

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

**SEPTEMBER 11, 2012
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET**

AGENDA

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

**II. ADOPTION OF JULY 10, 2012
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**

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

IV. INFORMATION ITEM:

**i. THE LINGERING CLOUD OF 911 – HOPE AND HEALING THROUGH ART AND
EXPRESSION**

**TERRY MILES, EXECUTIVE DIRECTOR
WTC ENVIRONMENTAL HEALTH CENTER**

**IRENE DAVID, PHD, DIRECTOR, THERAPEUTIC ARTS
BELLEVUE HOSPITAL CENTER**

**NOMI LEVY-CARRICK, MD, MPhil, PSYCHIATRIST & MENTAL HEALTH DIRECTOR,
WTC ENVIRONMENTAL HEALTH CENTER**

ii. 340 B PROJECT PRESENTATION

**ARTHUR WAGNER, SENIOR VICE PRESIDENT
SOUTH BROOKLYN & STATEN ISLAND NETWORK**

**JOSEPH QUINONES, SENIOR ASSISTANT VICE PRESIDENT
OPERATIONS**

VINCENT GIAMBANCO, DIRECTOR OF PHARMACY
MATERIALS MANAGEMENT

V. OLD BUSINESS

VI. NEW BUSINESS

VII. ADJOURNMENT

JOSEPHINE BOLUS, RN

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

JULY 10, 2012

The meeting of the Strategic Planning Committee of the Board of Directors was held on July 10, 2012, in the Board Room located at 125 Worth Street with Josephine Bolus, RN presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, RN, Chairperson of the Committee
Alan Aviles
Bernard Rosen
Michael A. Stocker, M.D., Chairman of the Board
Andrea Cohen, representing Deputy Mayor Linda Gibbs in a voting capacity

OTHER ATTENDEES

A. Diop, Director, Human Resources Administration's Office of Citywide Health Insurance Access
P. Corbett, Legislative Financial Analyst, New York City Council
M. Dubowski, Analyst, Office of Management and Budget
A. Edwards, Healthcare Advocate, Commission on the Public's Health System
C. Fiorentini, Analyst, New York City Independent Budget Office
J. Gallek, Student Intern, Commission on the Public's Health System
M. Heron, Assistant Director, District Council 37
M. Meagher, Analyst, Office of Management and Budget
J. Robin Moon, Senior Health Policy Advisor, Mayor's Office
D. Perella, Associate, Hogan Lovells, Washington, D.C.
M. Tavares, Chief of Staff, Mayor's Office of Immigrant Affairs
J. Wessler, Director, Commission on the Public's Health System

HHC STAFF

M. Belizaire, Assistant Director of Community Affairs, Intergovernmental Relations
A. Bloom, Chief Psychologist, Family Court Mental Health Services
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
- L. Chang, Data Center Administrator, World Trade Center Environmental Health Center
- J. DeJesus, Administrator, World Trade Center Environmental Health Center
- D. Guzman, Assistant Director, Metropolitan Hospital Center
- T. Hamilton, Director, HIV Services, Corporate Planning Services
- V. Henry, Senior Associate Director, Queens Health Network
- E. Hernandez, Director, Media Relations, Communications and Marketing
- L. Johnston, Senior Assistant Vice President, Medical and Professional Affairs
- J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations
- S. Kleinbart, Director of Planning, Coney Island Hospital
- V. Kim, Senior Director, Corporate Planning Services
- Z. Liu, Senior Management Consultant, Corporate Planning Services
- P. Lockhart, Secretary to the Corporation, Office of the Chairman
- P. Lok, Director, Corporate Reimbursement, Finance
- R. Lore, Psychologist, Family Court Mental Health Services
- T. Mammo, Deputy Chief of Staff, President's Office
- A. Marengo, Senior Vice President, Communications and Marketing
- 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
- T. Miles, Executive Director, World Trade Center Environmental Health Center
- J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
- S. Penn, Deputy Director, World Trade Center Environmental Health Center
- N. Peterson, Senior Assistant Vice President, Woodhull Medical and Mental Health Center
- E. Russo, Assistant Director, Corporate Planning Services
- S. Russo, Senior Vice President and General Counsel, Legal Affairs
- D. Thornhill, Associate Executive Director, Strategic Planning, Harlem Hospital Center
- J. Wale, Senior Assistant Vice President, Behavioral Health
- M. Werchol, Assistant Vice President, Family Court Mental Health Services
- 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 10:05 a.m. by the Strategic Planning Committee Chairperson, Mrs. Josephine Bolus, RN. The Minutes of the May 8, 2012, meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

Ms. Brown greeted and informed the Committee that her remarks would include brief updates on federal, state and city issues and the Corporation's Breakthrough work.

FEDERAL UPDATE

Ms. Brown reported that, on June 26, 2012, the Senate had passed bipartisan legislation, the Prescription Drug User Fee Act (PDUFA), to extend the Food and Drug Administration's (FDA's) authority for five more years to assess user fees on prescription drugs and medical devices. The House passed PDUFA by a voice vote during the week of June 17, 2012, and the president is expected to sign it. Most importantly for HHC, PDUFA has provisions to mitigate prescription drug shortages. It requires drug manufacturers to provide the FDA early notification of discontinuations or other situations that could lead to potential shortages; and would allow the FDA to expedite approval of manufacturing changes that would help prevent and mitigate shortages.

Ms. Brown explained that PDUFA would also improve public recordkeeping of a drug shortage list. It would require the FDA to issue updated guidance on repackaging, which would modify current practices to allow hospital systems to share shortage drugs among their facilities. This is an important issue for HHC. Ms. Brown added that the pharmaceutical industry also supported the legislation, which also included provisions that would accelerate approval and extend market exclusivity on some new antibiotics for an additional five years. She added that the reauthorization of PDUFA was an important bipartisan milestone for this Congress.

World Trade Center Health Program Update

Ms. Brown provided the Committee with an update on HHC's World Trade Center (WTC) Health program. She reported that HHC had successfully renewed its contract with the federal government for its Clinical Center of Excellence (CCE) for World Trade Center survivors for nearly \$3.5 million; and its associated Data Center for \$1.25 million. The renewed contract will cover the period beginning July 1, 2012 through June 30, 2013. Ms. Brown explained that, having signed these contracts was the first step toward negotiating an increase in the contract amounts.

Ms. Brown reported that HHC's WTC Health Program had been awarded an additional \$187,000 by the federal government to fund HHC's annual WTC Health Program subway ad campaign. She explained that this year's campaign would be focused on Staten Island. It will entail new bus shelter ads in targeted neighborhoods throughout Staten Island and the remaining four boroughs to reach the Chinese, Spanish and Polish communities. She added that, this was a particular focus because NIOSH's published data had documented that 91 percent of new enrollees for HHC's WTC Health Center program (i.e., not incumbent patients) had been primarily English speakers. This is a concern for HHC. This campaign will be launched for a period of one month and will begin on September 1, 2012.

STATE UPDATE

Ms. Brown reported that the New York State Legislature had adjourned on June 21, 2012. HHC and its advocacy partners had been successful in advocating against several bills that would have had a significant financial impact on HHC. Such legislation included two safe patient handling bills, which would have required health care facilities, nursing homes and hospitals to pass specific staffing and equipment requirements. Ms. Brown noted that this legislation was driven by nurses' concern about lifting and moving patients. She explained that the second bill would have imposed stringent, inflexible nurse to patient staffing ratios and recording requirements on HHC. Specifically, it would have required HHC to hire 4,100 new nurses in order to comply with that proposed legislation, at a cost of more than \$400 million.

