STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

JANUARY 13, 2015
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

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

II. ADOPTION OF DECEMBER 9, 2014 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

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

IV. INFORMATION ITEM

i. **PRESENTATION: METRO EAST 99TH STREET MEDICAID REDESIGN TEAM HOUSING PROJECT UPDATE**
DONA GREEN, SENIOR ASSISTANT VICE PRESIDENT, CORPORATE PLANNING SERVICES
CHRISTOPHER WONG, DIRECTOR OF PLANNING, CORPORATE PLANNING SERVICES

V. OLD BUSINESS

VI. NEW BUSINESS

VII. ADJOURNMENT — **JOSEPHINE BOLUS, RN**

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

DECEMBER 9, 2014

The meeting of the Strategic Planning Committee of the Board of Directors was held on December 9, 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.
Anna Kril
Robert F. Nolan
Bernard Rosen
Patricia Yang, representing Deputy Mayor Lilliam Barrios-Paoli

OTHER HHC BOARD MEMBER

Mark Page

OTHER ATTENDEES

J. DeGeorge, Analyst, New York State Comptroller
Val Grey, Executive Vice President, Healthcare Association of New York State
N. Howell, Analyst, Unite Here International Union
E. Quail, Research Analyst, Unite Here International Union
K. Raffaele, Analyst, Office of Management and Budget
D. Whalen, President, Healthcare Association of New York State
D. Woodrooffe, Analyst, Office of Management and Budget

HHC STAFF

P. Albertson, Senior Assistant Vice President, Operations
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations

C. Barrow, Associate Director, Lincoln Medical and Mental Health Center
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations
T. Carlisle, Associate Executive Director, Corporate Planning Services
D. Cates, Chief of Staff, Office of the Chairman
J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations
B. Keller, Deputy Counsel, Office of Legal Affairs
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman
K. Madej, Director of Social Media, Communications and Marketing
A. Marengo, Senior Vice President, Communications and Marketing
R. Mark, Chief of Staff, President's Office
A. Martin, Executive Vice President and Chief Operating Officer, President's Office
H. Mason, Deputy Executive Director, Kings County Hospital Center
K. McGrath, Senior Director, Communications and Marketing
I. Michaels, Director, Media Relations, Communications and Marketing
K. Park, Associate Executive Director, Finance, Queens Health Network
N. Peterson, Senior Associate Director, Woodhull Medical and Mental Health Center
S. Ritzel, Associate Director, Kings County Hospital Center
L. Sainbert, Assistant Director, Chairperson's Office
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
D. Thornhill, Associate Executive Director, 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 10:00 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, NP-BC. The minutes of the November 12, 2014 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

Federal Update

Lame Duck Session

Ms. Brown reported that members of the House and Senate continued to debate long-term and short-term funding issues for the Federal Government, as the Lame Duck session was drawing to close on December 12, 2014. Ms. Brown added that members had to pass a spending measure in order to avoid a government shutdown that would begin on December 11, 2014. She explained that some members of Congress sought to pass an omnibus bill that would fund the Federal Government through September 2015. Other members, especially some hardline Republicans, wanted to pass a series of short-term Continuing Resolutions, which would fund the government for a few months at a time (this latter strategy was in response to President Obama's recent Immigration Order). Ms. Brown added that there were other members of Congress who wanted to combine the best of both worlds by funding most federal agencies through 2015, with the exception of those federal agencies that administer immigration policies (i.e., Department of Homeland Security) as identified in the President's recent Immigration Order. In Washington terms, they favored a "Cromnibus."

Ms. Brown stated that House appropriators had been working for weeks on an omnibus bill that would fund all government agencies for one year. They have shared their preference for going that route and relying on a bipartisan vote to pass the bill. Assembling and ultimately moving a broad year-end spending package would likely require the support of Democrats to pass the House and would also require trade-offs among appropriators in both parties. Given growing opposition from conservatives, House GOP leaders may need the support of Democrats to pass the pending "Cromnibus" package as they have on several fiscal deals in recent years.

Ms. Brown reported that Senate Appropriations Chairwoman, Barbara A. Mikulsk, had stated that it was her intention to be done with the omnibus spending package at the Appropriations Committee level by Friday, December 5th, with remaining decisions to be made by leadership. She added that some conservatives in Congress had insisted they would not support any deal unless it contained a rider that would bar the President's actions. As such, GOP leaders may need to count on support from Democrats if hard-liners continued their efforts.

Schumer Presses the Fight for Ebola Funds

Ms. Brown reported that Senator Charles Schumer had held a press conference at Bellevue Hospital on November 16, 2014 to raise awareness and secure federal reimbursement for the city and HHC's Ebola-related expenses. The senator called for the creation of an "Ebola Trust Fund "to reimburse New York City for more than $20 million in expenses that had been incurred. Of that total, more than $14 million was

attributable to HHC. Senator Schumer's efforts to cast a spotlight on this important issue are beginning to pay off because House Republicans have recently agreed to allow some emergency Ebola funding. The senator and his staff are pushing for additional federal monies for hospitals like Bellevue Hospital that have incurred expenses by treating Ebola patients. Other hospital associations and national medical groups have rallied around this Ebola funding effort. For instance, the American Hospital Association has written to Senate appropriators requesting $500 million for Ebola preparedness funding.

Federally Qualified Health Centers Look Alike (FQHC-LAL)

Ms. Brown reported that, in mid-November, HHC had begun to lobby and engage NYC Members of Congress to support the HHC-Gotham application to secure Federally Qualified Health Center Look Alike (FQHC-LAL) designation for HHC's six diagnostic and treatment centers. The East New York, Cumberland, Gouverneur, Renaissance, Segundo Belvis-Ruiz and Morrisania Diagnostic and Treatment Centers are located in the congressional districts of Reps. Rangel, Jeffries, Serrano and Velazquez. HHC has also enlisted New York Senators' Schumer and Gillibrand support to weigh in with HHS Secretary Sylvia Burwell and HRSA Administrator Mary Wakefield. Beginning in December 2012, HRSA staff has twice denied HHC-Gotham's application for unwarranted and questionable elements.

President Obama's Executive Actions on Immigration

Ms. Brown reported that, on November 20, 2014, President Obama had announced executive actions focused on immigration accountability during a national television address. These actions are designed to help secure the border and hold nearly 5 million undocumented immigrants accountable. President Obama indicated that he was acting within his legal authority. Republicans in Congress immediately disagreed with that assessment and vowed to struggle with the Obama Administration over other issues like funding the federal budget.

