Doc Fix” Patch Bill that had been adopted last week moved the start date to 2017. Ms. Chesser explained that, unfortunately, these cuts were being stacked up and getting bigger and bigger through the out years, making it more difficult should Congress wish to roll them back.

	<b>Current Law</b>	<b>House/Senate Agreement on SGR Patch</b>
<b>FFY</b>	<b>In billions</b>	<b>In billions</b>
<b>2016</b>	\$1.2	
<b>2017</b>	\$1.8	\$1.8
<b>2018</b>	5.0	\$4.7
<b>2019</b>	\$5.6	\$4.7
<b>2020</b>	\$4.0	\$4.7
<b>2021</b>	\$4.1	\$4.8
<b>2022</b>	\$4.2	\$5.0
<b>2023</b>	\$4.2	\$5.0
<b>2024</b>	-	\$4.4
<b>Total</b>	\$30.1	\$35.1

**Medicaid DSH Cuts – Impact on HHC**

The table below shows the impact of Medicaid DSH (\$ millions) funding cuts on HHC. These figures do not include any state or local match:

<b>FFY</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>Total</b>
<b>Current Law</b>	-173.5	-260.2	-308.3	-316.7	-325.2	-334.0	-342.9	-351.9	0.0	-2,412.6
<b>Under HR 4302</b>	0.0	-260.2	-308.3	-316.7	-325.2	-334.0	-342.9	-351.9	-361.1	-2,600.3

Ms. Chesser reported that New York State was the largest recipient of Medicaid DSH and HHC was the largest recipient of DSH within New York State. She added that originally when the ACA had passed, and before the Supreme Court decision, the assumption was that every state would have to expand their Medicaid program. Ms. Chesser reported that, the most recent legislation, the SGR patch, included a study that was supported by the America's Essential Hospitals (AEH). The study could serve as tool to fight DSH cuts in the future because it demonstrates the essentiality of the Medicaid DSH program and that the program should be restored to full funding.

#### Medicare DSH Redistribution

Ms. Chesser reported on the Medicare DSH redistribution. She informed the Committee that HHC had benefitted because of the new allocation. Ms. Chesser explained that under the new allocation, every hospital would receive 25% of their past Medicare DSH share and the remaining 75% of the funds would be redistributed through a new "uncompensated care payment" strategy to hospitals serving low-income patients. Ms. Chesser noted that these numbers go down precipitously but, unlike Medicaid, Medicare DSH cuts were calculated on best available data. These cuts are based on the amount of progress being made to get people insured. She added that the figures presented in the table below were based on a projection that there would be far fewer uninsured individuals in the future.

<b>HHC Medicare DSH Gains (in millions)</b>					
FFY	2014	2015	2016	2017	2018
Fee-for-Service 55.3	29.5	12.0	3.1	3.1	
Managed Care	59.6	38.3	23.8	16.6	16.9
<b>Total</b>	<b>114.9</b>	<b>67.8</b>	<b>35.8</b>	<b>19.7</b>	<b>20.1</b>

Ms. Chesser noted that New York State was the second largest Medicare DSH recipient. She explained that, for a while, Washington had considered delaying both Medicaid and Medicare DSH funding cuts. HHC, along with some other organizations had advocated for Medicare DSH, not to be delayed, as they would benefit from its new allocation. Ms. Chesser reported that HHC won this argument. The "losers" under the Medicare DSH redistribution have continued to lobby, so far unsuccessfully, to eliminate or delay the Medicare cuts but keep the hospital-specific gains. Ms. Chesser noted that Senator Schumer had been one of the leaders advocating to delay the cuts for the "losers."

#### Sustainable Growth Rate (SGR) – "Doc Fix"

Ms. Chesser reported on the Sustainable Growth Rate, also known as the "doc fix". Ms. Chesser reported that H.R. 4015 had passed the House and the Senate was about to take the bill to the floor. While an agreement was made on the substance on how to permanently fix Medicare payment to physicians, no agreement could be reached on how to pay for it. As part of the "pay for", the House of Representatives adopted a repeal of the employer mandate to provide health insurance that was part of the ACA. The President promised to veto any such repeal. The Senate, by comparison, proposed to "pay for" the Medicare "doc fix" payment by using funds in the overseas contingency fund, which is the money that was budgeted for the wars. Ms. Chesser reported that, in light of the collapse of negotiations on the bill, Congress had adopted a "patch" last week that would keep the physician reimbursement rates from decreasing until March 31, 2015 (into the next Congress). She noted that the

“patch” bill became a vehicle for many other provisions, one of which was the delay in the implementation of ICD-10, which has now been delayed for a year.

