

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

**APRIL 8, 2014  
10:00 A.M.  
HHC BOARD ROOM  
125 WORTH STREET**

**AGENDA**

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

**II. ADOPTION OF MARCH 11, 2014  
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**

**III. INFORMATION ITEMS:**

**i. 2014-15 STATE FISCAL YEAR FINAL BUDGET OVERVIEW**

**WENDY SAUNDERS, ASSISTANT VICE PRESIDENT  
OFFICE OF INTERGOVERNMENTAL RELATIONS**

**ii. THE VIEW IN WASHINGTON – FEDERAL ADVOCACY UPDATE PRESENTATION**

**JUDY CHESSER, ASSISTANT VICE PRESIDENT  
OFFICE OF INTERGOVERNMENTAL RELATIONS**

**IV. OLD BUSINESS**

**V. NEW BUSINESS**

**VI. 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**

**MARCH 11, 2014**

The meeting of the Strategic Planning Committee of the Board of Directors was held on March 11, 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  
Alan Aviles  
Anna Kril  
Robert F. Nolan  
Bernard Rosen  
Steven Newmark, representing Deputy Mayor Lilliam Barrios-Paoli

##### **OTHER ATTENDEES**

C. Crowther, Patient Care Advocate, Independence Care System  
J. DeGeorge, Analyst, State Comptroller  
M. Dolan, Senior Assistant Director, DC 37  
R. Estein, Chief Operating Officer, Independence Care System  
C. Fiorentini, Analyst, New York City Independent Budget Office  
N. Mylan, Director of Women's Health, Independence Care System  
K. Raffaele, Analyst, Office of Management and Budget  
M. Saviola, Vice President of Advocacy and Women's Health, Independence Care System  
R. Surpin, President, Independence Care System  
J. Wessler, Guest

##### **HHC STAFF**

S. Abbott, Assistant Director, Corporate Planning and HIV Services

M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations  
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  
E. Fishkin, M.D., Medical Director, Woodhull Medical and Mental Health Center  
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations  
T. Hamilton, Assistant Vice President, Corporate Planning Services  
L. Haynes, Assistant Systems Analyst, President's Office  
L. Isaac, Assistant Director, Corporate Planning Services  
C. Jacobs, Senior Vice President, Patient Safety, Accreditation and Regulatory Services  
D. John, M.D., Medical Director, Morrisania Diagnostic and Treatment Center  
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations  
V. Kim, Senior Director, Corporate Planning Services  
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  
T. Mammo, Deputy Chief of Staff, President's Office  
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  
I. Michaels, Director, Media Relations, Communications and Marketing  
K. Park, Associate Executive Director, Finance, Queens Health Network  
C. Pean, Associate Director, Harlem Hospital Center  
S. Penn, Deputy Director, World Trade Center Environmental Health Center  
P. Phillip-King, M.D., OB/GYN Physician, Woodhull Medical & Mental Health Center  
C. Philippou, Assistant Director, Corporate Planning Services  
E. Russo, Assistant Director, Corporate Planning Services  
S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs  
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations  
D. Shi, Senior Director, Medical and Professional Affairs  
R. Solomon, Associate Director, Lincoln Medical and Mental Health Center  
D. Surh, Senior Executive Administrator, Morrisania Diagnostic & Treatment  
J. Wale, Senior Assistant Vice President, Behavioral Health  
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

**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 February 11, 2014 meeting of the Strategic Planning Committee were adopted.

**SENIOR VICE PRESIDENT REMARKS**

Ms. Brown greeted and informed the Committee that, in lieu of her remarks, she would provide the Committee with an update on New York State's Medicaid Waiver. She noted that her presentation included content from various sources including New York State Department of Health and the Healthcare Association of New York State (HANYYS).

**INFORMATION ITEMS:****New York State Medicaid Redesign Team (MRT) Waiver Update**

LaRay Brown, SVP, Corporate Planning, Community Health & Intergovernmental Relations

Ms. Brown began her presentation by describing the evolution of New York State's Medicaid Redesign Team (MRT) Waiver:

- I. Two years ago, the MRT made a recommendation for New York State to apply for a Medicaid waiver. New York State sought approval from the federal government to use Medicaid program savings, resulting from the implementation of MRT initiatives and the imposition of a Medicaid Global Cap, to further invest those savings to transform health care services delivery. The States of California, Texas and New Jersey had each received approval of a waiver.
- II. In August 2012, New York State submitted a \$10 billion waiver to the Centers of Medicaid Services (CMS) but negotiations were stalled due to Super Storm Sandy in October 2012. In summer 2012 and at the beginning of 2013, discussions turned to a prior waiver that was specifically focused on persons with disabilities (OPWDD) with concern raised that the State would have to return funding back to the federal government. This occurrence significantly delayed negotiations related to the waiver.
- III. In summer 2013, the State refocused its attention on the waiver that had as one of its major components delivery system reform or improvements specifically focused on public hospitals with these entities playing a major driver vis-à-vis the local math that was required.
- IV. In fall 2013 and winter 2014, New York State submitted more revisions of its proposal to CMS as a result of many questions and some push back on the part of the CMS.
- V. In late January and early February 2014, New York State received conceptual approval of a waiver, not valued at \$10 billion, but \$8 billion. Discussions are ongoing to finalize terms and conditions, which would in fact serve as the final official approval of the waiver.