Ms. Brown explained that the President's executive actions would reduce illegal immigration at the border, prioritize deporting felons not families, and require certain undocumented immigrants to pass a criminal background check and pay their fair share of taxes as they register to temporarily stay in the U.S. without fear of deportation. For HHC, the President's executive actions would help tens of thousands of New York residents to become eligible for Medicaid coverage in New York. Ms. Brown reminded the Committee that New York's Medicaid program was required under the 2001 Aliessa v. Novello decision to grant Medicaid eligibility to any immigrant residing legally in the state. Federal regulations require immigrants to generally be in the United States for five years. Immigrants who are granted temporary stay under the President's actions would be considered Persons Residing under the Color of Law (PRUCAL). These individuals are eligible to apply for Medicaid coverage in New York State. However, the Federal Government would not contribute its normative 50% match as the eligibility designation is being granted only through state law. It is unclear how many HHC patients would gain insurance coverage as a result but it would be significant.

STATE UPDATE

Start of the Legislative Session

Ms. Brown reported that the 2015 State Legislative Session would kick-off on January 7, 2015 when the Governor delivers his annual State of the State Message to a joint session of the Senate and Assembly. Work

on the 2015-16 New York State Budget is already underway with much attention focused on how to spend the projected $5.1 billion surplus. Because the surplus is derived from one-time settlement payments, State Comptroller Tom DiNapoli and others have urged that it be spent on non-reoccurring expenses. Healthcare associations are advocating for $1 billion of the surplus to be added to the Healthcare Capital Restructuring Financing program. The Governor must release his executive budget proposal by February 1, 2015.

Gottfried to Hold Hearings on Single-Payer Healthcare Legislation

Ms. Brown informed the Committee that Assembly Health Committee Chair Richard Gottfried was holding a series of six public hearings across the State on his legislation to create a single-payer healthcare system. This bill, known as the New York Health Act, would implement a system of comprehensive, universal health insurance paid for by payroll taxes. The Medicaid program would be subsumed into the New York Health program. Gottfried has carried the legislation for more than twenty years. Senator Bill Perkins co-sponsors the legislation.

CITY UPDATE

Council Approves Leasing of Draper Hall for Development of Low-Income Housing

Ms. Brown reported that, on December 8, 2014, the City Council had voted to approve HHC's proposal to enter into a long term lease for the development of 203 units of housing for low-income elderly and/or disabled individuals in Draper Hall, which is part of the campus of Metropolitan Hospital Center. HHC has worked closely with several city agencies, local elected officials, community representatives and the developer, SKA Marin, on this project. Ms. Brown explained that, through the efforts of Speaker Melissa Mark-Viverito, the U.S. Department of Housing and Urban Development (HUD) had agreed to a 25% community preference requirement for the units that would be developed. This will ensure that at least (50) of the apartments to be developed would be set aside for eligible residents of the community. HUD also agreed to perform a demographic analysis to determine if a higher community preference would be feasible for this project. Additional conditions negotiated by the Speaker include a requirement for NYCHA to conduct targeted outreach to all seniors on the Section 8 waiting list from Community Board 11 in Manhattan and the section of the Speaker's district that extends into the Bronx. Ms. Brown added that the developer of the project would be required to conduct a coordinated marketing campaign with the assistance of local community-based organizations. Ms. Brown thanked the Speaker and members of the City Council for approving this project and providing $2 million in capital funding as part of the budget agreement that was adopted in June for Fiscal Year 2015.

INFORMATION ITEM

Presentation: Federal and State Healthcare Trends and Challenges

Dennis Whalen, President, Healthcare Association of New York State
Val Grey, Executive Vice President, Healthcare Association of New York State

Ms. Brown respectively introduced Mr. Dennis Whalen, and Ms. Val Grey, President and Executive Vice President of the Healthcare Association of New York State (HANYS). Ms. Brown informed the Committee that Ms. Grey had been extremely helpful with HHC's negotiations concerning North General Hospital, which enabled HHC to build a new skilled nursing facility, the Henry J. Carter Specialty Hospital and Nursing

Facility. Ms. Brown invited Mr. Whalen and Ms. Grey to provide an overview of the healthcare trends at the federal and state levels; the potential challenges resulting from the transitioning of leadership post the mid-term elections; and the policy directions and their implications for HHC and the rest of the healthcare community in New York State.

Mr. Whalen thanked Ram Raju, MD, HHC's President, HHC Board Members and members of the Strategic Planning Committee for the opportunity to provide a presentation on federal and state level healthcare trends and challenges. Mr. Whalen stated that there was a blizzard of initiatives underway. He explained that there was a dynamic of elemental changes which were not only driven by government reforms at both the state (i.e., DSRIP, SHIP) and federal (value based purchasing) levels, but also changes that were driven by societal behavior such as technology and the demand for convenience. These shifts will not only drive changes in the way payment is going to be made in healthcare and how services will be organized, but will help to break new ground in terms of partnerships and relationships among different sectors of the healthcare arena. Mr. Whalen informed the Committee that these issues would be discussed in his presentation and that he would also provide a snapshot of HANYS' perspective on these changes. Mr. Whalen further stated that his presentation would also cover predicted dynamics in the coming year and ensuing reactions of the hospitals and health systems in New York. Mr. Whalen added that, because these changes were happening all over the country, it was important to understand how systems are behaving and their impact on HHC.

Ms. Grey began her presentation by highlighting the outcomes of the recent elections. She stated that, at the national level, the Republicans swept the Senate as well as Congress. She noted that, as a result of the Louisiana run-off results, there were 53 seats in the Senate. She informed the Committee that to get anything done at the federal level 60 seats were needed. Ms. Grey reminded the Committee that Senator Schumer would continue to be a formidable advocate on behalf of the hospitals in New York State, and that Senator Schumer had already endorsed the Ebola funding issue.

Ms. Grey stated that, at the State level, Governor Cuomo was unsurprisingly re-elected. However, she noted that there had been some shifts in terms of his standing. She explained that, looking at the map and the counties that the Governor carried, there were big differences across the entire State. The Governor's current favorability ratings are the lowest in his term to date. Ms. Grey commented that these factors were worth mentioning because the willingness of the legislators to take on certain issues and to debate with the Governor oftentimes depended upon his popularity. Ms. Grey stated that there was an opportunity for further legislative engagement. Ms. Grey informed the Committee that all eyes were on the New York State Senate. She added that, although the Republicans had gained the majority, it was a very thin majority. She stated that Senator Skelos would continue to seek out an arrangement with Senator Klein, the head of the Independent Democratic Coalition, to figure out a power sharing agreement. Ms. Grey stated that, while the Republicans have a bit more leverage than they did the last go round, it was hopeful that something would get worked out. Ms. Grey stated that this arrangement was smart on the part of the Republicans because they do not have a cushion. She added that, with the Senate being a different party, this provided an opportunity to make changes to proposals that are advanced by the Governor or the Assembly.