### Long Term Care Hospitals (LTCHs) – Henry J. Carter Specialty Hospital

Ms. Chesser informed the Committee that last year, Congress had enacted new criteria for facilities to qualify as a Long Term Care Hospital (LTCH). To receive payment as an LTCH, a facility had to show that 50% of all of its medical discharges have either: (1) been in an ICU for 3 days prior to admission; or (2) received ventilator services for more than 96 hours. Unfortunately, the requirement included that 50% of discharges from all payers had to be Medicare patients. Thus, if a facility had less than 50% Medicare patients it would never qualify as an LTCH. In the recent SGR patch, HHC worked with our Congressional delegation to get amendment language that included only the “Medicare FFS” discharges in the denominator, thus allowing the Henry J. Carter Specialty Hospital to continue to qualify as an LTCH.

### Two Midnight Rule

Ms. Chesser reported that, in August 2013, CMS had issued a rule to clarify that patient stays in hospitals for less than 2 midnights would be considered outpatient care and not inpatient care for purposes of Medicare reimbursement. HHC estimates that this rule could cost HHC \$23 – \$38 million in Medicare revenue each year. CMS delayed enforcement until October 1, 2014. In the “patch” bill, HHS may extend auditors’ prepayment “probe and educate” policy through March 31, 2015. Also auditors are prohibited from conducting patient status reviews on a post-payment review basis for inpatient claims for admission from October 1, 2013 to March 31, 2015. The SGR patch, however, did not establish a short-stay payment mechanism.

### President’s Budget

Ms. Chesser reported on important health care related proposals that had been included in the President’s budget. She informed the Committee that the President’s Budget included:

1. A \$402 Billion cut to health providers over 10 years - \$354.1 Billion from Medicare providers and \$8.9 B from Medicaid. These cuts included a Medicaid DSH cut extension for an additional year (FFY 2024) – for HHC a loss of \$361 million in that year alone.
  - a. HHC opposed but such an extension was passed last week as part of the “patch”
2. Extension of Temporary Medical Assistance (TMA) and Qualified Individuals program (QI) thru FFY 15.
  - b. In the bill enacted last week, TMA and QI were extended through March 31, 2015
3. Cuts to Medicare Indirect Medical Education (IME) of 10%.
  - c. Reallocates \$5.23 billion over 10 years to create a HRSA competitive grant program to train 13,000 primary care residents

4. Extension of 100% Medicaid Match for primary care thru CY 15 includes physician assistants and nurse practitioners and excludes emergency room codes to better target primary care.
  - d. Effective for dates of service from Jan 1, 2013 thru Dec 31, 2014. States reimburse at Medicare rate w/ fed government covering 100% of difference between Medicaid and Medicare rate - \$5.4 b costs over 10 years
5. Expansion of National Health Services Corps to at least 15,000 individuals annually - \$3.95 b over 10 years

### 340B Mega-Regulation

Ms. Chesser reported on forthcoming comprehensive regulation that is anticipated for the 340B program. She reported that:

- The 340B discount drug program has been operating without regulations since its inception in 1992 but a proposed "mega-reg" is expected this June.
- On January 9, 2014, HRSA's Office of Pharmacy Affairs (OPA) stated that the draft regulation would cover patient eligibility, compliance requirements for contract pharmacy arrangements, hospital and off-site facility eligibility criteria, GPO exclusion, inventory management, annual re-certification, audit procedures and appeals processes, among other issues.
- The 340B program provides pharmaceutical discounts to safety net providers including DSH Hospitals, FQHCs and Ryan White AIDS program grantees, for outpatient (not inpatient) drugs.
- HHC's 1.3 million patients have benefited from this program. HHC purchased approximately \$200 million worth of pharmaceuticals for its ambulatory care patients at a discounted price of approximately \$65 million for a savings of \$135 million through the 340B program

Ms. Chesser commented that Commander Krista Pedley, Director, Office of Pharmacy Affairs, had told the American Essential Hospitals (AEH) last month that she anticipated that hospitals would not like the regulation and that recommended that they should push back. Ms. Chesser commented that it remained to be seen if those regulations would be published in June.

### World Trade Center (WTC)/ September 11th Health Program

Ms. Chesser reported on the World Trade Center Health Program, which would expire on September 30, 2016. Under the statute that was enacted in 2011, a total of \$1.556 billion was authorized and appropriated. The original funding has proven more than adequate and thus it may be possible to extend the program without the need for additional funding. According to the Centers for Disease Control, the program served nearly 67,000 members nationally. As of December 31, 2013, many have received screening (26,133); diagnostic evaluations (14,158), had outpatient treatment (15,365), inpatient treatment (133), or medications (17,014) through the national program. Ms. Chesser reported that HHC's World Trade Center Environmental Health Center served 7,074 survivors.