Funding Allocations

Ms. Brown described the waiver's funding allocation strategy based on its original \$10 billion waiver proposal. This funding allocation is described in the chart presented below:

<b>DSRIP \$7.6 B</b> (December 2013 Submission)	<b>State Plan Amendment:</b> <b>\$0.5 B</b>	<b>Managed Care Contracts: \$1.9 Billion</b>
<ul style="list-style-type: none"> <li>• Hospital transition</li> <li>• Public Hospital innovation</li> <li>• Vital Access Provider (VAP)</li> <li>• Long Term Care Transformation</li> <li>• Public Health Innovation</li> <li>• Health Workforce</li> </ul>	<ul style="list-style-type: none"> <li>• Health Homes</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care expansion</li> <li>• Health workforce</li> <li>• Managed long term (MLTC) services and supports for serious behavioral health/substance abuse</li> </ul>
<b>DSRIP \$7.3 B</b> (January 2014 submission)	<b>State Plan Amendment:</b> <b>\$0.5 B</b>	<b>Managed Care Contracts: \$2.2 B</b>
<ul style="list-style-type: none"> <li>• Hospital transition</li> <li>• Public Hospital innovation</li> <li>• Vital Access Provider (VAP)</li> <li>• Long Term Care Transformation</li> <li>• Public Health Innovation</li> </ul>	<ul style="list-style-type: none"> <li>• Health Homes</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care expansion</li> <li>• Health workforce</li> <li>• Managed long-term (MLTC) services and supports for serious behavioral health/substance abuse</li> </ul>

Ms. Brown informed the Committee that, in the month of January, following negotiations with the Centers for Medicare and Medicaid Services (CMS), the State had made some minor changes in what it was going to put forward in terms of the allocation of the \$10 billion. A total of \$300 million was transferred from the DSRIP (Delivery System Reform Incentive Payment) program and placed into the managed care column. This was done specifically to provide the State with greater opportunities to invest in health care and workforce transformation. Ms. Brown emphasized that after the \$2 billion reduction, the waiver amount would be reduced to \$8 billion; however, it was not yet clear how the \$2 billion reduction would be allocated. Whether the reduction would be proportionate, that is 75% of the \$2 billion would be taken from DSRIP or not. Notwithstanding, a proportionate reduction is anticipated over each of the three components: DSRIP, State Plan Amendment program and managed care contracts. Ms. Brown explained that DSRIP was the primary funding source for hospitals and health systems; and HHC would apply for \$2.6 billion over the five year term of the waiver.

DSRIP Funding Flows

Ms. Brown described the Delivery System Reform Incentive Payment (DSRIP) program funding flow as the following:

- Public hospitals provide Intergovernmental Transfers (IGTs)
- Part of federal match for IGT will be used to support DSRIP for non-publics

- Significant funding contingent on public hospitals' cooperation and success

Ms. Brown explained that waivers were based on the concept of budget neutrality. This means that the State has to demonstrate to the federal government that it will not be spending more than what it would without a waiver. In addition, there needs to be a local match to be able to draw down federal funding. Ms. Brown stated that the presumption with waivers is that, if a state is going to make major changes to its Medicaid services and health care delivery system, both the state and the federal government would incur savings. She reminded the Committee that, in the case of New York State, 50% of the Medicaid program is state funded (with some county inclusion) with the remaining 50% funded by the federal government. Ms. Brown explained that, in this scenario, the State was proposing that HHC and the other public hospitals would provide the Intergovernmental Transfers (IGTs) to provide a significant part of the match. The remaining component of the local match would come from Designated State Health Programs (DSHP), which is state health program related expenditures that the federal government would have to approve as meeting the criteria for local match. Ms. Brown explained that state health program expenditures that will be combined with public hospital funds to produce the local match does not necessarily have to be generated by hospitals or the Medicaid program but could include other types of healthcare programs such as health care expenditures for services for children who are in foster care etc. Ms. Brown noted that the lion share of the local match that would be used to draw down waiver funds would come from public hospitals. Accordingly, the failure or success of not only the negotiations with regards to the waiver, but the flow of the funds on an ongoing basis over the five-year period would significantly depend on public hospitals' cooperation and success in achieving the outcomes of the waiver.

#### DSRIP Key Themes

Ms. Brown reported that there were some key themes that were different in this current waiver compared to past waivers. These themes are outlined below:

- Different kind of waiver
- Focus on delivery system transformation
- Safety-Net sustainability
- Potential support to build ability to assume risk
- State proposing to link other investments (\$2B Capital Fund in Executive Budget)

#### DSRIP Key Components

Ms. Brown described the key components of the Delivery System Reform Incentive Payment (DSRIP) program, which included the following:

- Reduce avoidable hospitalizations
- Statewide initiative for public hospitals and array of Safety Net providers
- Payments will be performance-based
- Menu of CMS-approved programs
- Collaboration is expected and rewarded
- DSRIP payments can be used to refund front-loaded investments, support new investments, or other needs

Ms. Brown highlighted that, what the state is proposing is significant delivery system change. She stressed that the State is focusing on avoidable hospitalizations. She informed the Committee that, in

the waiver, the State has made a commitment to achieving a 25% reduction in avoidable hospitalizations state wide at the end of the five-year waiver period. In addition, following the waiver, that momentum would continue to produce reductions in avoidable hospitalizations by 50% over 10 years state wide.

### DSRIP Eligible Providers

Ms. Brown described DSRIP eligible providers as including:

- Major public general hospitals
- Safety Net providers
  - Hospitals, nursing homes, clinics including FQHCs, behavioral health providers, and home care agencies
- Safety Net criteria – under negotiation
  - December – DOH proposed broad parameters
  - January- DOH proposed 3 domains
  - HANYS advocating for definition that represents diversity across the State
- State proposing non-Safety Net hospitals and Safety Net hospitals can partner
  - Lead applicant must be a Medicaid provider

### DSRIP Overarching Goal

Ms. Brown informed the Committee that the DSRIP overarching goal is to reduce preventable hospitalizations – 25% in 5 years and 50% in 10 years, which will be measured using the following metrics:

- Potentially preventable Emergency Room visits
- Potentially preventable readmissions
- Prevention quality indicators (PQI) – adult
- Prevention quality indicators – pediatric

### DSRIP Program Menu

Ms. Brown shared with the Committee the three broad categories of programs that were included as part of the DSRIP program menu. They included:

- Hospital transition projects:
  - Disease management
  - Transitional care
  - Expand/co-locate primary care
  - Integrate behavioral health with primary care
  - Care management infrastructure
  - Infrastructure for improved geriatric health services
  - Telemedicine strategies
  - Ambulatory detox capability in community
  - Evidence-based medication adherence programs
  - Expansion of palliative care
  - Comprehensive strategy to reduce AIDS/HIV Transmission

- Long term care transformation projects:
  - Transfer avoidance
  - Hospital-Home Care collaborations
  - Pressure ulcer prevention programs
  - Medication error prevention programs
  - Bed buy back
  
- Public health innovation projects:
  - Asthma self-management
  - Home visits (Lead poisoning/new mothers etc.)
  - Collaborations for community-based strategies to reduce health disparities
  
- Off-menu option projects:

Ms. Brown commented that CMS does not encourage off menu programs. Such projects will be subject to greater scrutiny with expectations of higher levels of performance.