Ms. Brown reported that a medical malpractice bill was also rolled back, which would have increased HHC's malpractice costs by an estimated five percent. That bill also had a requirement that a defendant could decide prior to trial how their liability would be determined if a co-defendant settled the case. Ms. Brown explained that a provision of that same bill, which reversed a 2007 Arons Decision, would prohibit defendants from privately interviewing later-treating providers to determine extent of a plaintiff's injuries.

Ms. Brown noted that there were other key legislative items that were of importance to HHC that were not addressed in this legislative session. Of these items, a priority concern for HHC is the indigent care methodology used by the state to allocate charity care funding to hospitals. It is expected that this issue will be addressed in the next legislative session.

CITY UPDATE

Ms. Brown reported that, on June 25, 2012, the City Council had passed the Fiscal Year 2013 Budget. She explained that the City Council had restored more than \$14.5 million in expense funding and appropriated \$21 million in capital funding to HHC. On the expense side, the City Council provided:

- \$6 million - HHC's Unrestricted City Subsidy
- \$5 million - Child Health Clinics
- \$2 million - Expanded HIV Testing
- \$1.46 million - Developmental Evaluation Clinics
- \$50,000 - Substance Abuse training funds

Ms. Brown highlighted some key HHC projects that received capital funding from the City Council. The City Council allocated:

- \$7 million in FY 13 and FY 14 for construction of a comprehensive diagnostic and treatment center (D&TC) at 155 Vanderbilt Avenue on Staten Island
- \$2.5 million for Metropolitan Hospital to renovate their Cancer Center and to purchase a new Ultrasound System
- \$2.25 million for Coney Island Hospital to purchase new cardiac monitors for the ED, new pneumatic tubes for the ED as well as a new Communication System
- \$2.06 million for Kings County Hospital to purchase a new MRI

Ms. Brown reported that every Borough Delegation had provided some significant level of funding for capital equipment and/or capital projects for HHC's hospitals. She stated that HHC is very appreciative of the City Council, the Borough Delegations and the Council Speaker's leadership and their commitment to HHC.

HHC INITIATIVE UPDATE

Breakthrough

Ms. Brown provided the Committee with an update on the Corporation's Breakthrough efforts on behalf of her colleague, Joanna Omi, HHC's Senior Vice President, Organizational Effectiveness and Innovation. Ms. Brown reported that, as of June 30, 2013, there had been more than 1,000 Rapid Improvement Events (RIEs). This work generated more than \$225 million in new revenues and cost savings, with more than that 12,750 HHC employees having now participated in some form of Breakthrough activity. In addition, a total of 5,700 staff members have participated in the centralized training program to learn skills including event facilitation, problem solving and process control board development.

Ms. Brown reported that Jacobi Medical Center had initiated a model value stream in Perioperative Services. This model value stream will build on the Breakthrough improvements that are already in place in Perioperative Services and will take those improvements to the level of improvement hyper-drive. As Jacobi experiments with improving their staffing models and in-depth value stream mapping, it will dig deeply to understand the root cause of problems. Ms. Brown noted that the enhanced improvements gained would be transferred to other HHC facilities.

Ms. Brown informed the Committee that in May, the first of a new, multi-level Breakthrough manager training program, designed to ensure the maximization of RIE outputs and to prepare managers to sustain the outcomes of those events, had been piloted. Additionally, the Corporation has expanded its use of Hoshin Kanri, a Lean management tool that will help HHC to achieve greater alignment and focus toward key strategic goals.

Ms. Andrea Cohen, who represented Deputy Mayor Linda Gibbs in a voting capacity, asked how many employees had been involved in some form of Breakthrough activity. Ms. Brown responded that 12,750 staff members have participated in some form of Breakthrough activity; and another 5,720 HHC staff members have participated in training. Mr. Rosen, Committee Member, asked if the 5,700 total staff members who had participated in training was also part of the 12,750 staff who had participated in Breakthrough. Ms. Brown responded affirmatively. She explained that staff members who had been engaged in Breakthrough activities have also received some form of Breakthrough training.

INFORMATION ITEM:

THE HEALTH CARE CASE: OUTCOME AND POTENTIAL IMPACTS

DOMINIC PERELLA, ASSOCIATE, HOGAN LOVELLS LEGAL PRACTICE, WASHINGTON, DC

Ms. Brown introduced Mr. Dominic Perella, an associate with Hogan Lovells legal practice in Washington D.C. She informed the Committee that Mr. Perella would be walking the Committee through the most recent Supreme Court decision on the Affordable Care Act (ACA) or the health care reform law and would engage the Committee in a conversation about the implications of that decision. Ms. Brown introduced Mr. Perella and summarized Mr. Perella's background as the following:

"Dominic Perella concentrates his practice on appellate and Supreme Court litigation. Mr. Perella has argued before the U.S. Court of Appeals for the District of Columbia Circuit and the D.C. Court of Appeals, and has briefed numerous cases before the Supreme Court and the majority of the federal circuits. He was

named, and one of his arguments mentioned, in the *National Law Journal's* 2011 Appellate Hot List. Mr. Perella's appellate practice has covered constitutional questions, insurance law, environmental regulation, Medicare regulation, and white-collar criminal appeals, among other areas. He also has developed a focus on communications law, and in that capacity has litigated matters on behalf of cable industry clients and participated in rulemakings before the Federal Communication Commission."

Mr. Perella began his presentation by stating that the Supreme Court Decision concerning the Affordable Care Act (ACA), announced on June 28, 2012, had been momentous in a lot of ways. At first glance, it appeared that the Supreme Court upheld the ACA across the board, but that was not the case. He explained that there were serious ramifications for Medicaid coming out of that decision, and would discuss the implications for the Medicaid program going forward.

Mr. Perella informed the Committee that he had drafted on behalf of the American Hospital Association and other major hospital associations, their briefs in the Supreme Court. He explained that this work began in 2010, when the first lawsuit suit was filed in the state of Florida. This lawsuit was elevated to the Supreme Court. The lawsuits covered issues including the ACA's individual mandate, Medicaid, severability etc. He explained that a lot of those issues are now off the table following the Supreme Court's decision.

Mr. Perella reported that the driving force behind the ACA was the uninsurance crisis. There are 50 million uninsured individuals, at last count, in the United States. This figure is more than five times the population of New York City. He explained that the goal of the ACA is to expand health insurance coverage to 30 million Americans. Coverage would be expanded in two big ways. That is, through an individual mandate and secondly through the expansion of Medicaid to new groups, including individuals up to 133 percent of the federal poverty level (FPL).

Mr. Perella stated that the Supreme Court's decision was a surprise to all of the prognosticators including him. It was expected that Supreme Court Justice Kennedy would have had the swing vote. It was also widely expected that the original mandate would rise and fall on Congress' laws. Mr. Perella informed the Committee that Chief Justice Roberts had issued an opinion which upheld the individual mandate and the rest of the law based on Congress' tax power. Mr. Perella commented that it has been widely reported in the media that Chief Justice Roberts had actually flipped. He originally voted with the other four conservative Justices to strike down the law. When he began drafting the majority opinion, Chief Justice Roberts changed his mind and decided to uphold the law and joined the Court's four Democratic appointees.

Mr. Perella explained that the main argument that was made by challengers of the ACA was that the Commerce Clause only authorized Congress to regulate commerce. In the case of the ACA, Congress would not be doing that but would be creating commerce. This would force individuals who were not in the market into the market. Congress had never done so before and should not do that. Mr. Perella stated that there were a number of responses to that argument that had been articulated by the government and in hospital associations' briefs. He stated that an obvious response was what Congress was doing with the ACA was not regulating an activity or regulating something that wasn't commerce. It was regulating the massive interstate commercial problem, which is the dislocation caused by the uninsurance crisis. That is, the monies that individuals with insurance, insurance companies and providers are being forced to pay to cover those who are not insured. All of that crossed state lines.

