

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

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

**AGENDA**

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

**II. ADOPTION OF MAY 8, 2012  
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**

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

**IV. INFORMATION ITEM:**

**i. THE HEALTH CARE CASE: OUTCOME AND POTENTIAL IMPACTS**

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

**V. OLD BUSINESS**

**VI. NEW BUSINESS**

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

# **MINUTES**

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

**MAY 8, 2012**

The meeting of the Strategic Planning Committee of the Board of Directors was held on May 8, 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  
Robert F. Nolan  
Bernard Rosen  
Michael A. Stocker, M.D., Chairman of the Board  
Ian Hartman-O'Connell, representing Deputy Mayor Linda Gibbs in a voting capacity

#### **OTHER ATTENDEES**

M. Dolan, Senior Assistant Director, DC 37  
J. DeGeorge, Office of the State Comptroller  
A. Edwards, Healthcare Advocate, Commission on the Public's Health System  
C. Fiorentini, Analyst, New York City Independent Budget Office  
M. Meagher, Budget Analyst, Office of Management and Budget  
J. Wessler, Commission on the Public's Health System

#### **HHC STAFF**

M. Belizaire, Assistant Director of Community Affairs, Intergovernmental Relations  
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations  
D. Cates, Chief of Staff, Office of the Chairman  
A. Frisch, Executive Director, Health and Home Care  
D. Green, Senior Assistant Vice President, Corporate Planning Services  
L. Hansley, Director, Organizational Innovation and Effectiveness  
V. Henry, Senior Associate Director, Queens Health Network  
E. Hernandez, Director, Media Relations, Communications and Marketing

T. Hixson, Associate Executive Director, Metropolitan Hospital Center  
J. Jurenko, Senior Assistant Vice President, Intergovernmental Relations  
S. Lehrer, Associate Executive Director, Care Management and Telehealth Program  
Z. Liu, Senior Management Consultant, Corporate Planning Services  
P. Lockhart, Secretary to the Corporation, Office of the Chairman  
T. Mammo, Deputy Chief of Staff, President's Office  
A. Marengo, Senior Vice President, Communications and Marketing  
A. Martin, Executive Vice President and Chief Operating Officer, President's Office  
K. McGrath, Senior Director, Communications and Marketing  
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness  
K. Park, Associate Executive Director, Finance, Queens Health Network  
S. Penn, Deputy Director, WTC Environmental Health Center  
S. Russo, Senior Vice President and General Counsel, Legal Affairs  
R. Siegel, Senior Associate Director, Metropolitan Hospital Center  
R. Solomon, Network Associate Director, Generations+ Northern Manhattan Network  
S. Spalluto, Physician Assistant, Metropolitan Hospital Center  
F. Visco, M.D., Chief of Cardiology, Metropolitan Hospital Center  
J. Wale, Senior Assistant Vice President, Behavioral Health  
M. Weinberg, Executive Director, Metropolitan Hospital Center  
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

**CALL TO ORDER**

The meeting of the Strategic Planning Committee was called to order at 10:00 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, RN. The minutes of the April 3, 2012, meeting of the Strategic Planning Committee were adopted.

**SENIOR VICE PRESIDENT REMARKS****LaRay Brown**

Ms. Brown informed the Committee that her remarks would include a brief update on federal issues, New York State's recent promulgation of its final Medicaid Redesign Team (MRT) Report, and an update on the City's budget.

**FEDERAL UPDATE**

Ms. Brown reported that, at the federal level, the House of Representatives had adopted a Budget Resolution that would require the House Committees to report large cuts in domestic programs in order to avoid the automatic sequester cuts to the Defense Department's budget. She reminded the Committee that, as part of the Budget Control Act (BCA), there is a requirement of across the board cuts beginning in January 2013, which would apply to all programs with the exception of Medicaid. Ms. Brown noted that, the Republican leadership's Budget Resolution would, in fact, offset the automatic sequester cuts to Defense on the backs of other domestic programs, not just health care.

Ms. Brown reported that the Senate leadership had announced that the Senate would continue to abide by the BCA, and would not take up any additional or new cuts. She noted that, it is expected that a lame duck session would follow after the election, along with major efforts by both parties to push for reconciliation cuts. Ms. Brown added that the House Committees had reported their domestic program cuts; and the reconciliation bill containing these cuts is expected on the floor as early as the week of May 8, 2012.