Mrs. Bolus asked Ms. Brown for clarification on the Bed Buy Back program. Ms. Brown explained that the State has proposed that, if a provider could reduce its institutional beds by investing in community-based services, the State would value the number of reduced beds and provide that amount of funding to the provider to invest in non-institutional types of strategies. Ms. Brown referred to the work that had been conducted over the last eighteen months at HHC's Coler and Goldwater facilities. She shared with the Committee the Corporation's intent to leverage that body of work.

#### DSRIP Project Plan Requirements

Ms. Brown reported on the DSRIP project plan requirements. She stressed that funding decisions would be based on the criteria listed below:

- A new initiative for the provider
- Substantially different from other CMS-funded initiatives, but could build, expand or augment
- Address significant health issues in the catchment area
- Substantial and transformative change
- Commitment to life-cycle change and organizational resources to ensure success
- Collaboration with other providers with special attention paid to coordination with Health Homes

#### Local Partnerships to Transform Delivery System

Ms. Brown described the types of local partnerships that were anticipated to transform the health care delivery system. Local partners are expected to include:

- Hospitals
- Nursing Homes
- Clinics and FQHCs
- Behavioral Health Providers
- Home Care Agencies
- Other key stakeholders

She described the role of the local partnerships as serving to:

- Identify community health needs, healthcare challenges and quality objectives.
- Develop programs and investments that address those needs, with measurable metrics and milestones.
- Transform the healthcare delivery system by working together to improve quality and health outcomes while lowering cost.

Ms. Brown discussed the DSRIP timeline as of January 2014 and for Year 1 – Quarters 1 through 3 – for Planning, Assessment and Project Development as shown in the charts provided below:

**DSRIP Timeline (as of January 2014, details will shift)**

Stage	Estimate
Target approval date by CMS	Early March 2014
Providers submit project planning application to DOH	April 4, 2014
DOH feedback on project planning applications	April 25, 2014
Funds allocated to approved planning projects	May 2, 2014
Providers submit final project plans	November 28, 2014
DOH reviews and decides on final project plans	December 26, 2014

**DSRIP Timeline: DY1: Planning, Assessment & Project Development**

Year 1 – Quarters 1 through 3			
Organizing and Learning	Assessment	Project Development	Deliverable For Planning Dollars During Quarter 1 Through 3
<ul style="list-style-type: none"> <li>• Orientation to DSRIP</li> <li>• Education &amp; Communication</li> <li>• Engagement with other providers and stakeholders</li> <li>• Committee Development (if needed)</li> <li>• Consensus on Principles and shared goals (if any)</li> </ul>	<ul style="list-style-type: none"> <li>• Interviews, Focus Groups</li> <li>• Funding Assessment (Finances/available funds)</li> <li>• IGT Assessment (publics only)</li> <li>• Community &amp; Regional Needs Assessment</li> <li>• Workforce Planning</li> </ul>	<ul style="list-style-type: none"> <li>• Program Identification based on needs and goals</li> <li>• Project valuation</li> <li>• Internal Evaluations (value, sustainability, etc.)</li> <li>• Buy-in &amp; Engagement</li> <li>• Proposal Development &amp; Submission</li> </ul>	

**DSRIP Final Application Requirements**

Ms. Brown reported that the DSRIP final application must include the following:

- Select goals and programs
- Performance assessment
  - Current status of the community
  - Evidence of regional planning
  - Root cause of poor performance
  - Evidence of public input
- Work plan development
- Milestones and metrics
- DOH developing a “data book” for providers

DSRIP Program Valuation – Application Scoring Being Negotiated

Ms. Brown reported that the State would utilize the criteria listed below to evaluate proposed DSRIP programs (1-5 points):

- o Alignment with avoidable hospitalization and quality objectives
- o Potential for cost savings
- o Degree of community collaboration and comprehensive partnerships
- o Robustness of evidence base
- o Number of Medicaid members impacted
- o Financial viability of lead applicant

DSRIP Program Measures

Ms. Brown reported on DSRIP program measures, which include:

- Process measures (i.e. plan, action steps)
- Outcome measures (i.e. QARR, HEDIS, CAPHS, BRFSS, SPARCS, CHIRS)
- Avoidable hospitalization measures
- Measures of overall system change (e.g., reduction in inpatient, increases in primary care)
- Financial sustainability metrics to assess long term viability

Ms. Brown explained the planned DSRIP funding distribution stages as outlined in the chart below:

**DSRIP Funding Distribution Stages (*under discussion*)**

<b>DSRIP Funding Distribution Stages</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>
<b>Project Process Metrics</b> (Includes Infrastructure and Project Design and Management)	70%	60%	30%	5%
<b>Project Specific Outcomes Metrics</b> (Includes quality improvement, chronic disease management and population health)	10%	15%	25%	25%
Provider Financial Viability Metrics (If applicable, if not applicable to a given provider, this percentage will get moved to the other three categories)	15%	15%	15%	15%
<b>Avoidable Hospitalizations</b>	5%	10%	30%	55%
<b>Total</b>	100%	100%	100%	100%

Note: Year 1 payments will be provided primarily for planning

Final Stretch

Ms. Brown concluded her presentation by emphasizing that:

- Many outstanding issues are being negotiated with CMS, which include:
  - o Safety net definition
  - o Valuation goals/distribution
  - o Program scoring
  - o Metrics and value for attainment

- The goal is to achieve an agreement on terms and conditions by early March 2014

### **Improving Access to Health Care Services for Women with Disabilities**

Marilyn Saviola, Vice President of Advocacy and Women's Health Program  
Catherine Crowther, Patient Care Advocate  
Nicole Mylan, Program Director, Women's Health Services  
Independence Care System

Dinah Surh, MPH, Senior Executive Administrator  
David John, MD, Medical Director  
Morrisania Diagnostic and Treatment Center

Edward Fishkin, MD, Medical Director  
Paul Kastell, MD, Chairman, OB/GYN Services  
Patrina Phillip-King, MD, OB/GYN  
Woodhull Medical and Mental Health Center

Sharon Abbott, PhD, Assistant Director, Corporate Planning Services

Ms. Brown informed the Committee that this presentation represented a small but growing body of work and important collaboration and partnership that HHC had formed with Independent Care System (ICS). She added that this initiative was established on multiple fronts by a core group of women with disabilities and advocates including the New York Lawyers for the Public Interest, who documented the difficulties that women with disabilities experienced when accessing health care services, across the health care spectrum, starting with mammography services. Ms. Brown reported that the New York Lawyers for the Public Interest had published a report in which HHC did not do too badly because of the work that had begun at HHC's Morrisania Diagnostic and Treatment Center. Ms. Brown reported that another stakeholder, the City Council had convened a public hearing on access to health care services for women with disabilities and HHC was asked to provide testimony at that Council hearing.