Mr. Perella stated that a number of well-respected conservative judges had accepted that argument including Lloyd Sullivan of the Eighteenth Circuit, Jeff Sutherland of the Sixth Circuit and Richard Bosner of the Seventh Circuit. Notwithstanding, five Justices accepted the challenger's argument. They said that Congress could not enact the individual mandate as a Congress power. Mr. Perella noted that Chief Justice Roberts ruled for himself only in that regard. The same opinion was voiced by the four dissenting conservative Justices. This resulted in five votes on the Supreme Court for the proposition that mandates were not permissible under the Commerce Clause.

Mr. Perella read Justice Roberts' key quote which states, "The individual mandate does not regulate existing commercial activity. It instead compels individuals to become active in commerce by purchasing a product." Mr. Perella explained that Roberts' key concern that he voiced throughout the entire proceeding in this case was "...construing the commerce clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to Congressional authority." Justice Roberts stated that, "if Congress could enforce a mandate on Americans in this context, why not with broccoli? Why not with cars?"

Mr. Perella stated that the first part of the decision concerning the Commerce Clause, which claimed that the individual mandate was not a good law under the commerce law powers, led Fox, CNN and other media organizations to place banners on their pages stating that the decision to mandate had been struck down. That turned out to be wrong but it was quickly corrected.

Mr. Perella stated that Justice Roberts joined by the four Democratic appointees, accepted the federal government's alternative argument, which was that the mandate is permissible under Congress' tax power. He explained that Justice Roberts said, "...Courts are required to give Congress the benefit of the doubt. If we can read a statute to be constitutional we have to do so. This statute looks a lot like a tax, it functions like a tax, and it is enforced by the Internal Revenue Service (IRS). We are therefore restrained to read it as a tax in order to save it from invalidation. The government asks us to interpret the mandate as imposing a tax; it would otherwise violate the Constitution. Granting the Act the full measure of deference owed to federal statutes, it can be so read. Therefore, the mandate survives." Mr. Perella stated that, because the mandate survived, the rest of the law including some sections with Medicaid also survived. Once the mandate was upheld, the question of severability disappeared.

Mr. Perella noted that Democratic appointees were unhappy with Justice Roberts' discussion concerning the Commerce Clause. Mr. Perella explained that Justice Roberts prepared a 20-page discussion of the commerce law to lay down a marker for Congress that mandates would not be permissible going forward. Justice Kagan wrote that Roberts should not have reached the commerce law at all, given the tax analysis. Mr. Perella added that, if another Justice had flipped the whole argument would have been struck down. They had five votes to strike down the mandate. Justice Kennedy seemed to be on board for striking everything else. So Roberts' decision to rest on the tax power, in fact, caused the entire argument to stand instead of fall.

Mr. Perella explained that the Medicaid argument was really about an obscure concept in constitutional law called the coercion doctrine. The way the doctrine works is that Congress can offer states funding in exchange for passing certain laws. He continued to explain that the Supreme Court had suggested in past cases that if the states ever had no choice about whether to accept funds, if the offer for some reason amounted to coercion, that would be the equivalent of a demand and it would violate the Tenth Amendment.

Mr. Perella added that, this was the first case after more than 200 years in which the Supreme Court had ever found unlawful coercion to exist. The vote was seven to two on this issue. In this circumstance, the Medicaid condition, which require states to expand their Medicaid programs as set

forth in the ACA or else the state would not only be stripped of ACA funding but all Medicaid funding was deemed coercion. Roberts said, "In this case, the financial inducement Congress has chosen is much more than relatively mild encouragement -- it is a gun to the head. A state that opts out of the ACA's expansion in health care coverage stands to lose not merely a relatively small percentage of its existing Medicaid funding, but all of it." As such, the seven to two votes is historic.

Mr. Perella stated that, there was a different majority for that remedy. Roberts and the four Democratic appointees decided that the Medicaid provision didn't have to be struck down to fix the problem. Instead, the Medicaid expansion had to be optional. That is, the Centers for Medicare and Medicaid Services (CMS) could not threaten to withhold all aid from the states that refused to expand their Medicaid offers. Mr. Perella emphasized that the bottom line is that the ACA is upheld with some limits on Medicaid. All programs other than Medicaid remain in place and unchanged. States will push ahead with implementation. Agencies will push ahead with rulemakings. The big exception is the Medicaid issue.

Mr. Perella explained that the first decision appeared to mean that states are free to entirely decline to expand the Medicaid programs along the lines suggested by the ACA. One question is which states would do so. The states with conservative governors, like Texas and Florida have threatened not to expand their Medicaid programs. Whether they will go through with it is to be seen. The second big question is what could CMS do about that? The Supreme Court makes clear that CMS could not threaten all previous funding. However, it does not make clear whether CMS could withhold other ACA funding or other ACA benefits from states that refuse to expand Medicaid. Notwithstanding, CMS could make a good faith argument that it is permissible under Justice Roberts' ruling. Mr. Perella stated that the third question is whether states can partially expand their Medicaid programs. Some states may want to expand Medicaid to only certain populations, which they may have to negotiate with CMS.

Concerning Disproportionate Share Hospital (DSH) funding, Mr. Perella stated that DSH hospitals that serve a disproportionate share of low-income individuals have received extra funds for many years under Medicaid. The ACA sets annual dramatic cuts in DSH funding. The idea was, because Medicaid would be expanded and because of the individual mandate, far more people would have insurance coverage. Accordingly, those funds that are provided to hospitals for uncompensated care would be reduced.

Mr. Perella described how DSH cuts would be implemented under the ACA. The DSH cut for the first year will be \$500 million. CMS has been instructed to divide those cuts up among the states. One strategy is to give the least amount of DSH funds to states with the lowest percentage of uninsured individuals. Mr. Perella described a scenario where a number of states that choose not to expand Medicaid could end up with higher percentages of uninsured individuals. Those states would actually get more DSH funds. States that went ahead and expanded Medicaid would get less DSH funds. Mr. Perella informed the Committee that, one of the questions he was asked to address was whether that would be the necessary outcome. His response was that, for states that are more likely to expand Medicaid is that, it is not necessarily so. The statute provides two methods for the Secretary to administer this provision. One way is to give those funds to states with the lowest percentage of uninsured individuals. The second way is for CMS to give the least funds to states that do not target hospitals with high volume Medicaid patients and hospitals that have high levels of uncompensated care. He explained that the Secretary can set up the distribution of DSH funds by giving the least amount of DSH funds to states that are doing the worst job of sending the DSH funds to the right places, which would be those hospitals that are helping with the highest percentage of poor residents. Mr. Perella reported that the Secretary appeared to have complete discretion to choose.

Dr. Stocker asked what impact would states that choose not to expand Medicaid have on how DSH funds would be distributed. Mr. Perella responded that, it would depend on the election. He added that a CMS run by the Obama Administration would likely take steps not to reward states that don't expand their Medicaid program. CMS could also provide a second piece of DSH statute to recalibrate things a bit. In the event of a President Romney, things may turn out differently. Mr. Aviles asked Mr. Perella if it was his impression that the regulation would require the Secretary to make a choice with respect to the country as a whole. Mr. Perella responded that, on its face, it appeared to be a choice. He commented that it is an arcane, lengthy and wordy statute.