### Other Advocacy Efforts

Ms. Chesser concluded her presentation by reporting on other advocacy efforts that were important to HHC. She reported that HHC had been advocating for FEMA funding for Sandy damage and future mitigation costs. She noted that the negotiations with FEMA were ongoing. In addition, Ms. Chesser



reported that efforts were being made to obtain Federally Qualified Look-Alike designation for HHC's diagnostic and treatment centers. Ms. Chesser informed the Committee that a HRSA site visit had been conducted ten days ago and it went well.

Mrs. Bolus thanked Ms. Chesser for her presentation.

## **ADJOURNMENT**

There being no further business, the meeting was adjourned at 11:09 AM.



# **HHC HIV SERVICES PROGRAM UPDATE**

**Presentation to the Strategic Planning Committee  
May 2014**

**Terry Hamilton**

AVP, Corporate Planning Services/HIV Services

**Simona Bratu, MD**

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HIVS Clinical Advisory Group

HIV Medical Director, KCH

# OVERVIEW: EVOLUTION OF HIV WORK OVER TIME

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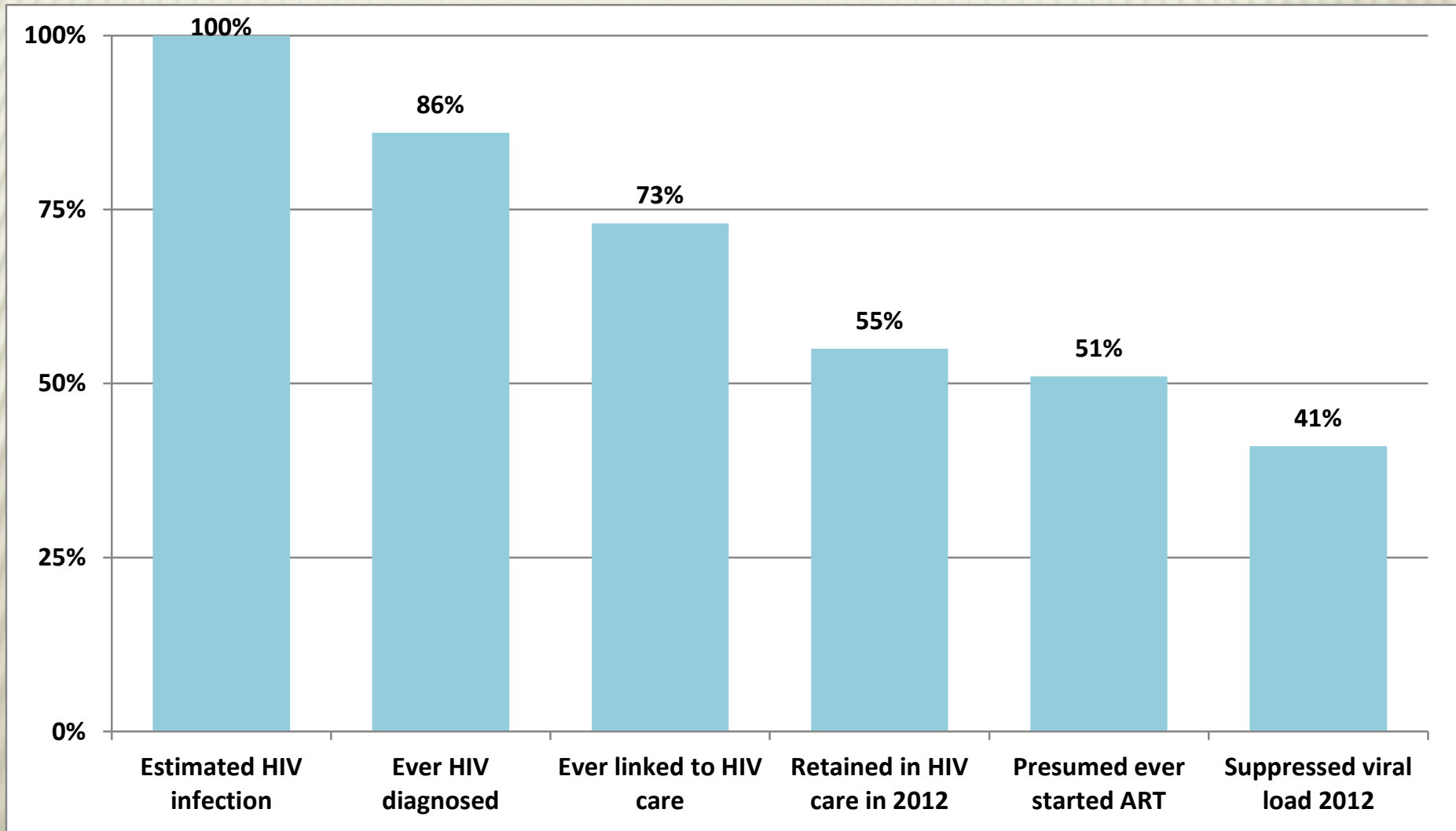
- How HHC has improved access to care from 2005 through present
- HHC's quality improvement initiatives
- National AIDS strategy and ending AIDS
- How HHC's future work will be transformed
- Recognition of HHC's work