Ms. Brown informed the Committee that following that hearing, the City Council had reached out to HHC to learn what could be done to ensure that this area of service could be improved in public settings. The City Council provided HHC with some capital funding for capital improvements. Consequently, HHC partnered with ICS to expand the work that it had initiated at Morrisania Diagnostic and Treatment Center and at Woodhull Medical and Mental Health Center by applying for a New York Community Trust grant to support ongoing staff training.

Ms. Marilyn Saviola, Vice President of Advocacy and Women's Health Program of Independence Care System (ICS) greeted and thanked the Committee for the opportunity to present on their work to improve access to health care services for women with disabilities. Ms. Saviola informed the Committee that she grew up in the HHC family. After being a resident at Goldwater for many years, she became an employee of Goldwater's Counseling Department. Soon after earning an education, she became a community advocate for services for people with disabilities. Ms. Saviola stated that women with disabilities often raised questions on how and where to get a mammogram or a pelvic exam. She stressed that, although healthcare access issues were very common among the uninsured and

underinsured, for women with disabilities the issue was a lack of competency, awareness and sensitivity. Ms. Saviola stated that, it was unfortunate that this was the first time that the issue of health care access for women with disabilities was being addressed. Ms. Saviola shared with the Committee the following comment that was made by an ICS member to describe the experience that women with disabilities face when accessing health care:

"There are too many women with disabilities who have been silenced. We can't be. Some people don't want to tell their stories because it's so painful. When it comes to health care, it's happened so many times, it feels like it's not going to change."

*M. Lyons, Member, Independence Care System*

Ms. Saviola provided the Committee with a brief overview of ICS and its services. This description is provided below:

#### Independence Care System - Who are we?

- Non-profit Medicaid Managed Long Term Care Plan (MLTC)
- Coordinates home care, health care, and social services to enable adults with physical disabilities and chronic conditions to live at home
- Only plan specifically designed for people with physical disabilities
- Serves over 5000 members in Brooklyn, the Bronx, Manhattan and Queens
- Half use wheelchairs or other mobility aides
- Over 30% require 24-hour personal care
- Most are Hispanic/African-American, as well as Russian and Asian
- Approximately half are over the age of 65.
- Many ICS members use HHC facilities to meet their healthcare needs

#### The Beginnings

Ms. Saviola described a report, *"Breaking Down Barriers, Breaking the Silence: Making Health Care Accessible for Women with Disabilities,"* authored jointly by ICS and New York Lawyers for the Public Interest with the Committee. She described the report as the following:

- Report released in 2012
- Described common barriers to receiving health care services
- Offered recommendations to improve access to care

#### Common Barriers to Accessing Healthcare Services

Ms. Saviola highlighted the common barriers to accessing health care services for women with disabilities as the following:

- Physical access
  - Facility design
  - Accessible equipment
- Communication barriers
  - Language access
  - Alternative media

## ü Signage

### Attitudinal barriers and lack of training

Ms. Saviola described the impact of attitudinal barriers and lack of training on access for women with disabilities. She shared with the Committee a statement made by an ICS member regarding her experience with accessing gynecological services:

“When you have a physical disability and you’re looking for a gynecologist, you usually have to settle. Most women don’t know that the facility should be accessible, so we tend to adapt. We don’t know any better, so we settle. For example, I went to one place and the only thing that was accessible was the front door.”

*C. Cruz, Member, Independence Care System*

Ms. Catherine Crowther, ICS’ Patient Care Advocate, read the following example of attitudinal barriers:

### Example: Attitudinal Barriers

“Another young lady with a disability was [at the gynecologist’s office] when I was there and the doctor raced around the place saying, “oh my god, she’s pregnant; I can’t believe it, she can’t be!” She was so loud everyone in the waiting room heard it. I was disgusted. When I went in for my appointment, they did a pregnancy test on me even though I didn’t request it. When it came back negative, they said “Oh, well thank god you’re not pregnant!” I cannot even begin to tell you how upset I was, not only for myself, but for the other woman – she was a grown woman with a job – and they carried on so horribly.”

*Kim Yancy, Member, Independence Care System*

Ms. Saviola reported on the legal framework for providing accessible care and described ICS’ access to healthcare program for women with physical disabilities program. The Anti-Discrimination laws that protect New Yorkers with disabilities include:

- Americans with Disabilities Act
- Section 504 of the 1974 Rehabilitation Act
- Local and State Anti-Discrimination Laws

Ms. Saviola described ICS’ Access to Healthcare for Women with Physical Disabilities Program. She informed the Committee that the program:

- Aims to improve cancer screening accessibility in New York City
- Reduce/eliminating physical barriers and inaccessible equipment
  - *Mammography Project*
  - *Gynecological Project*
- Educate staff to address provider misconceptions and lack of sensitivity, awareness and competencies
- Create procedures to increase efficiency and accessibility

Ms. Nicole Mylan, ICS’ Director of Women’s Health Services shared the following statement with the Committee from an ICS member:

"It's important because my mother had breast cancer and if I don't get that mammogram I could get cancer and not know it. If I get the mammogram maybe I could catch it in time. I like to have my mammogram every year."