Ms. Cohen commented that DSH is not so much a benefit for states but a benefit for hospitals. In some states that choose not to move forward with an expansion, hospitals will fight very hard to have that expansion. Without an expansion, hospitals will argue that they are at a disadvantage and need DSH funding even more. She stated that this is something to be concerned about. An Obama Administration would likely promise more DSH in advance to lessen the need for hospitals to fight as hard to get the expansion in their state. Ms. Cohen commented that, at the end of the day, an Obama Administration would be hard pressed not to give a state more DSH to be distributed among its hospitals. Mr. Perella stated that he was unsure if there would be pressure from hospitals in states that didn't expand Medicaid to get any funds. He added that, in states that choose not to expand; some individuals who are not covered by Medicaid would be eligible for subsidies. Those individuals who will receive subsidies and purchase insurance would pay hospitals at a higher rate. It is unclear how much that will offset the losses hospitals will face in those states, but it would help.

Ms. Brown stated that, for those states that choose not to expand, there will be people who can participate in the exchanges and be subsidized. Notwithstanding, the poorest of the poor will be the ones who would remain uninsured. Mr. Perella concurred. He added that this issue is now being referred to as the new doughnut hole. Individuals who are at income levels between 100 to 133 percent FPL in states that don't expand will be eligible for subsidies. Individuals below that level which are those individuals that should be covered, would not be eligible for subsidies. Mr. Perella commented that this was quite perverse. Ms. Brown added that, right now, there are many states where the state choose not to match; notwithstanding, the hospitals and localities of those states came up with the match. Ms. Brown added that there are at least 18 states that have stated that they won't participate; and another 18 that have said that they might not participate. As such, this decision may actually get reduced to state by state decision making, rather than a national policy. Mr. Perella added that the decision creates a state by state jockeying situation with Medicaid. There are states that are already offering Medicaid benefits above and beyond the most basic level required by federal law. These states may cut back to the baseline during the years the ACA regulates. The question is, if Medicaid expansion is optional, is the maintenance-of-effort also optional. Mr. Perella noted that there is an argument that it is not. There is an argument that the Robert's opinion is based on the idea that the Medicaid extension is a new program and that's why the Secretary can't threaten to withhold funds from states. Under that argument, maintenance-of-effort arguably is not a new program; it's really just the old program. Mr. Perella added that, even after the Supreme Court decision, states are not at liberty to stop following maintenance-of-effort. However, at least one state is already arguing that, they in fact could stop maintenance-of-effort. He noted that he had read in the blogosphere that other states were electing to follow suit. Other states are sending signals that they are not going to expand Medicaid and in fact will defend that decision.

Ms. Judy Chesser, HHC's Washington D.C., based lobbyist commented that, regarding DSH, where the Secretary has either the highest percentage of uninsured or the targeting, it's not absolutely clear whether she would pick one for the nation or she can mix and match for different states, it's not a perfect surrogate. Some states might have very limited Medicaid programs but they might have fabulous targeting. Another state might be very progressive and have very broad eligibility for their Medicaid program like New York State. This creates a real quandary where some states with progressive Medicaid programs could really end up getting punished where there's no good option for the Secretary to try to perfect one. Mr. Perella responded that CMS is going to have an idea of where it wants to go with distribution initially and is going to try to instruct a way to get there. From his read, the provision having to do with targeting is worded in such an arcane way that CMS could come up with any number of matrixes to determine their targeting needs. Whether that would solve the problem is not clear but it is possible.

Ms. Cohen commented that there are many more intricate issues concerning CMS. It is her impression that CMS would loathe having to go back to court, considering that they lost two Democratic appointee justices on this coercion question. She stated that CMS would try very hard not to litigate future decisions and would be conservative in their interpretation. Mr. Perella responded that it is impossible to know how much CMS would want to negotiate versus sue. If their concern is votes on the Supreme Court, the way the thing is written, again, could be read to say, only in this very peculiar situation (a new program and old program), and they're threatening to take away all the money from the old program and the old program is massive, do you have a coercion issue. It may well be that the Democrats who joined the opinion are excited to read it that narrowly so that it's limited to the situation.

Mr. Aviles commented, on the exchange issue. He stated that, for those who otherwise would have been eligible for expanded Medicaid coverage from 100 to 133 percent FPL, it seemed that the subsidies would likely have an insignificant impact on insuring folks in that category. This is because an individual would be paying for insurance rather than Medicaid, which is a no cost coverage option. While a subsidy would reduce the cost significantly, the overall cost will not be insubstantial; and these individuals would likely obtain the lowest tier insurance products with co-pays and deductibles. Mr. Perella concurred. He added that, it does not seem likely that an individual with a household income at 110 percent FPL would be interested in paying out-of-pocket co-pays and deductibles. Mr. Aviles inquired if these individuals would be exempt from the penalty and would be afforded an exemption. Mr. Perella responded that the number of individuals within this income category who would be purchasing insurance through subsidies would be low.

Mr. Salvatore Russo, HHC's General Counsel, commented that, in reading the decision, he found the treatment of the tax to be interesting. In one part of the opinion, the Tax Anti-injunction Act is discussed and found to be a penalty. In another part, the Justices upheld the whole purpose of the statute under the tax law. Mr. Russo asked Mr. Perella to comment on this issue. Mr. Perella responded by stating that this is something only a lawyer could love. There's a federal law called the Anti-injunction Act that was part of this case. What the Anti-injunction Act states is that one can't sue to challenge a federal tax statute until the tax is actually applied to or/are levied against that individual. He explained that there was an argument in the case that, if in fact the individual mandate is a tax, no one can sue to challenge it until the penalty has been levied against them. As such, the argument in this case could be kicked out of court and brought back in 2014 and 2015. Justice Roberts decided that the individual mandate is a tax but was faced with the situation that, if it is a tax why is the Supreme Court hearing the case at all. Justice Roberts issued an opinion that said, the individual mandate is a tax for constitutional purposes and it is not a tax for statutory purposes. The way he got there was by saying, the Supreme Court decides what a tax is for constitutional purposes and the individual mandate has all indicia of a tax.

Mr. Perella added that Congress is allowed to decide what falls under its purview and what doesn't. If they decide to call the individual mandate a penalty, and they don't want it to be a tax, Congress would defer to that decision. Mr. Perella informed the Committee that one of the lower courts decided exactly the opposite way. The lower court concluded that the individual mandate was a tax for statutory purposes and not a tax for constitutional purposes. Ms. Cohen asked what made something a tax rather than a mandate. Mr. Perella explained that there were several ideas presented why it's a tax. One thread of argument was that it looks like a tax, you pay it to the Internal Revenue Service (IRS), and the penalty is a revenue-raising device. Another line of argument is that the mandate operating under federal law is essentially a tax penalty that one could avoid by acquiring health insurance.

Ms. Chesser asked if the duplication of the Commerce Clause would have a spillover effect on issues like Civil Rights law. Mr. Perella responded that he did not think it would on first read. He added that the decision was very narrow and it targeted mandates. He added that there was a secondary argument from the government about the Necessary and Proper Clause, which is the clause that basically allows Congress to do things that it needs to do to effectuate its Congressional power. Mr. Perella reported that the most famous example in recent years had been a case concerning the regulation of medical marijuana. This case was about whether Congress could enforce criminal penalties on people that grow marijuana in their homes. He noted that there was some discussion in the Supreme Court's opinion that stated that this was okay even though it's not really commerce. In order to effectuate the larger regulation of marijuana trafficking, Congress had to put this piece in so it could do it under its Necessary and Proper Clause power. Mr. Perella added that Justice Roberts added certain things in the health care opinion that suggested a narrower view of that Necessary and Proper Clause. His view is that Congress should not create a big regulatory scheme and then use it as an excuse to do something else.