# STATE OF HIV IN UNITED STATES: HRSA HIV CARE CONTINUUM

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- 1.2 million living with HIV in U.S.
- 50,000 new infections each year
- Of the PLWAs only 82% know they are infected
- Only 66% are linked to care
- Only 37% stay in care
- Only 33% are on ART
- Only 25% are adherent to medication and virally suppressed

# STATE OF HIV IN NEW YORK CITY: NYC HIV CARE CONTINUUM



Source: NYC DOHMH June 30.2013

# EVIDENCE AND RESEARCH GUIDES HHC'S PLANNING AND CARE DELIVERY STRATEGIES

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Two continuing areas of focus:

- Improving Access to Care using the HIV Testing Expansion Initiative (HTEI)
- Improving Quality of HIV Services using our Peer-based, corporate-wide HIV Quality Improvement Learning Network

# HHC'S THREE STRATEGIES TO IMPROVE NEW YORKERS' ACCESS TO TREATMENT

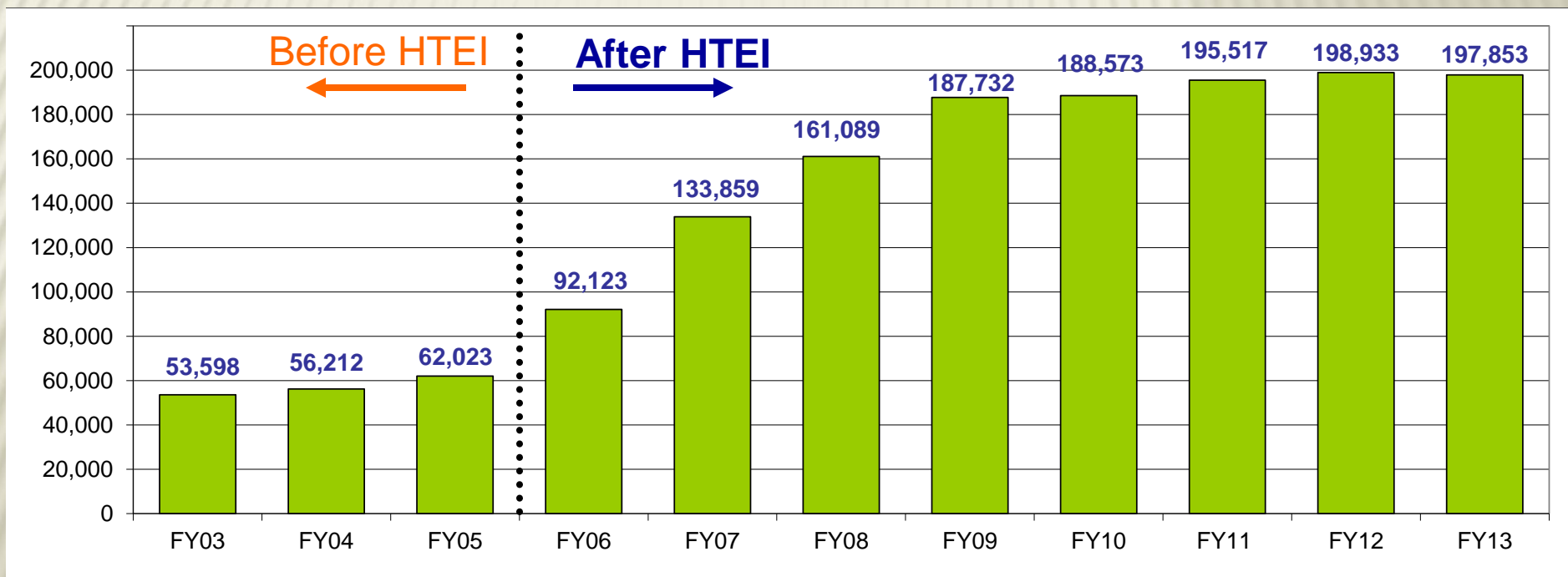
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- Increase the number of HIV positive patients who know their serostatus
- Increase the number of positive patients who enter care early
- Increase the number of HIV patients who are retained in care