Ms. Grey described some key upcoming events at the federal level as the following:

<u>Continuing Resolution</u>

Ms. Grey reported that the first big event would be occurring this week with the need for a Continuing Resolution to keep the government operating. She informed the Committee that, unlike other precedents, the expectation was that there would not be any government shutdown. She added that this vehicle, the Continuing Resolution, was being used to ensure that there would be funding for designated Ebola hospitals and for the rest of the hospitals across the State that have been preparing to treat, isolate, identify and transfer lots of activities. Ms. Grey commented that she would be remiss not to commend HHC, as HHC stood out as a beacon of that extraordinary and phenomenal work. Ms. Grey added that this was also the season to ensure that legislators' actions do not cause additional harm to the hospital and health care industry.

March 2015

Ms. Grey reported that, at the end of March 2015, the Medicare "Doc Fix" and Medicare extenders would expire. Ms. Grey informed the Committee that, if nothing is done, the Medicare doctor rate would decline by 25%. She added that, while it was not the right thing to let happen, "the pay for" (as it called in DC) should not be through reduced funding for the healthcare industry. Ms. Grey also reported that March 31, 2015 was also important because the delay of the enforcement of the Two-Midnight Rule was set to expire on that date. Ms. Grey explained that valuable resources were being wasted by the healthcare industry to fight these audits. She commented that, because these audits were neither helpful nor meaningful, especially looking at the appeals, HANYS along with the Greater New York Hospital Association had filed a lawsuit. She informed the Committee that HANYS would continue to fight at the federal level while, at the same time, also advocating at the State level.

Ms. Grey described the top federal issues as the following:
- Protecting Medicare and Medicaid payments
- Medicare Recovery Audit Contractors
- SES Risk Adjustment for Medicare Readmissions
- Disproportionate Share Hospital (DSH) Funding
- Two Midnight Rule Relief
- Extend Key Expiring Programs/Payments like MDH and LVH
- Improving Meaningful Use Program

Ms. Brown asked Ms. Grey to clarify the following terms: the socio-economic (SES) Risk Adjustment for Medicare Readmissions, the Medicare Dependent Hospital (MDH) and Low Volume Hospital (LVH).

Ms. Grey stated that, for Medicare readmissions, it had long been argued that it was not enough to just adjust for acuity for health conditions because there was so much more that goes into the ability of hospitals and health systems to help patients and prevent readmissions. As such, consideration should be given to the socio-economic factors, while trying to put them into the equation, to reflect the impact that poverty and other issues have on health outcomes. Ms. Grey explained that the MDH and LVH were programs to provide payments to offset some of the small volumes that rural or small hospitals have when they are very dependent on Medicare. She informed the Committee that these expiring programs were more of an upstate rather than a downstate/borough issue.

Ms. Grey described the major State issues as the following:
- American Health Planning Association/CON Web Sites
- Medical Malpractice

- Mandatory Nurse Staffing Ratios
- State Budget

Ms. Grey informed the Committee that the health planning issue would likely resurface next session. She stated that the governor's office had proposed fairly rigorous but not yet well-defined Regional Health Improvement Collaboratives. A major concern with the prior proposal is the potential of allowing regional planning entities to have a role in the Certificate of Need (CON) process. She explained that the collaboratives were of concern because the CON process was already a lengthy and tough process; and hospitals and health systems have difficulty competing with other providers as they do not have to go through a similar process.

Ms. Grey reported that there were several damaging medical malpractice proposals on the horizon. She stated that HANYS would be fighting against them. However, if these proposals were to move forward they would have significant impact on HHC.

Ms. Grey reported that mandatory Nurse Staffing Ratios was another hot topic that would be at the center of discussions moving forward. Ms. Grey cautioned that there was no evidence that indicated that quality improved with ratios and that an arbitrary ratio was not the way to go.

Ms. Grey stated that the state budget would provide a huge opportunity because it would include a $5.1 billion surplus going forward into next year. The Independent Democrat Conference (IDC) released their ideas on December 8, 2014, and they were all about infrastructure. Ms. Grey repeated a common statement used by elected officials, which states, "A onetime surplus should be used for one time needs." Ms. Grey added that HANYS recognized the urgency to discuss the necessity to invest more in healthcare. Ms. Grey explained that looking at the state's capital needs and the reforms that were being implemented; the available resources were far from sufficient. As an example, Ms. Grey referred to the Delivery System Reform Incentive Payment Program (DSRIP) which would disburse $1.2 billion in capital funding over five years. Ms. Grey commented that, while this amount appeared to be a lot of money, once it is duly allocated, it would not be adequate to support the expected reforms that were afoot. Ms. Grey stated that legislators must be reminded that DSRIP funds are not guaranteed and that they would be collected over time based on providers' performance. Ms. Grey informed the Committee that there had been some discussions concerning additional capital funding because the current funding was not enough. She added that additional transition funding was needed in that and other areas. Ms. Grey referred to the Vital Access Provider (VAP) program through which the State of New York would assist financially challenged providers that are vitally needed in their communities as they seek to attain stability. Additionally, Ms. Grey stated that there were a number of other priorities.

Ms. Brown commented that the State budget included a cap on Medicaid spending. Ms. Grey added that one of the priorities was first and foremost, "keep your promises." Ms. Grey added that this past year, HANYS and other healthcare advocacy institutions had worked hard to restore the across board two percent (2%) Medicaid rate cut. Ms. Grey also noted that the Global Cap was a big concern and was also another promise that the State needed to keep. Ms. Grey explained that oftentimes there are movements of monies outside of that cap to fund other things even though those funds should have been retained in healthcare. She added that one of those risks is the Office for People with Developmental Disabilities' (OPWDD) audit. Ms. Grey stated that significant funding was at risk to fight the audit at the federal level; however, if not successful, OPWDD may try to come back to the Global Cap.

Ms. Grey informed the Committee that there were some concerns about what form of Medicaid funding would evolve from the immigration order that the President had issued and that HANYS was working hard on that risky issue. Moreover, Ms. Grey stated that, as the Affordable Care Act (ACA) moves through the process, there would be more savings that should be put back into the healthcare industry. Ms. Grey reminded the Committee of the shared savings agreement, which would allow savings to be shared with everyone if spending levels remained under the expected spending limit (i.e., the cap). She commented that HANYS was also working to ensure that would occur.

Ms. Grey added that, in addition to Mr. Whalen's blizzard statement, what she had highlighted were only a sampling of the current issues. She added that there were other State policy initiatives which included the waiver, the exchange, the all payer database and the continuation of the Medicaid Redesign Team (MRT) initiatives. Ms. Grey added that there were other important transitions which included the transition from fee-for-service to managed care for some of the most vulnerable populations. These transitions are major and happening now including SHIP and the big data portal that the State has created.