*Esther J., Member, Independence Care System*

Ms. Saviola described the program challenges as the following:

- Finding medical facilities willing to create partnerships
- Securing executive and clinical staff buy-in
- Accommodations
  - ü Accessible equipment
  - ü Transfer assistance
- Time Commitments
  - ü Longer appointments
  - ü Staff Training

Ms. Saviola shared with the Committee the experience of an ICS member who was able to receive care through ICS in a manner that was sensitive and appropriate for her:

"My first time in the ICS program, everything was in one room so I didn't have to undress and come in through the back door. I usually have a real hard time with spasticity, but the chair lift worked and I was able to get on the chair pretty much by myself. That the table actually came down to me – that made a huge difference. She did the examination the way it should be done. I'm 49 years old and that was the first time I had a totally accessible experience."

*M. Lyons, Member, Independence Care System*

Ms. Saviola informed the Committee that after the release of the report titled, *"Breaking Down Barriers, Breaking the Silence: Making Health Care Accessible for Women with Disabilities,"* the New York State Department of Health sent a letter to all hospitals, nursing homes, diagnostic and treatment centers and health centers, and large health care practices reminding them that they may be breaking the law by not providing accessible care for people with disabilities. They were asked to respond with a check list. Ms. Saviola informed the Committee that HHC was the only provider that responded. She added that Ms. LaRay Brown, at the City Council Meeting, made a commitment to partner with ICS. Ms. Saviola stated that, since then, she had met some of HHC's invaluable employees starting with the staff of Morrisania Diagnostic and Treatment Center (D&TC) including Dr. Patrina Phillip, Dr. David John, Medical Director and Ms. Dinah Surh, MPH, Senior Executive Administrator. For the past two years, ICS has partnered with Morrisania Diagnostic and Treatment Center (D&TC) to serve the needs of women with disabilities.

Ms. Brown introduced Ms. Dina Surh, Senior Executive Administrator, Morrisania D&TC and invited her to share with the Committee HHC's work with ICS at Morrisania D&TC. Ms. Surh stated that the Independence Care System and Morrisania collaboration was a life changing partnership, not only for patients, but also for the staff and the community. Ms. Surh described the evolution of the ICS/HHC collaboration as the following:

- In 2011, Marilyn Saviola, VP, Advocacy and the Women's Health Access Program (ICS) and staff began a series of meetings with Morrisania D&TC leadership to explore the possibility of creating new access to services for women with disabilities.
- In May 2011, a Business Agreement was signed by HHC and ICS to start a pilot project at the Morrisania D&TC to accept ICS referrals for mammography services.

Ms. Surh provided the Committee with an overview of Morrisania D&TC. She informed the Committee that the major focus of all diagnostic and treatment centers like Morrisania is to provide primary and preventative health care services. She also described Morrisania D&TC's services and operations as the following:

- Part of Generations+ Northern Manhattan Network
- Provides comprehensive Primary Care, Women's Health, Adult Medicine, Pediatrics, Behavioral Health, Dentistry, HIV, Optometry, Podiatry, Child Development Clinic (CDC), Pharmacy, Radiology, Social Work, Nutrition, WIC, and enabling services including Medicaid Assistance Program (MAP) onsite.
- Hours: Mondays- Fridays 7:30 AM – 8:00 PM
- 190 staff
- 80,000 visits annually

Ms. Surh reported that, in recent years, the HHC Generations+ Northern Manhattan Network had developed the following Vision Statement which reads:

*"We provide a caring, value added outpatient experience that anticipates patient and community needs and exceeds expectations through a highly engaged patient centered workforce."*

Ms. Surh added that the Vision Statement was crafted not to be placed on a board or to be jotted down on a piece of paper but to be a living document to serve the community. After meeting with Ms. Saviola, Ms. Surh stated that it was clear that ICS' needs matched perfectly with Morrisania D&TC's vision. The first step was to assess Morrisania D&TC's Mammography suite.

Morrisania D&TC – Mammography Equipment:

- Assessments of mammography and sonography suites were conducted to identify equipment needs
- ICS provided recommendations to create a comfortable setting for women with disabilities
- Special mammography chair and cushions were purchased to position patients for procedures
- Hoyer lifts were obtained from HHC's Goldwater facility

Ms. Surh stated that through a series of meetings that had been convened, the Mammography services processes at Morrisania had been enhanced to include the following:

- In 2011-12, joint ICS/Morrisania Partnership meetings were convened to develop patient referral processes, appointment schedules, communication strategies between caregivers, patients and support staff to coordinate care and provide consultative reports and plan for staff training.
- Traditional mammography and sonography services were offered in 2012.
- In 2013, Morrisania D&TC installed a new digital mammography unit with federal funding from HRSA.

Ms. Surh introduced Dr. David John, Medical Director, and invited him to describe the various gynecological services offered at Morrisania D&TC. Dr. John stated that he always felt that his role as a physician was to humbly serve all. Dr. John added that as a medical director of a facility, he was embarrassed after learning from Ms. Saviola about the various barriers that women with disabilities faced in accessing care and felt that those barriers must be addressed if HHC were to remain truthful to its mission to serve all New Yorkers. Following the improvements made to the mammography services area, Morrisania D&TC made the following improvements within gynecological services:

- Special equipment purchased: Hoyer lifts, weight scale, exam table, large exam room
- Women Health Services has provided 400+ visits/year:
  - Routine GYN visits
  - Colposcopy services
  - Abnormal uterine bleeding evaluation and treatment
  - STD testing and treatment
  - Mammography and sonography services
- ICS has a dedicated nurse educator who accompanies ICS' members to appointments at Morrisania D&TC.

Dr. John's emphasized that ICS's nurse educator facilitated the visits in many ways. He added that this service provided by ICS worked well at Morrisania D&TC.