# THEREFORE HHC ENGAGED IN HIV TESTING EXPANSION INITIATIVE (HTEI)

## Unique Patients Tested



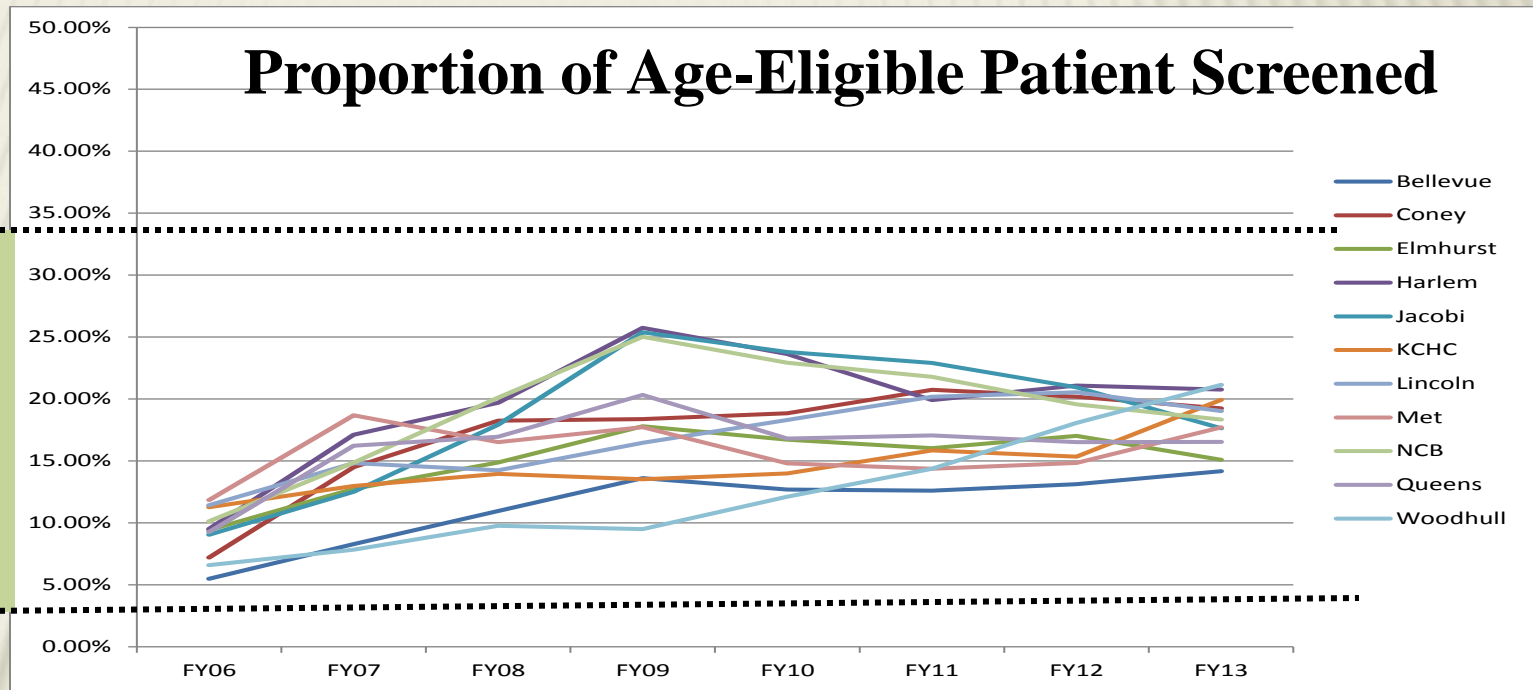
FY03 to FY04 Outpatient only (Source: PLM)

FY05 Outpatient and ED pilot sites only (Source: PLM and PHT in ED pilot project reports)