Ms. Bolus commented that, she recalled a time (when she was working) that there were large influxes of people from other states coming to New York because it was more difficult for those people to receive services in their own state. She asked if it was anticipated that this would occur again. Ms. Brown responded that this would not likely be an impact that would result from the health reform law or from the Supreme Court's decision. Ms. Brown added that the decision to come to New York for care would more likely be based on those individual's decision about how they can access health care. She stated that she didn't think the Supreme Court's decision would either precipitate an increase or would cause a diminution in that practice. Mr. Aviles agreed. He added that there is so much disparity now in the Medicaid programs from state to state, which have motivated some individuals to make that move. He noted that the Supreme Court's decision would not likely impact that practice.

Ms. Bolus thanked Mr. Perella for his presentation.

ADJOURNMENT

There being no further business, the meeting was adjourned at 10:50a.m.

THE LINGERING CLOUD OF 9/11

Strategic Planning Committee
September 11, 2012

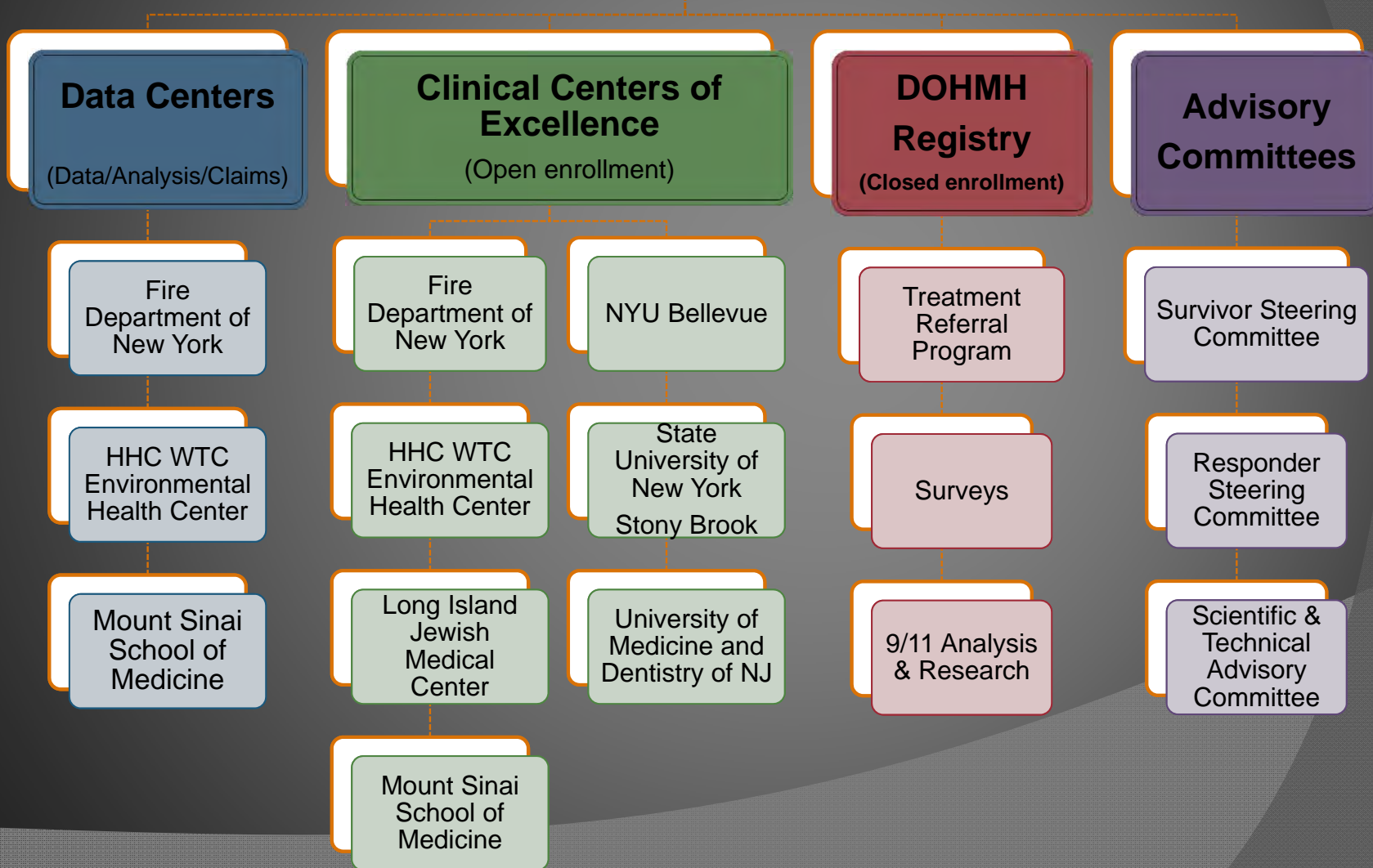
Terry Miles, Executive Director

Nomi Levy-Carrick, MD., Mphil., Mental Health Director

Irene David, PhD., Director of Therapeutic Arts

The World Trade Center Environmental Health Center

The World Trade Center Health Program



Three Clinical Locations

Gouverneur Health Services

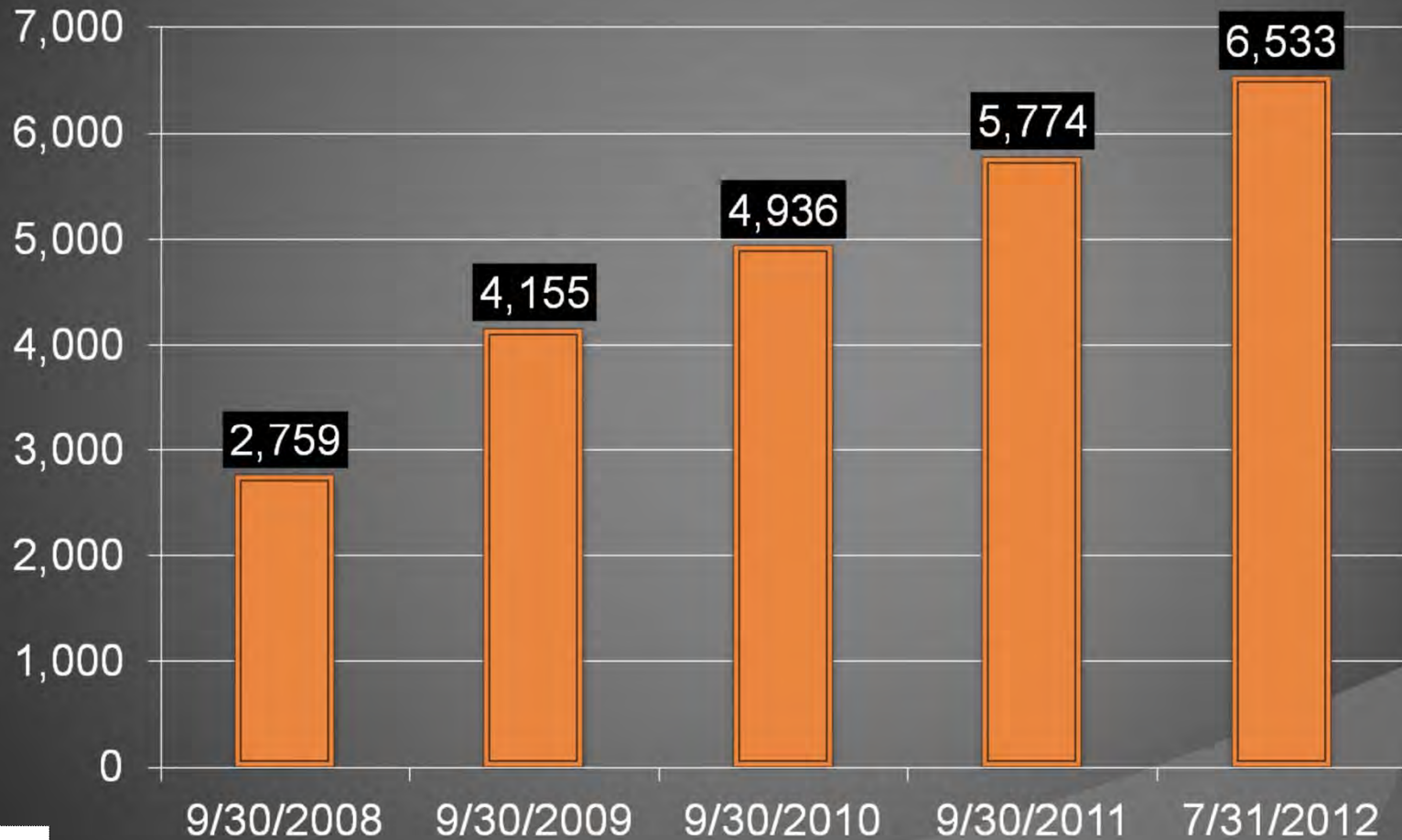
Elmhurst Hospital Center

Bellevue Hospital Center



Total WTC EHC Patients

Total Pediatric Patients: 94



Federal
Fiscal Year
Ended

Since 9/29/11 total new patients: 759 (733 adult and 26 pediatric patients)



THE LINGERING CLOUD

Who Are Our Patients?

What Are Their Challenges?

Who are our patients?

- Significant diversity

Why 11 years later?

- Stress-related issues persist 11 years after 9/11

What are their mental health problems?

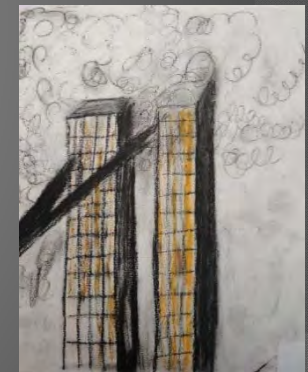
- Treatment modalities need to be individualized
- Presentations are complex: PTSD/Depression/Anxiety, Substance issues and Medical problems

What is the WTC EHC Mental Health Program?

- Medical and mental health program for “Survivor” members, i.e. local workers, residents, clean-up workers, students and passersby
- Treatment restricted to defined WTC-related or WTC-associated medical and mental health conditions
- Monitoring for PTSD, anxiety, depression performed at initial visit and subsequent monitoring visits using standardized tools
- Team of psychologists, psychiatrists and social workers
- Treatment for patients who score positive for 9/11 related issues on initial or subsequent mental health screening
- Individual, group, psychopharmacology, case management services
- Integrated medical/mental health management

Immediate and Direct Psychological Stressors

- Fleeing the dust cloud, injury, fear of death