Ms. Grey stated that DSRIP was new and was constantly evolving. Each DSRIP is unique. Therefore, New York State has its own special version of DSRIP. Ms. Grey added that, while the health care industry was grateful for DSRIP, it was also important to identify some of the major DSRIP issues and continue to work with the State to resolve them.

Ms. Grey described key DSRIP issues as the following:

- <u>Governance</u>
  DSRIP applications are due in less than two weeks. Governance remains a big issue as there are some tough elements to sort through especially as dance partners are changing every day. Ms. Grey added that HANYS had worked very hard to ensure that the State allowed for some flexibility.

- <u>The "Bridge"</u>
  DSRIP is about reducing avoidable hospitalizations, collaborations and doing all of the right things, while at the same time ensuring that safety net hospitals are stabilized as all these major changes happen. Ms. Grey explained that, the idea is that if everything worked out as planned, on April 1, 2015, DSRIP funds would flow and bridge funds would be made available for safety net hospitals. Ms. Grey commented that not much would happen on April 1, 2014. Therefore, HANYS remains concerned about seeking additional transitional funds. Ms. Brown clarified that, as hospitals are making those required DSRIP transformations, such as reducing admissions and readmissions, there would be a revenue stream that would diminish for those very same hospitals that are now in financial distress. The issue is how those performance-based payments would be reconciled with a significant reduction in some of the foundational reimbursements for those hospitals; and how DSRIP funding would help to bridge that transformation. Ms. Grey added that PPSs are having difficult conversations right now because the stabilization of safety net hospitals and lost revenue are important factors for DSRIP. Mr. Whalen commented that there is a math challenge. He explained that DSRIP funds that would flow to PPSs are to:
  1. Provide some cushion - as readmissions and admissions drop, the pathway is smoothed
  2. Support other distressed facility members of the PPS
  3. Get some revenue for the services they provide

Mr. Whalen added that there is a governance challenge and a front end challenge. Front end dollars will be needed to set up the systems and mount the services to build the coordinating steps. He explained that HANYS' comment to the State on the bridge issue was that there was not enough money to do all these things and that it does not flow that way. Whether or not the system is performance-based, there should be some front infusion of dollars, and then the focus should be placed on hitting the benchmark. Mr. Whalen emphasized that facility members were expecting to obtain some revenue as part of the DSRIP process. Mr. Whalen added that, in addition to the federal dollars, bridge and gap filling dollars were also needed to make this work.

Mrs. Bolus asked Mr. Whalen what was being done to help those hospitals that were providing the bulk of the uncompensated care for uninsured New Yorkers to get the lion share of DSRIP funding and to ensure that there would be sufficient funds to help them. Mr. Whalen responded that this was a major portion of the challenge because DSRIP has made, in some ways, Medicaid more attractive. He added that there are health care systems that are now getting into the game of population health and focusing on Medicaid beneficiaries; specifically, to provide services in various ways such as through partnerships. However, there are a lot more institutions and systems where Medicaid is higher on their priority list or radar screen. Mr. Whalen stressed that, for HANYS, the challenge was to make sure that the State understood that this would be a long term commitment. It just cannot be about getting through DSRIP and realizing a revenue stream. He added that some of the issues were also about geography. While PPSs may form through partnerships, it does not necessarily mean that well-off institutions or institutions that, prior to DSRIP that did not have a significant role in delivering services to the Medicaid population, can replace the long term commitment and mission of those who have served these populations as part of their core set of services and commitment. Mr. Whalen affirmed that the State understood that. He added that the problem to some degree is that the waiver is a combination of a couple of bad things including:

1. The State's anxiety in getting the dollars – the application occurred at a point and time when the governor had just closed a $10 billion deficit and there were not dollars to invest in healthcare. Therefore, the waiver was viewed as an avenue to bring federal dollars to the State.

2. The Federal Government mistrusts New York when it comes to Medicaid. New York is aggressive about making use of these dollars because there is a substantial need for those dollars to serve the Medicaid beneficiaries. However, Mr. Whalen noted that the result of that has been intractability on the part of the Federal Government. He explained that, when the State goes and makes reasonable requests for flexibility, the federal answer is always no because it is thought that the State is trying to pull something. Mr. Whalen commented that, as PPS are put together with multiple facilities and systems, that the role of safety net institutions must be preserved, recognized and supported because these institutions have served Medicaid for so long and so superbly. That is a key part of HANYS' message.

Ms. Grey continued her presentation of key DSRIP issues which included the following:

- <u>MMC Role & Value-based Purchasing</u>
  Ms. Grey added that for strategic planning, it was important to think about the multi-year effect and questions such as what would be the role of Medicaid managed care going forward. Ms. Grey reported that a goal of DSRIP is achieving 90% of payments being value-based. She clarified that value-based is not traditional fee-for-service. She explained that value-based purchasing was a common theme not only just in DSRIP, but also on the non-Medicaid side of the world which

includes the State Health Innovation Plan (SHIP). Ms. Grey commented that were a lot already happening in the commercial world concerning value-based purchasing.

- Meaningful Regulatory Reform
  Ms. Grey stated that, while everything appeared to be positive and with the Federal Government working on allowing for meaningful DSRIP waivers, HANYS was also pushing for a much more robust and long term waiver.

- Anti-Trust
  Ms. Grey stated that there have been a lot of debates concerning anti-trust. She added that, despite the Certificate of Public Advantage, (COPA), the Accountable Care Organization (ACO) regulations, and the exchanges between the State and the state agency, the bottom line was that the Federal Government can trump the State. Therefore, HANYS is urging the State to talk to the Federal Government. Ms. Grey informed Committee members that there was already a 13-page document outlining some concerns.

Mr. Whalen added that remaining key DSRIP issues included: timing, intersection with other initiatives, end view, government consistency and shared agenda, adjustment, coordination and the federal view.