Ms. Surh emphasized that a key factor that was essential for the success of the Morrisania/ICS partnership was staff training. She described Morrisania D&TC's staff training initiatives as the following:

- In 2012, a series of Disability Sensitivity and Awareness staff training workshops were conducted by ICS
- Training included didactic training and role playing with interdisciplinary staff in Women's Health, Radiology and Adult Medicine
  - Staff participants included clerical, nursing, clinical providers, administrators and other support staff
- Staff responded positively to training workshops

Dr. John concluded his presentation of the Morrisania/ICS partnership experience by sharing with the Committee that the collaboration with ICS had helped to:

- Improve access to services for women with disabilities
- Increase awareness among staff about clinical barriers to care (e.g. spasticity)
- Enriched clinical acumen of providers
- Improve staff expertise and promoted staff ease in providing care to women with disabilities

Dr. John described Morrisania D&TC's next steps in spreading this work as the following:

- Adult Primary Care services to start in April 2014
- Special emphasis on preventative medicine
- Chronic disease management
- Expand the number of physicians providing services
- With City Council funding, a bathroom located within mammography suite will be renovated to become handicap accessible

Ms. Brown introduced Dr. Edward Fishkin, Network Medical Director for HHC's North Brooklyn Healthcare Network and invited him to present the initiatives that were being conducted at Woodhull

Medical and Mental Health Center to address health care access issues for women with disabilities. Dr. Fishkin informed the Committee that he had the privilege of meeting Ms. Saviola and her team at ICS almost two years ago. He emphasized that the meeting had been an epiphany. Ms. Saviola made it abundantly clear how much trouble women with disabilities experienced every day trying to obtain quality and dignified health care services. Dr. Fishkin reported that, at the first meeting he had a soul searching experience similar to what Dr. John described. Dr. Fishkin informed the Committee that until then, Woodhull Medical and Mental Health Center's staff had served patients who were disabled or had special needs on a one to one basis, not really considering the "community of disability." Dr. Fishkin commented that Ms. Saviola had actually sensitized him, in this case, on the need to consider not only the individual patient's experience with care but the need to address the health of the community of disabled women.

Dr. Fishkin stated that a commitment to extend access to timely, quality and respectful care and service to Ms. Saviola's patients was made. He reported that together with its partners from ICS, Woodhull's leadership held its team of physicians, nurses and support staff accountable to deliver the same health outcomes for ICS patients as for all of its patients. Dr. Fishkin affirmed that Woodhull's leadership was willing and committed to implementing new ideas and new approaches, and to collaborate with ICS to exceed its goals and patients' expectations. He added that Woodhull wanted to be a model for others and to become a center of excellence for its disabled patients. Dr. Fishkin introduced Dr. Patrina Phillip King, to describe the staff training initiatives that had been launched at Woodhull Medical and Mental Health Center as part of the collaboration with ICS.

Dr. Patrina Phillip-King introduced herself as an attending physician within Woodhull Medical and Mental Health Center's Women's Health Practice. Dr. Phillip-King emphasized that the Women's Health Practice was committed to providing optimal care for women with physical disabilities. She explained that the facility worked with ICS to design a two-part training exercise to prepare staff to be able to provide quality and compassionate health care services. Dr. Phillip-King explained that the most important objective of that exercise was to overcome attitudinal and environmental barriers that contributed to lack of access to care for women with physical disabilities.

Dr. Phillip-King reported that the first exercise was sensitivity training. She informed the Committee that nurses, physicians, clerks, financial counselors and social workers had taken part in that session. She noted that the scope of disability in women was covered. The staff role played real life scenarios of cultural insensitivity experiences. The training also included interactive discussions with the audience. Dr. Phillip-King reported that the second exercise was competency training. It included a power point presentation followed by questions and answers. She highlighted that nurses, physicians, physician assistants and midwives were the active participants in that session. Also in that session, areas in the medical interview, which are particularly sensitive for women with physical disability, such as sexuality and psychosocial issues with an emphasis on caretaker and domestic abuse were also covered and addressed. Dr. Phillip-King stated that the mechanisms involved with examining women with physical disability with more sensitivity were reviewed. She explained that, in this segment, the staff was introduced to different techniques used to transport patients with impaired mobility to the examination table. She added that clinicians were shown the different positions in which a patient could be examined and different types of specula that could be used to facilitate cervical cancer screening. Dr. Phillip-King explained that the issues of screening and documentation of skin health, which are of significant importance for women with disabilities but frequently overlooked were also addressed during the training.

Dr. Paul Kastell, Woodhull Medical and Mental Health Center's Chief of Obstetrics, reported on the environmental improvements and enhanced accommodations for ICS patients that were currently underway at Woodhull Medical and Mental Health Center. Dr. Kastell stated that, when the leadership staff first met with the ICS team several years ago, they had a walkthrough, followed by a review of practice areas that would be primarily utilized by ICS patients. Dr. Kastell added that special attention was given to the Woman's Health Pavilion and the outpatient mammography unit. Dr. Kastell informed the Committee that the Women's Health Pavilion had recently been constructed and all bathrooms, hallways and rooms were built to be ADA compliant. Dr. Kastell added that several items have been identified that needed to be available, specifically a Hoyer lift and a patient scale. He noted that both items have been purchased and were currently being used to provide optimal care.

Dr. Kastell also informed the Committee that the mammography unit had been recently updated and contained state-of-the-art digital equipment. He reported that the walkthrough had indicated the need to retrofit a bathroom to make it ADA compliant. Funds have been identified and renovations will begin shortly.

Ms. Brown introduced Sharon Abbott, Ph.D., Assistant Director, Corporate Planning Services and asked her to share with the Committee, other aspects of HHC's current efforts to improve access to services for women with disabilities across HHC. Dr. Abbott informed the Committee that there were currently three projects underway, which are described below:

Three key projects:

- An environmental survey of accessibility at 9 HHC facilities
- Accessibility renovations made possible by City Council funding
- Curriculum development and staff training made possible by a New York Community Trust grant

Dr. Abbott described the environmental assessment initiative. She stated that HHC contracted with ICS to conduct environmental assessments of the Women's Health Services areas of nine HHC facilities including:

- **Manhattan:** Bellevue, Renaissance D&TC, Metropolitan
- **Bronx:** Lincoln Hospital, North Central Bronx Hospital
- **Brooklyn:** Cumberland D&TC, Woodhull
- **Queens:** Elmhurst Hospital, Queens Hospital
- **Staten Island:** 155 Vanderbilt D&TC (desk review)

She stated that ICS developed a standardized assessment tool. ICS will provide HHC with findings and short term recommendations that could be implemented with minimal investment at targeted facilities to improve access to services for women with disabilities.