- Witnessing death and destruction
- Loss of loved ones and colleagues



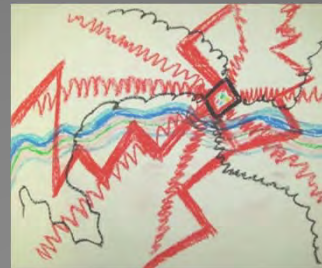
Ongoing Psychological Stressors

- Continuous exposure to toxins and images of disaster
- Loss of homes, jobs, income, social supports
- Development of a chronic and/or disabling medical illness



WTC-related and Associated Mental Health Issues

- PTSD
- Anxiety
- Depression
- Substance abuse
- Adjustment disorders to 9/11-related medical conditions
- Other common symptoms: insomnia, headaches, memory/attention problems, interpersonal difficulties, chronic pain



Interplay of Mental & Physical Health

- Respiratory symptoms cause psychological distress, exacerbating PTSD/anxiety symptoms
- Respiratory symptoms may function as reminders/triggers of the traumatic event
- (Mis)perception of asthma and panic/anxiety symptoms



Ongoing Challenges

- Continue to provide care for those with chronic or recurrent PTSD symptoms
- Develop diverse modalities that address evolving symptoms i.e. PTSD remitting, depression rising
- Analyze outcomes of WTC EHC mental health program (monitoring evaluations)

Implications for therapy

- Treatment modalities need to include understanding of co-morbid medical conditions
- Treatment modalities need to include an appreciation of continued stressors (loss of job, loss of home)
- Treatment may be complex and needs to be individualized
- Therapy may need to be long term in some patients
- Treatment modalities may change over time, i.e. individual and group psychotherapy, psychopharmacology, creative arts therapies

Why 11 Years Later?

- Broad themes
- Conflicting impulses
- Overwhelming experience of lost control

Who Are Our Patients?

- Heterogeneous mix of ages, ethnicities, levels of education

What Are Their Challenges?

- Patients in their 20s who were students at the time, managing their asthma...
- Patients in their 30s who were starting their careers downtown and now find lack of trust, fear, magical thinking, avoidance, anger and other symptoms...
- Patients in their 40s with young families who panic as their asthma worsens when trying to keep up with their children...
- Patients in their 50s who had lined up to help with the clean-up efforts and now are physically disabled with asthma and other issues...
- Patients in their 60s, indeed of all ages, who had sought care elsewhere until they lost their jobs and have been overwhelmed by their medical bills...

Art Therapy

- *Psychotherapeutic modality via creative expression*
- *By-passes the verbal censor, accesses 'inner life'*
- *Therapeutic as a means of externalization*
- *Art productions serve as catalyst for reflection and insight*
- *Art productions are revealing for caregivers*
- *Emphasizes art processes vs. art quality*
- *Art-making is a life-enhancing activity*
- *Group participation encourages socialization*





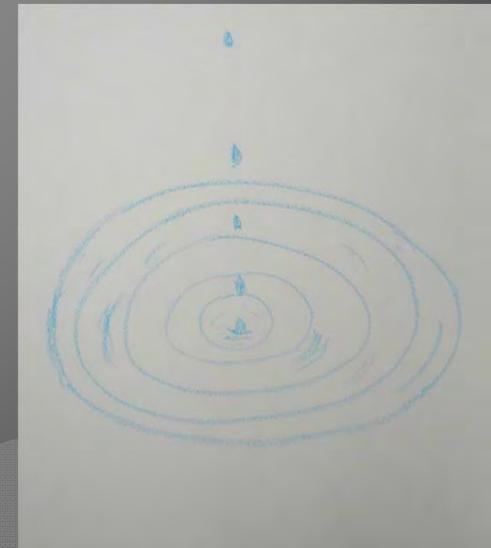
"...just as I was about to ask God for a miracle, I heard the rescuers' voices."