Ms. Grey reported on the New York State Health Innovation Plan (SHIP). She described the SHIP program as the following:

- State's entry into commercial market
- Mirror image of DSRIP for non-Medicaid
- Same goals for avoidable hospitalizations
- CMMI and DOH concept –actions will reduce healthcare spending in the commercial market that can be reinvested via health plans for primary care. Ms. Brown asked who would make the decision for reinvestment and how these reinvestments would occur. Ms. Grey's stated that, like DSRIP, it would be figured out along the way. It is believed that the Department of Financial Services (DFS), the rate setting authority, has a lever to push the plans to pay for advanced primary care. Since HHC has many clinics and provides a significant amount of primary care services, it would be extremely helpful to HHC if those plans agree to share it. Ms. Grey stated that, thinking through the next few years for HHC, the magnitude of the change that was occurring across the entire spectrum, all at the same time, was also part of the challenge.
- Decision on grant expected soon - Ms. Grey reported that the state had applied for a CMMI grant to fund the SHIP program. Ms. Grey stated that the grant amount is for $100 million, which is almost insignificant in the big world of New York State spending.
- SDOH may pursue elements regardless -- Ms. Grey informed the Committee that it was the State's vision and that it would try to pursue these elements regardless of a grant award.
- No transition funding for hospital inpatient decline

Ms. Grey explained that the New York State Health Innovation Plan and the Medicaid Waiver had different constituencies and funding sources, but shared the same goals, which were described as the following:

1. Reduce preventable hospitalizations by 25% in 5 years
2. Transform 80% of provider payment to value based (not fee-for-service)
3. Investment in HIT: APD & SHIN-NY
4. Population Health Improvement Projects (PHIPs) to:
   a. Align with Prevention Agenda

   b. Promote and Advanced Primary Care Model
5. Evolve the health care workforce

Ms. Grey stated that some of the key SHIP issues were very similar to those related to DSRIP. These issues include:

- Commercial market intrusion
- Need for reinvestment and "bridge"
- Governance
- Meaningful regulatory reform
- Value-based purchasing
- Ensure flexibility
- Don't stifle innovation
- Intersection with other initiatives
- PHIP scope creep

Mr. Whalen continued the presentation and informed the Committee that he would focus on what institutions and systems were doing in reaction to these changes. He added that he would also provide a more global way to think about all of these changes. Mr. Whalen stated that these changes were not unique to New York State. Many other states are doing similar initiatives. He also informed the Committee that New York's waiver had been highlighted by the National Governor's Association as the template for future waivers around the country because it brought together the necessary elements of federal Medicaid waivers. Mr. Whalen explained that this was about increasing the value of the health system for healthcare investments. Mr. Whalen described some of the major areas as described below:

1. Cost
   A big set of innovations that are underway to make the system more efficient, some of that is about the theory that, if providers to take on risks through capitated payments or some other mechanism, that would drive efficiency in the system.

2. Payment
   Payment should be tied to outcome and incentives should be provided for the right kind of outcome. Health care services should be paid partly on the basis of how well services are provided. There is a need to be more transparent as people do not understand how much a test costs, how much an MRI costs and how they might be responsible for paying some portion of that out of pocket in some ways.

3. Incentivize the way services are organized and provided
   People are using their phones to do various things; they want to be able to use their phones to make an appointment with their physicians that same way. They want to be able to use their telephone to find out the best knee replacement at the cheapest cost in their area. Mr. Whalen stated that technology was making the data available to do just that. The State and the Federal Government are increasingly interested in collecting this information to be able to document variations in costs for the same services and to identify if there are quality differences. Are we getting a better outcome for paying more? The State's all-payer database will collect all the information on the cost side and cross-tab it with quality.

4. Transparency

Mr. Whalen stated that every health system and every provider should simply assume that over the next several years, quality scores and costs were going to be available for anybody and everybody to see. He added that the State was moving in that direction in different ways as everything is being measured. Mr. Whalen commented that HANYS' concern is that this is an inexact science. Mr. Whalen reported that, originally the State had planned to use the information from the hospital charge master. He noted that HANYS' concern was that, even at its best, the charge master could be misleading.

5. Cost Control
   Mr. Whalen added that cost control was a consistent factor with continued downward pressure on reimbursement. The assumption is that providers are not going to get paid more for their services. In fact, the pressure would be the other way around, how do they become more efficient.

6. Quality
   Mr. Whalen noted that quality would be a benchmark and that there will be an intense focus on quality and outcome.

Mr. Whalen stated that all these issues were swirling now and behind many of these issues was the theory that hospitals and health systems should be at risk for the payment, which could be through capitation. Mr. Whalen explained that capitation is a payment arrangement for health care service providers. Capitation pays a physician or group of physicians a set amount for each enrolled person who is assigned to them, per period of time. If the physician or group of physicians is able to manage within that set amount and use fewer dollars to achieve the outcome, they are entitled to incentives for delivering quality and well-managed services to their patients. On the hand, when the cost of the services goes above the statistical value assigned to them, physicians will not receive extra dollars. Mr. Whalen informed the Committee that capitation was happening in various ways in many areas.

Mr. Whalen reported that there had been an emergence of retail medicine in our communities. Convenience stores such as Walgreens and Duane Reade pharmacies are hosting clinics that are offering services that are highly convenient and fairly inexpensive. Furthermore, Walmart is advertising a $40 same day appointment for a primary care visit. The question for providers around the country is whether to compete or partner with them.

Mr. Whalen summarized some of the common trends that were highlighted earlier as the following:

- Downward pressure on costs
- Quality and cost measurement
- Transparency
- Payment Reform – Mr. Whalen stated that there were a lot of talks about population risk. While everybody has their own definition of population risk, some of that is being responsible for a community defined by geography in some way, which is a very traditional role for HHC. Some other places are saying that they would be responsible for a population with a specific disease condition such as type II diabetic patients in a particular region. Some of it is about employers deciding to go out into the market in new ways and finding providers to contract with for care to their set of employees. Mr. Whalen explained that the usual way health insurance occurred was for employers to go through that process of working with a broker and designing a plan and offering that plan to their employees. He explained that this process was changing for a couple of reasons:

- Mr. Whalen referred to the North Shore LIJ affiliation with the Cleveland Clinic for cardiac surgery. He explained that the reason that happened was because Walmart decided a year or two ago that any Walmart employee who needed a cardiac by-pass surgery was going to get it at the Cleveland Clinic. A deal was struck with the Cleveland Clinic for a price and a guarantee on the outcome. North Shore LIJ, realizing the impact of that deal on their system, decided that they could not afford to lose those surgeries. They sought this arrangement with the Cleveland Clinic to partner.
- National employers could segment services by going to the market to find a best price and guarantee (ex. on joint replacements etc.,) on conceivably anything.

Mr. Whalen stated that, considering these changes and the development of the exchanges, including the possibility that private exchanges would come forward as employers worry about getting hit with the Cadillac Tax in 2018. These factors could provide a major changing dynamic in terms of the way patients get connected to healthcare systems. Mr. Whalen shared with the Committee that HANYS was facing a double digit cost increase for healthcare benefits. He added that this year for the first time HANYS, in a transparent way, had started the high deductible plan with a Health Savings Account as part of its benefit offering. In terms of the exchange, Mr. Whalen commented that consumers are totally price sensitive. He added that individuals are choosing plans that have high co-pays and high deductibles. Mr. Whalen explained that, taking into consideration average family incomes it appeared to be almost unaffordable for individuals to make those co-pays or meet those deductibles. As such, there are a lot of concerns on the provider side. Mr. Whalen reminded the Committee that the promise of the Affordable Care Act (ACA) is that this would be feasible because all patients would now have insurance. Mr. Whalen cautioned that this could create a situation where there would be a need to chase co-pays and deductible payments, which would likely increase bad debt and charity care.