**NOTE:** HIV Testing Expansion Initiative began with FY05 ED pilot project

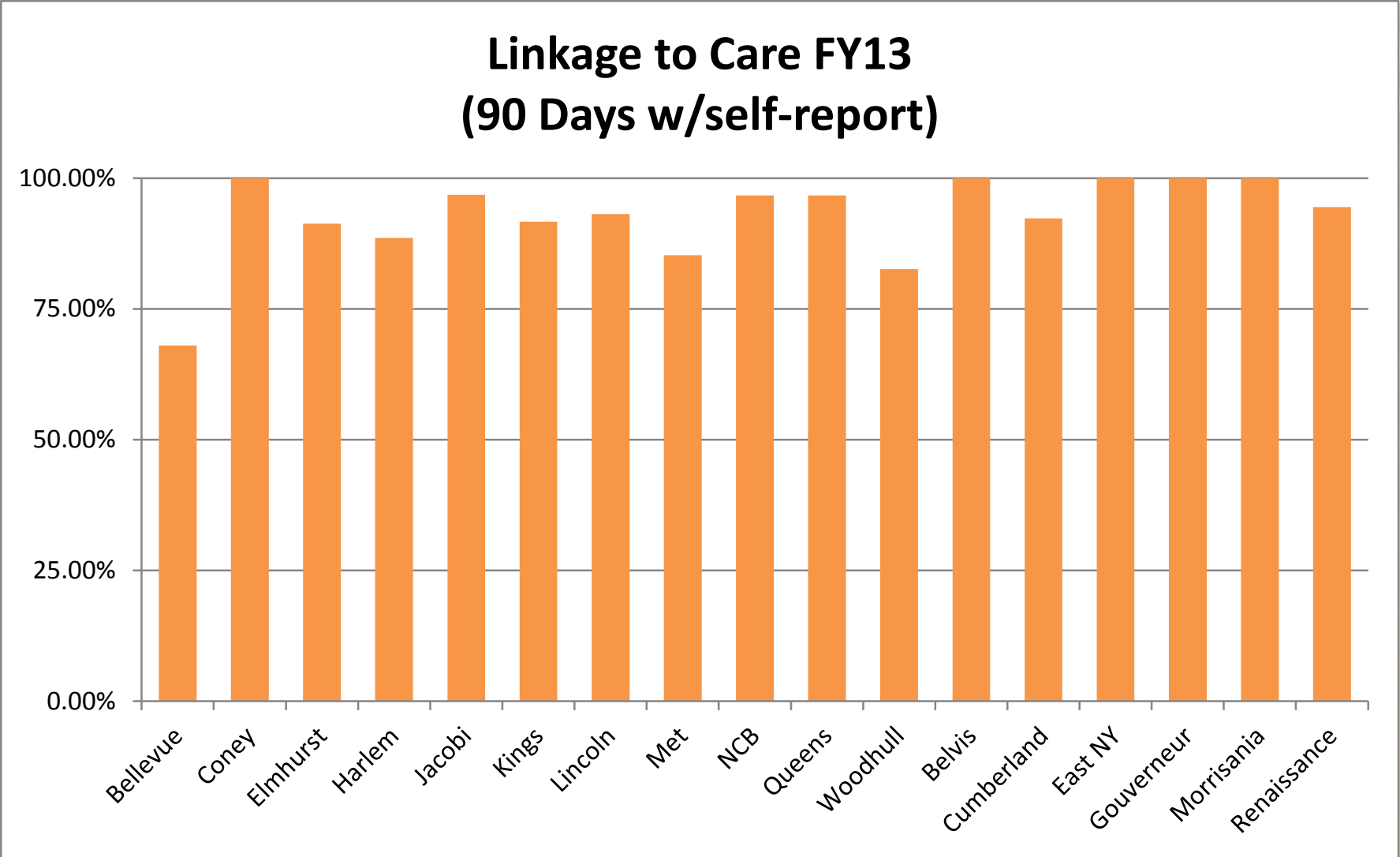
# CURRENT VIEW OF HIV TESTING

Range of  
Efficiency  
and  
Effectiveness



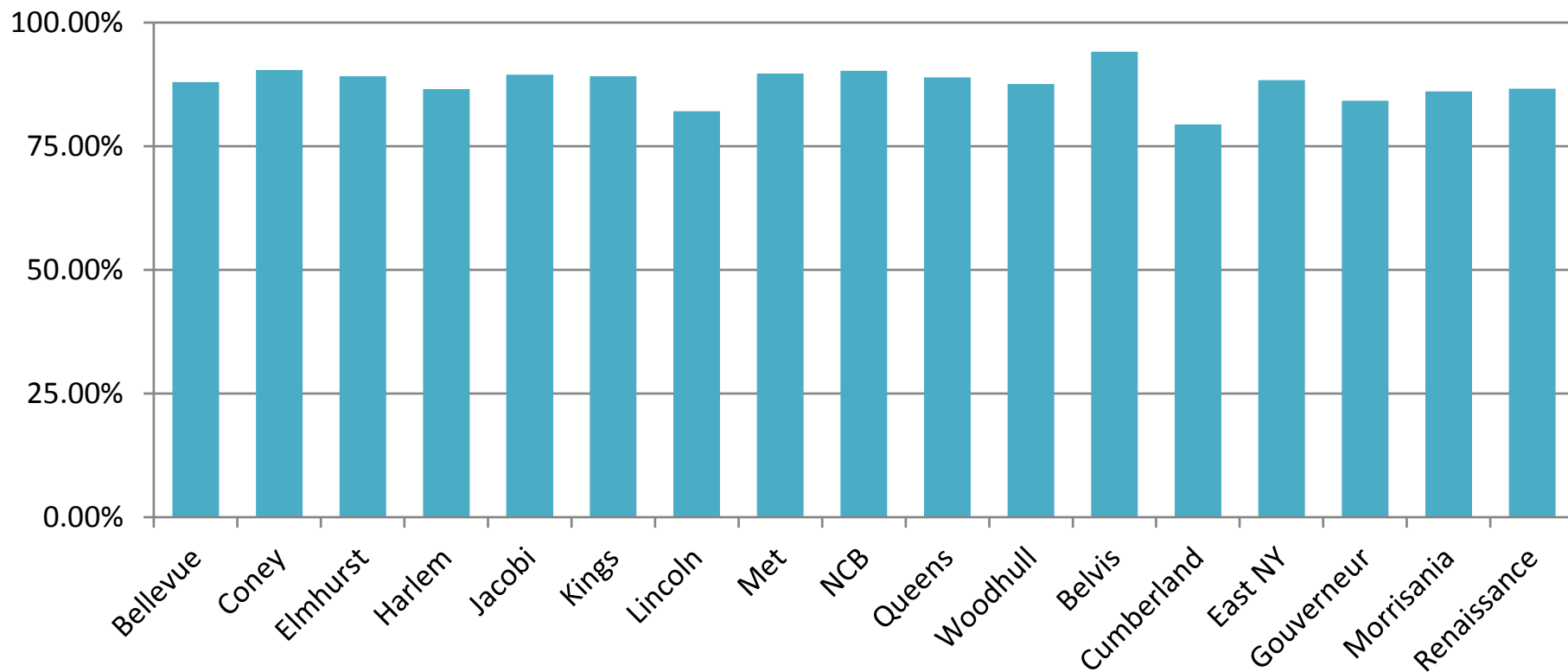
- The range between routine screening (20%) and 40% -- the tipping point of efficiency beyond which few positive will be identified.