"The road to somewhere safe."
Sept. 2001



*"It's peaceful and calm...water for life...
that says it all."* Sept. 2011



Art Therapy Goals

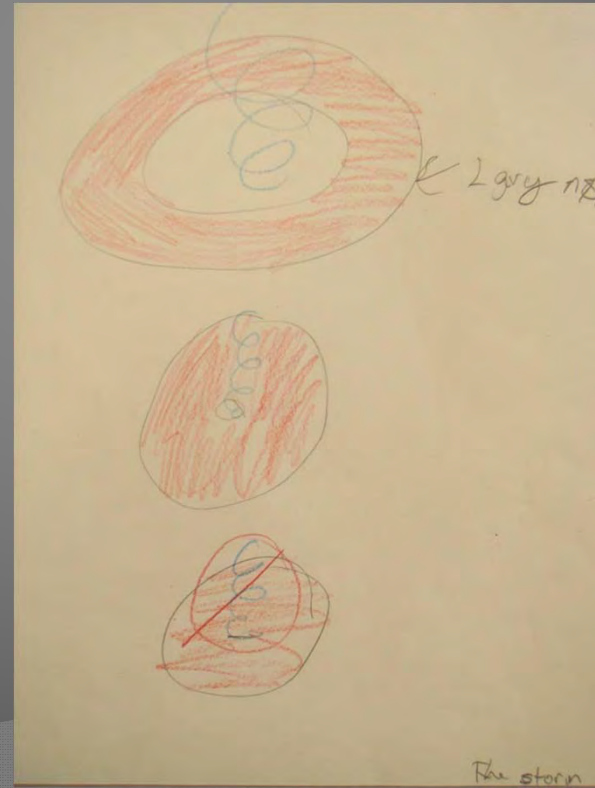
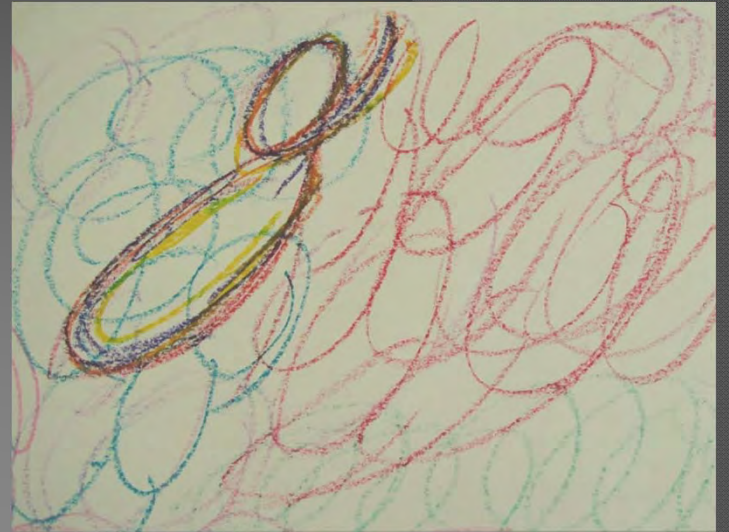
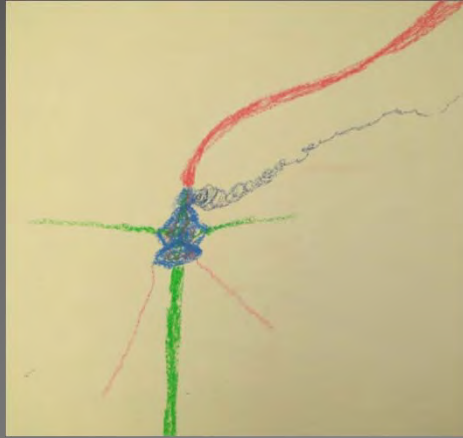
- *Stress reduction*
- *Anger management*
- *Pain management*
- *Understanding feelings*
- *Validation/Self-esteem/Self-care*
- *Means of expression and externalization*
- *Identification of issues*
- *Foster positive strategies*
- *Encourage coping and life-skills*
- *Encourage socialization/interaction*
- *Access traumatic memory within safe context*





“The tangible image allows one to reflect.”

Judith Herman





*"I found I could say things with color
and shapes I couldn't say any other way -
things I had no words for."*



“...traumatic experiences leave people feeling emotionally homeless.” Basel Van der Kolk



“The patient is not only a victim of pain, but of solitude.”
Elie Weisel



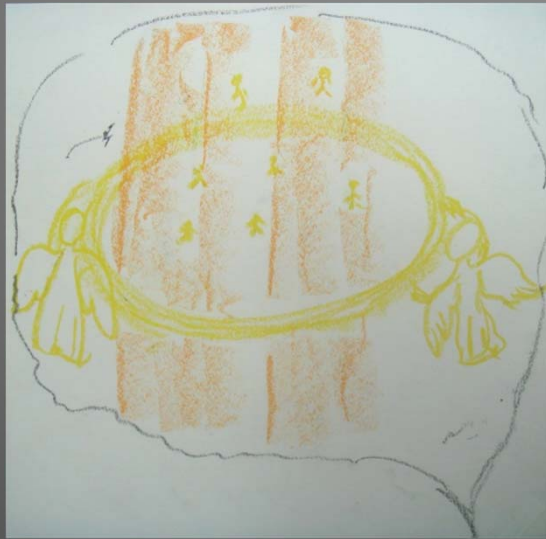
“Art is the place to run away - a place to escape.”

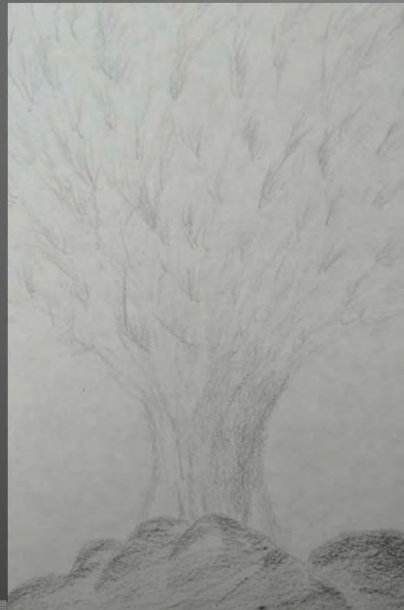
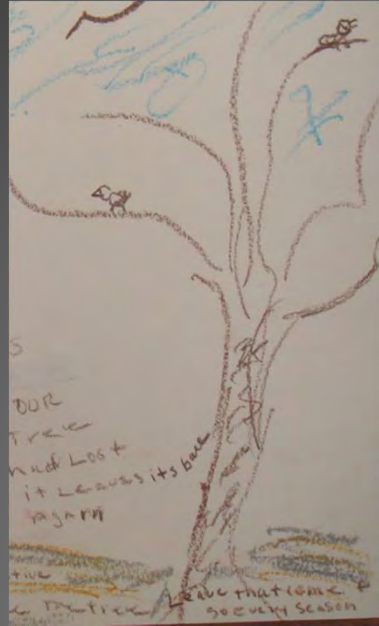


“Trauma cannot be undone, but its effects can be modified so life becomes livable.”

Robin Cruz, Editor *Arts in Psychotherapy*









"The art group is a repair shop."

Art Themes & Observations

Earlier elements of traumatic experience/impairment

- ☉References to memories of 9/11 (fire, smoke, dust, grey, cloud)
- ☉References to physical effects of 9/11 (pain, breathing, choking)
- ☉Emotional discharge with minimal insight
- ☉Less invested content, tendency toward abstract
- ☉Less processing, minimal participant interaction
- ☉Detached quality, weak affect

Increasing elements of well-being/life-enhancement

- ☉References to nature (trees, flowers, growth)
- ☉Emotions/images/symbolism/metaphor with insight
- ☉Range of color, fuller content, increased realism
- ☉Robust processing, considerable participant interaction
- ☉Engagement, greater affect/energy
- ☉Appreciation conveyed
- ☉Hopefulness



“The ultimate goal of all art is relief from suffering and the rising above it.”