Dr. Abbott reported on the \$5 million City Council funding commitment for FY'14 and FY'15. She stated that HHC received \$2.5 million in FY'14 with \$2.5 million pledged for FY15. This initiative is supported by Council Members Maria Del Carmen Arroyo and Julissa Ferreras; and is part of a Council initiative to expand access to women's healthcare services for women with disabilities. Council funding will be used to fund renovations and equipment to make exam rooms and bathrooms optimally accessible for persons with disabilities at HHC hospitals, diagnostic and treatment centers and long term care

facilities. Additionally, this funding will also be used to purchase adjustable exam tables and Hoyer lifts. The first phase preliminary design work and cost estimates for eight facilities are projected to be completed in June 2014.

Dr. Abbott reported on the training curriculum development initiative that is currently being done in collaboration with ICS:

- HHC secured grant funding from New York Community Trust totaling \$135,000 to develop a training curriculum and to train staff
- ICS will develop two curriculums
  - Face-to-face training
  - Online teaching using PeopleSoft
  - Provide face-to-face training at 8 facilities
- HHC will:
  - Purchase equipment for training
  - Facilitate a curriculum advisory group
  - Conduct a comprehensive project evaluation

Ms. Brown concluded the presentation by sharing with the Committee next steps for ICS/HHC partnership:

- Presentation to the New York State Department of Health Accessibility Workgroup convened by Deputy Executive Commissioner Sue Kelly (April 2014)
- Replication of model in additional facilities
- Development of Model Program/ "Center of Excellence" criteria
- Expansion to men with disabilities and other healthcare areas
  - Develop/train on clinical competencies
  - Extension of environmental survey to other areas of facilities
- Work in partnership to facilitate continuity of care

Mrs. Bolus, while applauding all the efforts being made to facilitate access for women with disabilities, raised the issue that chairs in the waiting room areas at some HHC facilities were too low. She stated that these chairs were uncomfortable because they were too low and made it very difficult for seniors to get up. In addition, Mrs. Bolus stated that city hospitals should only dispense adjustable walkers to patients as they can develop other major health issues by bending over.

Ms. Anna Kril, Board Member, inquired about Emergency Department services for persons with disabilities. Ms. Saviola responded that the ER Department was also another huge concern. Emergency Departments are not well-equipped to serve the disabled population. She explained that EMS will not take a patient in their wheelchair or a walking dog. She added that ICS' partnership with HHC was a first step in addressing healthcare access issues for people with disabilities. She noted that all ICS' members received their healthcare services at HHC.

Mr. Robert Nolan, Board Member, asked why these nine particular hospitals had been selected for the environmental assessments of their Women's Health Services areas. Ms. Brown responded that some of the hospitals were awaiting their Joint Commission survey and she did not want the assessments to interfere with their surveys. In addition, facility leadership had been consulted in terms of their readiness to participate in the environmental assessment. Ms. Brown added that she was hopeful that there would be another year to work on this project. She also commented that the Council members

who had committed capital funding last year were still members of the Council. Ms. Brown announced that these projects will be rolled out to other hospitals and diagnostic and treatment centers by next year.

Mr. Nolan thanked Ms. Brown and encouraged her to continue to seek funding not only at the City Council level but also at the Borough President level and citywide.

Mr. Aviles acknowledged Morrisania D&TC and Woodhull Medical and Mental Health Center's for taking the lead in making these changes that were well overdue. He stated that the Corporation looks forward to making these changes throughout the entire system.

## **ADJOURNMENT**

There being no further business, the meeting was adjourned at 12:00 noon.





# 2014-15 State Fiscal Year Final Budget Overview

**STRATEGIC PLANNING COMMITTEE**  
**APRIL 8, 2014**

# 2014-15 Executive Budget



2

- **\$137.9 Billion Budget**
- **Increases overall spending by 1.8%**
- **Includes a \$1.5 billion tax-cut package**
- **Increases education spending by \$1.1 billion**
- **Fourth consecutive on-time budget**

# Medicaid Spending



3

- Restores \$79.7 million in Medicaid spending
- Extends Global Medicaid Cap for one year (along with SDOH’s “superpowers” to make cuts to stay under Cap)
- Includes significant new reporting requirements for SDOH

# Medicaid Spending



4

- Restores the 2% across-the-board rate cut beginning April 1, 2014
- No inflation increase for Medicaid providers
- Authorizes “shared savings” if spending is below the Global Cap: SDOH must consult with the Legislature, providers, plans, workers and others on distribution formula

# Medicaid 1115 Waiver



5

- Requires greater transparency and legislative/public involvement in how Delivery System Incentive Payment Program (DSRIP) funding is spent
- Requires Statewide spending to the extent practicable and allowed in the final Waiver
- Creates DSRIP Advisory Panel

# Capital Funding



6

- Allocates \$1.2 billion over seven years for a new capital program
- Hospitals, nursing homes, diagnostic & treatment centers and licensed clinics are eligible
- Provides grants to improve financial sustainability and increase efficiency through collaboration

# Health Information Technology



7

- Reserves up to a total of \$95 million for Health Information Technology (HIT)
  - ✓ Operate the State Health Information Network of New York (SHIN-NY)
  - ✓ Create an All Payer Claims Database for health insurance claims
  - ✓ New State HIT Infrastructure Workgroup

# Hospitals



8

- Reinstates Medicaid presumptive eligibility
- Allows Medicaid rate adjustments (rebased and ICD-10 implementation). Creates new workgroup.
- Extends Excess Medical Malpractice Program (continues the current eligibility) for one year
- Adds \$40 million for Vital Access Providers

# Long Term Care



9

- Increases funding available through nursing home Upper Payment Limit
- Rejects proposal to prevent nursing homes from getting Medicaid rate increases for sicker patients
- Creates Medicaid nursing home default rate
- Allocates \$380 million for home health care workers' living wage

# Behavioral Health



10

- **Creates a Community Based Behavioral Health Services Reinvestment Program**
- **Advances co-location of behavioral health and physical health services**
- **Provides funding for the transition to managed care**
- **Increases rates for ambulatory services**
- **Rejects Collaborative Care Clinical Delivery Model**

# Other Issues



11

- Nurse Practitioner Modernization Act
- Safe Patient Handling
- Out-of-Network Proposal
- HIV Testing requirements
- Basic Health Plan
- New State requirements for Bronx health care facility construction projects

# Not Included



12

- Regional Health Planning Collaboratives
- Private equity pilot proposal
- Limited services “retail” health clinics, urgent care and office based surgery
- Certificate of Need (CON) changes
- Requires nursing homes to pay standard wage and benefits to direct care workers



13

# Questions?



# STRATEGIC PLANNING COMMITTEE

## April 8, 2014

### The View in Washington

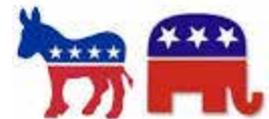
Judy Chesser

Assistant Vice President, Office of Intergovernmental Relations

# Overview

All House Members and one-third of the Senate are up for re-election:

- § Will the Senate stay Democratic?
- § How does the ACA play?
- § Expansion = some federal protection for Medicaid.