# HHC LINKAGE TO CARE FY 13

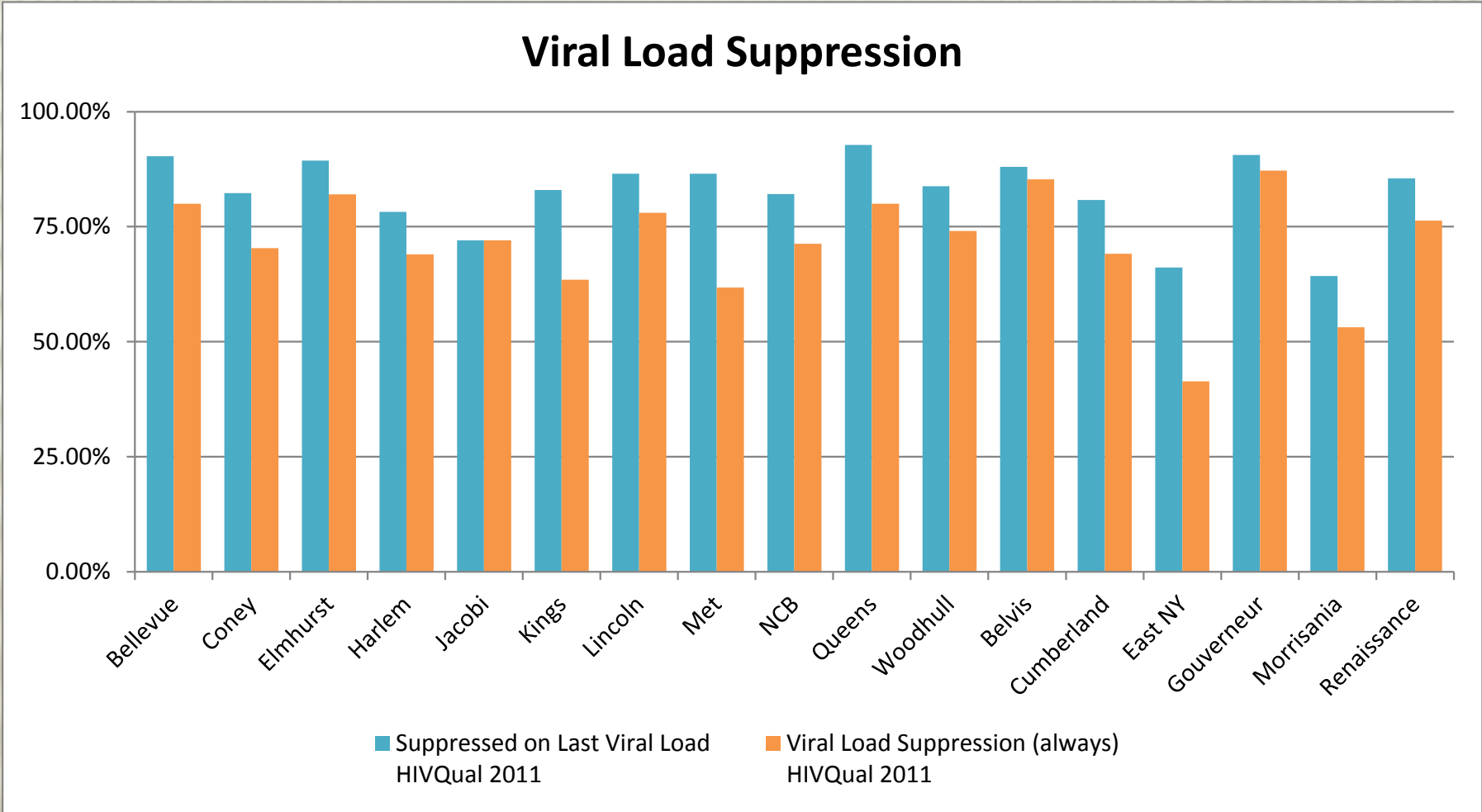


# HHC 12 MONTH RETENTION

**Retention in care FY12  
12 months**



# HHC VIRAL LOAD SUPPRESSION



# COMMUNITY WIDE ACTIVITIES

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- **NYS DOH *Three Years of Rapid Testing*** Conference, Special Project of National Significance (SPNS)
- **CDC HIV testing consultations**
- **HRSA Ryan White grantee presentations**
- **DOHMH Bronx Knows, Brooklyn Knows campaigns**
- **Health and Human Services Ryan White Part A Planning Council**
- **HIV Prevention Planning Group**

# COMMUNITY COLLABORATIONS

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- **United Nations** hosted international seminar at first UN Special Session on AIDS and presented at a women's conference sponsored by Non-Governmental Organizations
- New Approaches to the Epidemic in Vulnerable Populations of the African American Community with the *National Coalition of 100 Black Women*

# INTERNATIONAL DELEGATIONS

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- United Kingdom, Terrence Higgins Trust
- Singapore Ministry of Health
- USAID Project Ethiopian Delegation
- Bangkok Ministry of Health Delegation



# IMPROVING QUALITY

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## Evidence and research guide planning around care

- In unique collaboration with NYS DOH AIDS Institute established the first provider supported HIV Quality Improvement Learning Network (QILN), in the nation:
  - The QILN:
    - Hosts monthly topical conference calls
    - Provides quarterly HIV Quality Improvement Training
    - Focuses on providing planning support and objective feedback on facility-designed QI projects and inclusion of consumers in QI
  - Focus on improving quality of HIV services
    - Peer-based, corporate-wide HIV quality improvement

# EXAMPLES OF QUALITY IMPROVEMENT PROJECTS

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- HIV screening and flu shots provided at the same time (Renaissance D&TC)
- Brochure that encourages patients to ask questions of providers to get better care (Morrisania D&TC)
- Nutrition education and exercise to improve health outcomes (Harlem Hospital Center)

# CONTINUING TO IMPROVE ACCESS

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- Provider-Driven HIV Screening