Gustav Mahler

Outpatient Pharmacy 340B Enhancement

Background

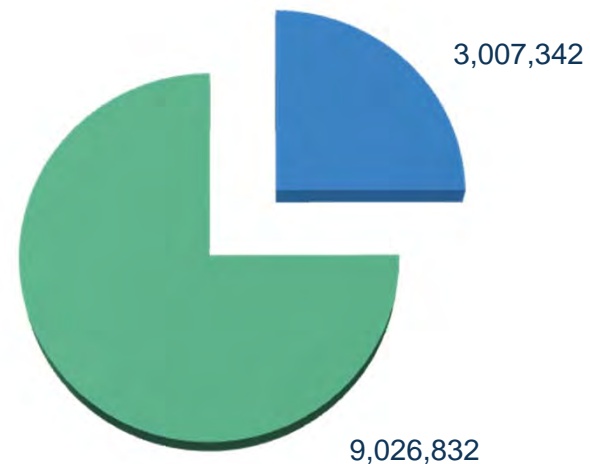
- ❖ **The 340B program was established to assist public safety net programs to create a new source of income to offset expenses for safety net patients.**
- ❖ **"Disproportionate Share Hospitals - DSH" (are eligible for the 340-B program (all HHC hospitals are eligible)**
- ❖ **On April 5, 2010 the 340B program was amended to allow covered entities to establish multiple contract pharmacy arrangements to dispense 340B discounted drugs to eligible patients of the covered entity (safety net providers, 340B eligible hospitals)**

340B Qualified HHC Facilities

**BELLEVUE HOSPITAL
CONEY ISLAND HOSPITAL
ELMHURST HOSPITAL
HARLEM HOSPITAL
JACOBI HOSPITAL
KINGS COUNTY HOSPITAL
LINCOLN HOSPITAL
METROPOLITAN HOSPITAL
NORTH CENTRAL BRONX HOSPITAL
QUEENS HOSPITAL
WOODHULL HOSPITAL**

HHC Outpatient Prescriptions (estimates)

- Prescriptions filled at HHC facilities
- Prescriptions filled at non-HHC facilities



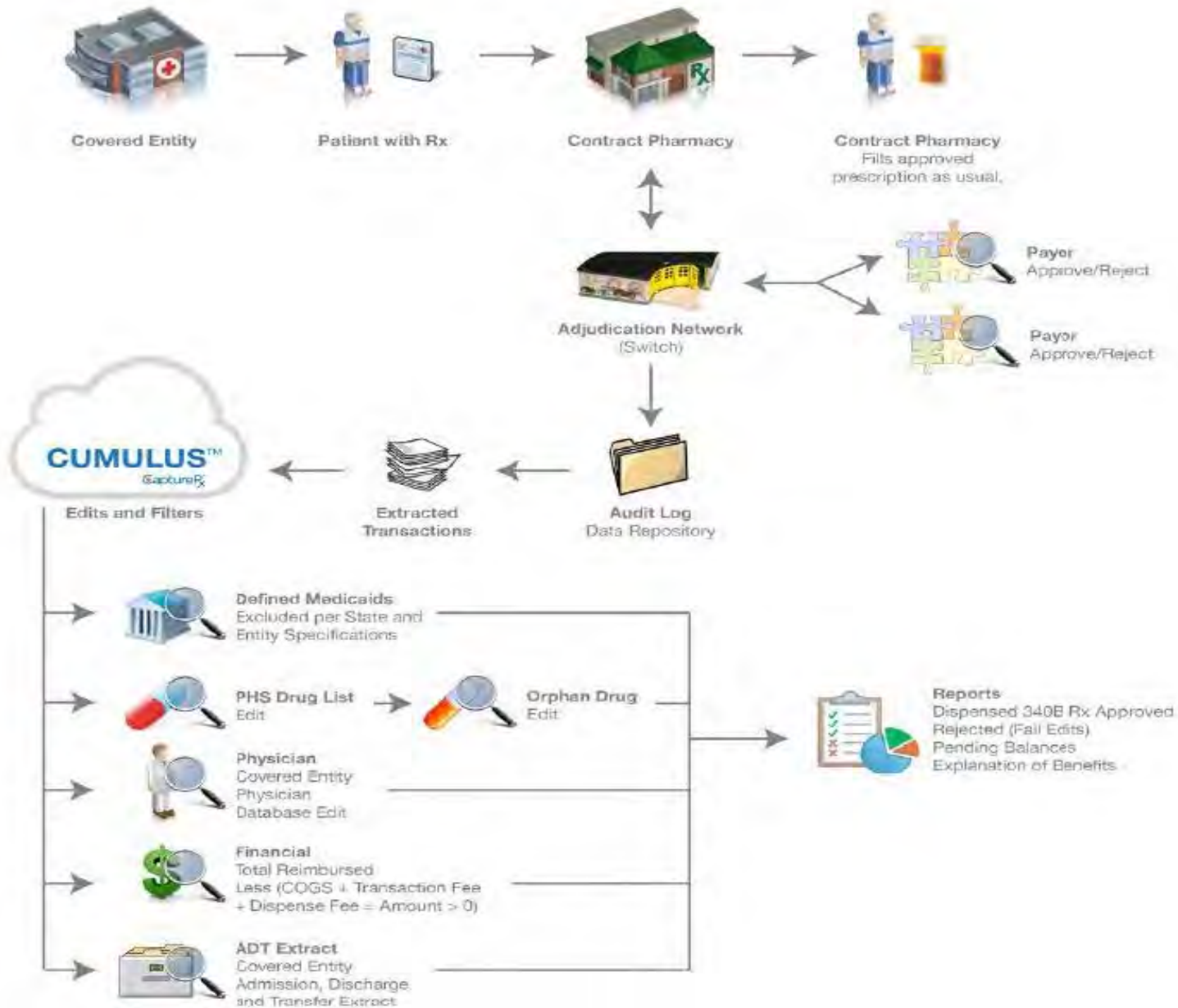
	Who Pays to Whom?		Nexium 40 mg (30 capsules)		Impact	
	Non-340B	340B	Non-340B	340B	Stakeholders	Revenue Change
Reimbursement Amount (same contract terms)	Third Party to Pharmacy	Third Party to Covered Entity	\$ 243.28	\$243.28 (+)	Patient	No change
Cost of Drug	Pharmacy to Supplier	Covered Entity to Supplier	\$ 218.07	\$ 0.29 (-)	Pharmacy	Slight Increase
Dispensing Fee	Third Party to Pharmacy	Covered Entity to Pharmacy	\$ 3.75	\$ 50.00 (-)	Third Party Plan	No change
Transaction Fee	-	Covered Entity to Vendor	-	\$ 1.00 (-)	Supplier/Manufacturer	Decrease
Co-Pay	Patient to Pharmacy	Patient To Pharmacy To Covered Entity	\$ 25.00	\$ 25.00 (+)	Covered Entity (HHC)	Significant Increase
NYCHHC Net INCOME			\$ 0.00	\$ 216.99		

Financial Projection

Estimated Number of Scripts to be Filled in Community:		9,026,832	
% Eligible Based on Payor:		18%	
Estimated Number of Eligible Scripts for 340B Program:		1,624,830	
	YEAR ONE	YEAR TWO	YEAR THREE
Market share expected:	10%	20%	30%
# of scripts:	162,483	324,966	487,449
Expected revenue per script (after dispensing fees).			
Average Net Revenue Per RX expected:	\$ 78.55	\$ 78.55	\$ 78.55
Administrative fee per proposal.			
Administrative Fee:	\$ 1.00	\$ 3.85	\$ 2.50
# of scripts that pass financial edit:	80,592	161,183	241,775
Net Revenue per script:	\$ 77.55	\$ 74.70	\$ 76.05
Net Total Revenue Expected:	\$ 6,249,875	\$ 12,040,378	\$ 18,386,963

INDIVIDUAL WITH THIRD PARTY INSURANCE

Edits and Filters



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