Ms. Brown reported that the reconciliation bill included the extension of the Disproportionate Share Hospital (DSH) funding reductions to federal fiscal year (FFY) 2022. Ms. Brown explained that the Affordable Care Act (ACA) included annual aggregate DSH funding reductions that would begin in FFY 2014 through FFY 2020. She reminded the Committee that, as part of last year's Physician Medicare Payment fix, DSH funding reductions had already been extended to FFY 2021. Ms. Brown informed the Committee that this extension had also been included in the President's budget proposals for fiscal year 2013. She explained that, if DSH funding reductions were to be extended to 2022, this action would save the federal government \$4.2 billion over 10 years, but would also result in a DSH funding loss for HHC of \$421 million.

Ms. Brown stated that, based on what is now written into law, HHC had projected that it could lose \$2.3 billion. She reported that the reconciliation bill included a health provider tax reduction proposal. She explained that states are able to use revenues generated from health care provider taxes to help finance states' share of Medicaid expenditures. Under the current law, states are limited to a provider tax threshold of no more than 6 percent of net patient or service revenues. Until October 1, 2011, the provider tax threshold was 5.5 percent. The reconciliation bill would return the cap to 5.5 percent beginning in FFY 2013. Ms. Brown noted that the budget that President Obama had proposed would have created a more restrictive policy and would have phased down that tax from 5.5 to 3.5 percent. The Congressional Budget Office (CBO) reported that this proposal would save approximately \$11.2 billion over 10 years. Ms. Brown explained that New York State generates between 5.25 and 5.5 percent

from provider taxes. The President's proposal would result in a significant reduction in a funding opportunity for New York State. Alternatively, the reconciliation bill caps the level at 5.5 percent and would not produce an impact for New York State.

Ms. Brown reported that the reconciliation bill included a provision that would eliminate the Prevention and Public Health Trust Fund (PPHTF). She explained that the ACA created the PPHTF, to be controlled by the Secretary of Health and Human Services (HHS), to invest in public health and disease prevention. These funds support efforts to reduce health care associated infections, to reduce tobacco usage, to expand immunization programs and to strengthen the primary care infrastructure etc. The ACA created an advanced appropriation of \$15 billion over the next 10 years for that program, and a permanent \$2 billion annual appropriation in perpetuity. The reconciliation bill would repeal the PPHTF. Ms. Brown noted that some of the funding that had been designated for the PPHTF had been reprogrammed as an offset for the Physician Payment Fix earlier in the Congressional session. She stated that the CBO had estimated that this proposal would save approximately \$11.9 billion over ten years.

Ms. Brown informed the Committee that the reconciliation bill also included a provision that would repeal the ACA's state exchange grants. The ACA provided "such sums as necessary" for grants to states to facilitate the creation of health insurance exchanges. The House reconciliation bill would strike the direct appropriation, and rescind any unobligated funds for that purpose. The CBO estimates that this proposal would save another \$14.5 billion over 10 years.

Ms. Brown provided the Committee with an update concerning drug shortage legislation. She explained that, the Food and Drug Administration's (FDA's) drug monitoring inspections are funded by fees paid by pharmaceutical manufacturers. These fees are set to expire on October 1, 2012. The FDA would have to terminate staff positions unless these fees are extended. This puts a great deal of pressure on Congress to act. Ms. Brown explained that the vehicle to extend these fees would also be used to address issues concerning drug shortages for certain pharmaceuticals. Ms. Brown noted that drug shortages include sterile injectables used to treat cancer. Ms. Brown stated that, on April 25, 2012, the Senate Health Employment Labor and Pensions or HELP Committee, chaired by Senator Harkin of Iowa, had reported a bill titled, "The Food and Drug Safety and Innovation Act." The principle objective of this bill is to extend the fees that fund the FDA and safeguard efforts to address drug shortages.

## **STATE UPDATE**

Ms. Brown reported that, last week, the Cuomo Administration had released the final report of the Medicaid Redesign Team's (MRT's) work. It was released as a multi-year action plan. The report focuses on the triple aim of better care, better health and lower costs; and announces the state's intention to also seek a new Medicaid 1115 Waiver. The Report states that New York's long-term goal to improve care is to also ensure that every Medicaid member has access to fully integrated care management. Ms. Brown noted that, the Administration had estimated that it would take up to five years to fully integrate and manage the complete health, long term care, behavioral health and social needs of the Medicaid population.