  - Multi-year, nationally oriented Gilead Sciences funding focused on systems and healthcare teams. Examples from KCH
- Consider how to implement recently revised NYS regulation which permits oral consent for HIV screening if documented in the medical record
- Consider move toward use of advanced technology such as 4<sup>th</sup> generation screening

# ADDITIONAL FOCUS MOVING FORWARD

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- PEP and PrEP: Pre and Post Exposure Prophylaxis
- Hepatitis C – Dual and Mono-Infected (name the law)
- Aging with HIV
- Having a Prepared and Appropriately Staffed Workforce
- Disparities and Caring for the Uninsured

# NATIONAL AND NYS FRAMEWORK GUIDES OUR WORK FOR THE FUTURE

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- Vision of **National AIDS Strategy** (July 2010) is that new HIV infections are rare
- Three goals:
  - Reducing the number of people who become infected with HIV
  - Increasing access to care and improving health outcomes for people living with HIV
  - Reducing HIV-related health disparities
- NYS DOH AIDS Institute and many AIDS organizations hope to END AIDS in New York State
  - Use newer technology and surveillance (e.g., 4<sup>th</sup> gen screening, “easier, regularized consent”, give DOH ability to use surveillance data to know and share that patients are in care),
  - Prevention for positives and negative (e.g., PEP, PrEP)
  - Fill gaps in the NYS Care Continuum
  - Funding should follow the need

# HOW HHC'S FUTURE WORK WILL BE TRANSFORMED

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- **To focus on** social and economic drivers of risk for positives and negatives
- **To intensify and expand** systems of diagnosis and treatment with adherence support
- **To employ the use of new technologies**

# HHC HAS BEEN RECOGNIZED

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- **NYS Health Foundation** Inaugural Award- Evaluation of Expanded HIV Screening
- **National Quality Center** Award for Quality Leadership
- **NYS DOH AI** Senior Leadership in Quality Award- first ever to a non clinician
- **CDC** recognizes- HHC' s testing 1 million unique patients for HIV
- **Lancet** accepts an abstract for presentation at the international translational conference on Ending AIDS

The work we do in HIV Services reflects a commitment from many providers and staff to improve and expand access to high quality care and treatment.

THANK YOU