Mr. Whalen described how to decide to share risk. The question should be, "Is it bundling, is it ACO, or is it sharing some upside risks only and not downside risks?" Mr. Whalen informed the Committee that he had participated in a Chief Financial Officer (CFO) retreat last August. In attendance were CFOs from Kaiser in California, Presbyterian in New Mexico and two for-profit hospital chains. A member from the audience asked the CFOs about their plan of choice and what should the payment model look like. Mr. Whalen stated that they all responded that they did not know but they would be playing in all of them to build their competency in terms of the right skill sets in order to be ready when a plan is chosen. Mr. Whalen added that another truism is that it is no longer easy to tell who is doing what in health care. He commented that are health systems like North Shore and Montefiore that are also insurers; and that there are also some insurers that are trying to get into the clinical game. Additionally, some unions have decided to open primary care operations. Mr. Whalen commented that, in Hudson Valley, there was a whole string of private physicians' specialty practices that have become an Accountable Care Organization (ACO) and have secured an insurance license.

Mr. Whalen informed the Committee that HANYS had spoken to hospitals that have decided to become insurers. North Shore is being the most aggressive with expanding into Connecticut and New Jersey. Others are at risk but do not yet want to become an insurer as it is not consistent with their mission. Mr. Whalen added that this would likely lead to the pathway of cost management decisions rather than care management decisions. Mr. Whalen noted that some places like Montefiore, for example, have invested heavily in care managers. Like social workers, the care managers build a file on each patient. This practice has drastically impacted readmissions and other services that they provide. Mr. Whalen added that there were a lot of activities in consolidations and partnerships happening across the City and across the State,

notably in the Hudson Valley, with lots of New York City providers reaching up into areas that are largely densely populated with good payer-mix.

Mr. Whalen shared with the Committee that, Mr. Mike Owen from Citi Group, who specialized in healthcare guilds, had made presentations to HANYS on two occasions. Mr. Whalen asked Mr. Owen what were the characteristics shared by their most successful arrangements. Mr. Owen responded that the emerging success model required:

- Scale and integration – Consolidation and partnership is about building a population of patients that you are responsible for in certain geographies.
- Aligned Physicians – The alignment of physicians with clinical and other staff is important for the transformation of the organization. Everybody needs to participate in the design of this new organization and its goal setting in order to operate as a closely integrated enterprise in order to succeed.
- Market essentiality
- Leading quality and patient safety
- Sophisticated IT with high adoption rates
- Highly efficient cost structures
- Post-acute linkages
- Progressive governance and leadership

Mr. Whalen concluded his presentation with the following key reminders:

- **Know when to jump . . . but be prepared**. Mr. Whalen stated that the healthcare industry's existence is based on a fee-for service environment because a substantial portion of services is fee-for-service. Therefore, to get ready, providers must ensure that skill sets are organized and practiced to be able to move at the appropriate time. Mr. Whalen cautioned that providers must be careful about when the indicators are right to make the move.

- **Every market is unique** – Mr. Whalen stated, "Do not think just because system X has done something that this is what you should do." He praised HHC for having a very long history of service to its communities and to its patients. Organizations should make decisions based on a study of the numbers for their own specific market. Organizations should not make decisions based on what other organizations have decided to do.

- **Most important ingredient is intellectual capacity to manage** – Mr. Whalen stated that, while pieces can be moved around, having the intellectual capacity to manage the enterprise was critical. He explained that this would require an investment in talent and training that should be cultivated and supported. He also encouraged the Board to think about the great team at HHC and to protect and support them.

- **"Build, buy, or partner?"** – Mr. Whalen stated that for any major undertaking the following questions should always come to mind: Do we build it ourselves because our system has those unique aspects – or do we just go out and buy it? Is it available on the market some place or do we get it through a partnership? Does it make sense to partner in some way to bring in the services, or to increase the system's capacity?

- **Grand experiment; change is constant and dynamic** - Mr. Whalen stated that no one is certain that all is going to change with the rise of health care costs. The goal is to control the growth line. He shared with the Committee his most common response to individuals concerning stability: "Things will not stabilize and that this challenge will persist overtime." He added that the change switch was frozen in the "*ON*" position. Mr. Whalen stated that the right metaphor in order to conceptualize this challenge is that, "These changes are just like ocean waves, they change intensity and speed, lose power and other things; they may sometimes be a little slower than other times, but they do not stop. "

- **Maintain organizational objectivity** – Mr. Whalen stated that the most valuable attribute for an organization to have was objectivity, which is a willingness to examine and re-examine decisions as circumstances change. The environment is so dynamic that, not only will there be a need to worry about changes occurring from the government side but also from the side of providers as they are also changing the way they do business. Mr. Whalen commented that, oftentimes, organizations do not like new ideas that challenge their deeply held mission. However, he cautioned that the environment is so dynamic that one really had to value this objectivity and be willing to re-examine and test decisions against new issues and new circumstances.

Mrs. Bolus asked Mr. Whalen to clarify the Cadillac Tax rule. Mr. Whalen responded that, in 2018, health plans that cost above a certain threshold would be taxed at 40% of their costs in excess of the established limit. Mr. Whalen added that there was a lot to worry about because it does not take much to bump against these thresholds.

Ms. Brown asked about HANYS' work on the expiration of the Charity Care law. She further inquired about HANYS' plans to ensure that organizations like HHC achieve a fair outcome. Mr. Whalen responded that talks were ongoing with the State regarding this issue. He added that, not only is it a general concern, it was also federally related. It is a lurking view wiring all hospitals on a level playing field. He explained that, at the federal level, this had been playing out for critical access hospitals. Mr. Whalen informed the Committee that there were about 12 critical access hospitals in New York. These hospitals receive additional reimbursement to continue to provide services. However, in some areas of the country, some members of Congress feel that the critical access designation should be eliminated. The idea is, if a hospital is needed in a community, it would be supported by the community. Mr. Whalen highlighted that there were some similar strands of that idea in the Bad Debt/Charity Care argument; and it was unclear where the Senate would land on this question. He reminded the Committee that Senator Kemp Hannon was reasonable and had, in the past, supported the idea that this issue should be re-examined continually. Mr. Whalen explained that HANYS' traditional position is to support the idea of a level playing field. Moreover, HANYS continue to be concerned about the role for safety net institutions and their long term commitment to those communities. He noted that there were just some places where other providers would not undertake the necessary set of services to serve those populations.