# Issues 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 DSH – National Cuts

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

# Medicaid DSH Cuts – HHC Impact

§ HHC Medicaid DSH Cuts (FFY)

§ \$ millions (federal funds only, local share is retained)

§ FFY 2014 and 2015 no longer have cuts under current law

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

§ ACA law states that largest cuts should be allocated to states with lowest percentages of uninsured or the poorest targeting of their DSH payments to hospitals with high volumes of Medicaid inpatients and hospitals with high levels of uncompensated care (excluding bad debt)

§ NYS largest Medicaid DSH recipient

§ In the recent bill, America’s Essential Hospitals successfully sought inclusion of a mandated study by the Medicaid and CHIP Payment and Access Commission (MACPAC) to create a record of the ACA impact on safety net hospitals in relation to the Medicaid DSH cuts

# Medicare DSH Redistribution

- § ACA better targeted Medicare DSH to focus on hospitals that serve the greatest number of low-income patients
- § 75% of funds to be redistributed through a new “uncompensated care payment” to hospitals serving low-income patients
- § New York State is the 2nd largest Medicare DSH recipient
- § The “losers” are lobbying to eliminate or delay the cuts
- § HHC would gain \$114 million in FFY 2014

HHC Medicare DSH Gains (in millions)					
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
Total	114.9	67.8	35.8	19.7	20.1

# Sustainable Growth Rate (SGR) – “Doc Fix”

- § The Medicare payment rate for physicians would have decreased by 24% on March 31st unless Congress enacted new rates
- § Although a permanent fix was supported by many, no agreement on how to pay for it was possible
- § Last week, Congress adopted a “patch” that keeps the rates from decreasing until March 31, 2015 (into the next Congress)
- § The “patch” bill also become a vehicle for many other provisions



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

- § Last year, Congress enacted new criteria to qualify as an LTCH
  - ü To receive payment as an LTCH, a facility had to show that 50% of medical discharges have either:
    - Been in an ICU for 3 days prior to admission; OR
    - Received ventilator services for more than 96 hours
- § The requirement included **ALL** discharges to show that 50% of Medicare patients qualified. Thus, if a facility had less than 50% Medicare patients they would never qualify as LTCHs
- § In the recent SGR patch, HHC got an amendment to include only “Medicare FFS” discharges in denominator
- § Few LTCHS in New York
- § Future challenges
  - ü The Medicare Payment Advisory Committee (MedPAC) March Report to Congress continues to focus on site neutral payments
  - ü LTCH criteria would include requirement of 8 day stays in ICU
  - ü Savings to be redistributed thru a new outlier pool for Chronically Critically Ill (CCI) cases treated in inpatient prospective payment systems (IPPS) hospitals - phased in over 3 years.

# Two Midnight Regulations

- § Began as response to consumers being billed for long observation stays as outpatient stays when consumers thought they'd been admitted
- § In August 2013, CMS issued a rule to clarify that patient stays in hospitals for less than 2 midnights would be considered outpatient care and not inpatient care. A stay of less than 2 midnights would be reimbursed by Medicare as an outpatient event.
- § HHC estimates that this Rule would put \$23 – \$38 million of Medicare revenue at risk per year.
- § CMS has now delayed enforcement until October 1, 2014.



## In “patch” bill enacted last week includes several Two Midnight provisions:

- § Extension of auditors' prepayment "probe and educate" policy through March 31, 2015
- § Prohibition of auditors from conducting patient status reviews on a post-payment review basis for inpatient claims for admission Oct 1, 2013 to March 31, 2015

# President's Budget

- § \$402 B cuts to health provides over 10 years - \$354.1 B to Medicare providers and \$8.9 B from Medicaid. Included Medicaid DSH cut extended an additional year – for HHC loss of \$361 m in that year alone.
  - ü HHC opposed but such an extension was passed last week.
- § Proposes to extend Temporary Medical Assistance (TMA) and Qualified Individuals program (QI) thru FFY 15.
  - ü In the bill enacted last week, TMA and QI extended through March 31, 2015.
- § Proposes cuts to Medicare Indirect Medical Education (IME) of 10%
  - ü Reallocates \$5.23 billion over 10 years to create a HRSA competitive grant program to train 13,000 primary care residents
- § Extends 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.
  - ü 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
- § Expand National Health Services Corps to at least 15,000 individuals annually - \$3.95 b over 10 years

# 340B Mega-Regulation

- § The 340B program provides pharmaceutical discounts to safety net providers including DSH Hospitals, FQHCs and Ryan White AIDS program grantees, for outpatient drugs (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
- § 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 draft regulation covered patient eligibility, compliance requirements for contract pharmacy arrangements, hospital and off-site facility eligibility criteria, GPO exclusion, inventory management, annual re-certifications, audit procedures/appeals processes etc.

# WTC/ September 11th Health Program

- § WTC Health Program expires Sept 30, 2016
- § Under the statute enacted in 2011, a total of \$1.556 billion was authorized and appropriated
- § The original funding has proven more than adequate and thus the hope is to extend the program for more than a decade without the need for additional funding.
- § According to the Centers for Disease Control, nationally the program services almost 67,000 members, including 6,831 survivors
- § Nationally, as of Dec 31, 2013, many have received screening (26,133); diagnostic evaluations (14,158), had out-patient treatment (15,365), inpatient treatment (133), or medications (17,014) in the national program

World Trade Center Health Program. **Learn More.**



# Other Advocacy Efforts

- § FEMA funding for Sandy damage and future mitigation costs
- § Designation of HHC's D&TCs as FQHC Look-Alike