Mr. Rosen, Committee Member, asked Mr. Whalen if concierge medicine was a new term used in the healthcare industry. Mr. Whalen responded that concierge medicine was linked to physicians' practices, although practiced by some institutions around the country. Mr. Whalen defined concierge medicine as a customized plan for money that a patient can buy to get special services. He added that it was essentially a premium plan that a patient can buy into to obtain house calls and other types of services. Mr. Whalen informed the Committee that Presbyterian Health Systems in New Mexico had a service called ICU at home.

He explained that, if a patient resides 30 miles away from the hospital and had a certain diagnosis such as Congestive Heart Failure, instead of bringing the patient to the hospital, the bed, telemetry and home care visits would sent to the patient's home along with the services. Mr. Whalen commented that, while Concierge Medicine may not be practical in New York, it demonstrates that there is a willingness to examine the traditional way services are being provided. Mr. Whalen added that New York is also behind the times in its willingness to experiment with telemedicine. He explained that telemedicine is only used in New York for psych services, where psychiatrists conduct interviews with patients with the help of an IPad. Mr. Whalen noted that the traditional bureaucratic worry was, considering the number of services included, would Medicaid pay for it instead rather than thinking about the resulting cost saving opportunities that telemedicine provides.

Mr. Mark Page, Board Member, referred to Mr. Whalen's example of the use of Concierge Medicine for Congestive Heart Failure patients in New Mexico and asked if it was more expensive to move the bed to the patient's home rather than treating the patient in a hospital's ICU. Mr. Whalen responded that the claim is that it was extraordinarily less expensive. Ms. Anna Kril, Committee Member, commented that the patient outcome would likely improve because the patient would not be exposed to hospital acquired infections. Mrs. Bolus also added that family care would also be included.

Mrs. Bolus thanked Mr. Whalen and Ms. Val Grey for their presentation. She commented that the presentation was very thoughtful. Ms. Brown promised to invite Mr. Whalen and Ms. Grey again to present to the Committee.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:25 AM.

Metro East 99th Street Housing

Process Overview & Status Update

Strategic Planning Committee
January 13, 2015

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

Changing health care landscape impacts healthcare delivery

1999-2001: United States Department of Justice expands enforcement of the Supreme Court's Olmstead decision, which requires states to eliminate unnecessary segregation of persons with disabilities and ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.

2010-2011: New York's Medicaid Program expenditures were $53 billion a year, which is twice the national average when compared on a per recipient basis, to serve 5 million people. To remedy this situation, New York State created the Medicaid Redesign Team to identify significant health care cost savings and enhance health care delivery through the improvement of health outcomes and quality of care.

2008- Present: Programs such as the Nursing Home Transition and Diversion Medicaid Waiver and mandatory enrollment in managed long term care plans are aligned with having medically cleared individuals access health care services in a home and community based setting rather than in an institutional setting.

2013: New York State Department of Health recognizing that affordable and stable housing with the proper supportive health care services improves health, reduces hospital use, and decreases health care costs and prioritizes permanent housing for the disabled as part of Medicaid Redesign Team's work.

Burning Platforms for HHC

Aging Physical Plant

- The 70+ year old Goldwater campus on Roosevelt Island required significant and cost prohibitive infrastructure upgrades to comply with new state and federal regulations governing skilled nursing facilities.

Relocated LTC facility

- Rightsizing of Coler-Goldwater and the relocation of the Goldwater campus long term care facility to East Harlem would result in the restoration of health care services to the community, reduction of LTACH and SNF beds and necessitate the transition of eligible patients/residents to other community-based care settings.

Lack of discharge options

- Certain HHC skilled nursing facility residents achieved medical stability through the medical care received at Coler-Goldwater, but could not be discharged but for the fact that they lacked access to affordable and stable housing. At a point in time 400 plus SNF residents needing housing.

Affordable housing

- Existing NYNY supportive/affordable housing eligibility designation does not include persons at risk for homelessness upon discharge from either skilled nursing facilities or hospitals
- Much of existing housing stock not accessible to persons with physical disabilities

Current State: December 2011 – December 2013

- Right-sizing Coler-Goldwater LTACH and SNF would reduce the LTACH by 426 beds and the SNF by 410 beds
- A Fall 2011 CPS assessment of administrative data of all Coler-Goldwater SNF residents identified 413 SNF residents potentially eligible for discharge
- Coler-Goldwater SNF residents eligible for discharge had to be transitioned by November 2013
- CPS and Coler-Goldwater met bi-weekly with NYCHA and NYS NHTD program to prioritize the identification of affordable and accessible housing for Coler-Goldwater residents
- To house individuals who were disabled and who could not be served through the existing housing stock, HHC identified parcel leased to the Corporation - across from Metropolitan Hospital Center - to develop accessible and affordable housing for the Coler-Goldwater SNF residents

Identified Solution

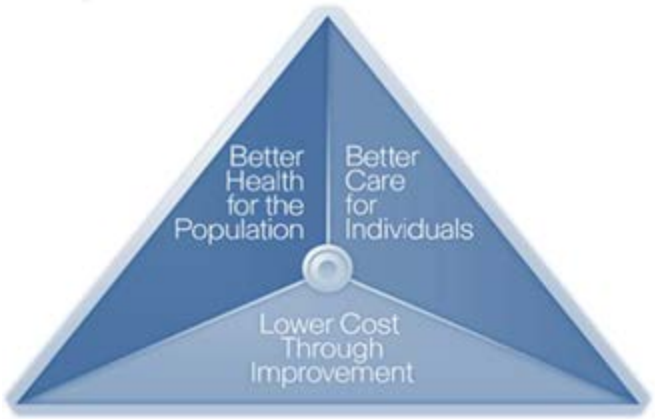
- HHC established partnership with city, state, and federal agencies and a private developer, SKA Marin, to develop 175 units of affordable and accessible housing on Metropolitan Hospital parcel at East 99th Street. Originally slated for completion in 2013 (project would not be completed until 2014).
- SKA Marin, working with HHC, responds to July 2012 RFP from NYS Homes and Community Renewal for housing for tenants who are ready for independent living. Receives first MRT funding for permanent housing for long stay disabled Medicaid beneficiaries.
- Coler-Goldwater SNF residents were assessed for capability to reside independently and surveyed for their interest in permanent housing at the Metro East 99th Street development. Prospective tenants were provided with on-site skills training and transition orientation through both Coler-Goldwater and community-based partners such as Center for the Independence of the Disabled, New York (CID-NY)
- Project originally envisioned to be exclusive for Coler-Goldwater discharges, however, CPS and facility were successful in placement of significant number of the original 413 SNF residents. Therefore, patients/residents from other HHC facilities who are high Medicaid users and/or unstably housed were afforded an opportunity to apply for units.
- HHC facility social workers and discharge planners were engaged in identifying patients/residents that met the eligibility (i.e. income, level of functioning etc.) criteria

Metro East 99th Street Building Details

- Located at East 99th Street between First and Second Avenues, across from the Metropolitan Hospital Center campus
- 175 units consisting of one bedrooms and studios
- Complies with Americans with Disabilities Act (ADA) standards for accessibility
  - Certain units exceed ADA standards to accommodate bariatric patients who require additional doorway clearance and turning radius
- Rent up commenced in November 2014 and concluded on December 24, 2014

Partnerships: New York State Department of Health Medicaid Redesign Team

- Metro East 99th Street became the first development in the state to receive Medicaid Redesign Team (MRT) funds for projects focused on populations with a high Medicaid utilization
  - $7.3 million MRT mortgage loan to SKA Marin (developer) for construction for which total cost was $51.8 million. Other sources of funds were from HPD, HDC and tax credits
  - MRT funding assumes estimated savings of $10 million annually in state and federal Medicaid expenditures
  - SDOH and HCR will track the tenants' Medicaid expenditures and patient outcomes to assess program effectiveness



Partnerships: Metro East 99th Street Development

- **New York City Housing Development Corporation**
  - Provided financing to realize creation and preservation of affordable housing
  - Oversight responsibility for the marketing plan (i.e. rent-up process and logistics)
- **New York City Housing Preservation and Development**
  - Provided financing to realize creation and preservation of affordable housing
- **New York City Housing Authority**
  - Worked with HHC to obtain HUD approval for project based Section 8 vouchers for all apartments
  - Partnered with HHC to transition another 67 Coler-Goldwater SNF residents into public housing and independent living as part of the relocation of the Goldwater campus and rightsizing of Coler-Goldwater
  - Provided on an expedited basis required eligibility determination for all HHC patients referred for these 175 units

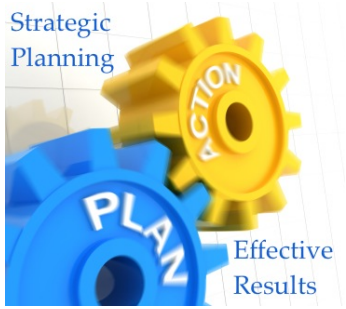
Partnerships: Metro East 99th Street Development

- **New York City Human Resources Administration**
  - Provided expedited tenant funding assistance with first month's rent, security, and a modest furniture allowance through the One Shot Deal program
- **SKA Marin (developer)**
  - Experience in affordable housing, senior housing, and construction management within New York State and New York City
  - Founder and principal possesses more than thirty years of experience in community and real estate development
- **The Carter Burden Center (community based organization)**
  - Selected by SKA Marin to integrate a social adult day care center into the building with dedicated onsite space for programming and activities
  - Received an award from the New York State Balancing Incentive Program Innovation Fund to provide transition support for those transitioning into Metro East 99th Street, including tele-health monitoring
- **The Fund for HHC**
  - Awarded funding to provide each household with a $100 gift card to supplement the HRA allowance for furnishings and other essential items

It Took a Village to Achieve HHC's Goal and Comply with HUD and Other Agencies' Rules

- **Corporate Planning Services (CPS):**

Planning Stage (January 2014 – March 2014)



- Developed process overview, eligibility criteria, and application checklist
- Produced an instructional guide so that HHC facility staff can assist patients in completing applications
- Provided consultation services and technical support to HHC facilities
- Convened conference calls with designated HHC facility liaisons to explain the application process and eligibility criteria prior to process commencement
- Engaged the HHC Executive Directors to identify liaisons who would serve as a centralized point of contact with CPS to facilitate the housing selection process

Review Stage (March 2014 – Present)

- Reviewed application package for accuracy and completion
- Performed criminal background checks using state and federal databases
- Engaged facility social work and case management staff staff to troubleshoot eligibility concerns and/or incomplete applications
- Engaged facilities to coordinate dates and locations for applicant interviews
- Submitted application packages to SKA Marin
- Convened weekly workgroup conference calls with SKA Marin, NYCHA, HDC, and Wavecrest (developer's compliance and background check agent)

It Took a Village…

- **SKA Marin**
  - Reviewed application packages submitted from HHC
  - Interviewed qualified candidates onsite at HHC facilities
  - Performed criminal background and credit checks through an intermediary

- **NYCHA**
  - Reviewed the application materials for Section 8 eligibility
  - Performed verification of application packages and background checks of applicants
  - Certified eligible applicants for Section 8

- **HDC**
  - Reviewed the application materials for accuracy and perform verification of information submitted
  - Certified that eligible applicants are in compliance with the low-income housing tax credit regulations

- **Final Stage**
  - Applicants signed leases and received move-in dates for their new apartments
  - HHC facilities continue to work with patients to support continuity of care through case management (managed care plans, health homes, Nursing Home Transition and Diversion Medicaid waiver program, etc.), home care, primary care/ specialty care appointment scheduling and follow-up

Tenant Applications & Eligibility

Number of applications received (as of 12/24/2014)	**500**
Certified by NYCHA (approval for Section 8)	183
Certified by HDC (approval for low income housing tax credit)	175
Ineligible applications	127
Incomplete applications – additional information required	190

Tenants at Metro East 99th Street: HHC Referral Source

Facility	Number of Tenants Referred by Facility
Bellevue	15
Coler	19
Dr. Susan Smith McKinney	4
Elmhurst	18
Gouverneur	25
Harlem	15
Henry J. Carter	1
Jacobi	14
Kings	17
Lincoln	2
Metropolitan	21
Queens	6
Woodhull	18
Total	**175**

Metro East 99th Street: Tenant Profile

Selected Demographics*	
Female	Male
47.6%	52.4%
Under 60 Years of Age	60 Years and Older
48.8%	51.2%
Percent of tenants with behavioral health diagnoses	Percent with mobility impairments or using an assistive device (cane, wheelchair, walker, scooter)
20%	17.1%

*Percentages based on a n of 175.

Next Steps

- Create opportunities for Metro East 99th Street tenants to speak with representatives from managed care plans (i.e. MetroPlus, Healthfirst, Independent Care Systems and others)
- Continue to coordinate with Metropolitan Hospital Center to identify opportunities to inform tenants of available health care services, have tenants become better acquainted with the hospital, and provide tenants with the option of receiving some or all of their care at Metropolitan
  - ➢ Tenants have the option of continuing their care at their existing HHC facility
- Engage the HHC facility liaisons to develop standard work for contractual maintenance of a wait list of viable potential tenants and requisite assurances that patient connections and support post-discharge are maintained
- Provide ongoing monthly monitoring and reporting to the New York State Department of Health's Medicaid Redesign Team on patients with established tenancy at Metro East 99th Street; work with SKA Marin on provision of data
- Conduct in service on standard work for all relevant HHC staff
- Distribute $100 gift cards to Metro East 99th Street households in January 2015 so that patients can continue to furnish their apartments