Ms. Brown explained that the second aim of the Medicaid reform plan is to improve population health. According to the Report, instead of solely focusing on reducing costs, the Medicaid program should also focus on addressing preventable conditions and more broadly promote health initiatives, instead of acting solely as the largest insurer in the state. Moving forward, the Report declares that New York must lead the nation in payment reform, get out of the Medicaid fee-for-service business and ensure that care management partners shift away from volume-based payments in favor of other payment systems that reward quality of care and outcomes.

Ms. Brown reported that, it was also announced last week, that the state had reduced its spending by \$2.3 billion, which was the state's principal aim by establishing a Medicaid spending cap. The state concluded the fiscal year \$14 million under the cap. Ms. Brown explained that, by remaining under the cap, the need for across the board cuts or deeper cuts within different components of the health care sector would be eliminated. Ms. Brown announced that copies of the MRT Report and its 500 page supplemental document are available on the New York State Department of Health's website at [www.health.ny.gov](http://www.health.ny.gov).

Ms. Brown introduced her colleague, Joanna Omi, Senior Vice President, Organizational Innovation and Effectiveness. Ms. Brown informed the Committee that a Breakthrough presentation would be made by Metropolitan Hospital Center's Breakthrough staff. Ms. Brown introduced and acknowledged Mrs. Meryl Weinberg, Executive Director, Metropolitan Hospital Center. She stated that Metropolitan Hospital is a leading proponent and innovator in the deployment of Breakthrough techniques and resources to make operational changes at that hospital.

### **INFORMATION ITEM:**

#### **Rapid Improvement Event: Post Discharge Care Coordination at Metropolitan Hospital Center**

Susan Lehrer, Associate Executive Director, Care Management & Telehealth  
Richard Siegel, Senior Associate Director, Social Work

Ms. Omi informed the Committee that the Post Discharge Care Coordination Rapid Improvement Event (RIE) had occurred in July 2011. This event was special because it represents a collaboration that engaged MetroPlus Health Plan, Metropolitan Hospital Center and Health and Home Care. She stated that more recent Breakthrough activities are usually presented to the Committee. However, this event serves to demonstrate sustained improvement through Breakthrough. Ms. Omi stated that the results demonstrated that the changes that were made continued to bear fruit, and have resulted in improved care for patients at Metropolitan Hospital Center. Ms. Omi announced that Mr. Todd Hixson, Metropolitan Hospital's former Breakthrough Deployment Officer, had been promoted to an operational role, which included oversight of a very large service line, from the Emergency Department (ED) to inpatient care. She stated that it was important for Committee members to know that sustaining Breakthrough over time is a priority; and HHC's aim is to embed Breakthrough throughout the entire enterprise. Ms. Omi noted that other HHC staff had also moved into key operational roles from Breakthrough positions. Ms. Omi thanked Ms. Anne Frisch, Executive Director of HHC's Health and Home Care program. She stated that Health and Home Care had been very innovative in deploying Breakthrough throughout the Home Care program. Ms. Omi introduced both Mr. Richard Siegel, Senior Associate Director of Social Work, and Ms. Susan Lehrer, Associate Executive Director for Care Management at Health and Home Care, who would lead the presentation.

Mr. Siegel thanked the Committee and began his presentation by stating that the work that had been conducted reflected a collaboration that created a heart failure program that provides excellent, sustained care to patients through the continuum of care. This project has reduced the readmission rate for heart failure, which is one of the federal goals, and targeted a challenging group of patients. Mr. Siegel acknowledged Dr. Visco, the Process Owner and Chief of Cardiology at Metropolitan Hospital Center. He stated that Dr. Visco represented all that is good about Breakthrough. Dr. Visco manages and sustains the program on a daily basis using Breakthrough methodology and his skills as a cardiologist. Mr. Siegel noted that Dr. Visco would be available to answer questions from Committee members.

Ms. Bolus, Committee Chairman, asked what is meant by the term "fresh eyes." Mr. Siegel responded that "fresh eyes" referred to a Breakthrough team member who had not been actively involved in the process. He explained that it is important to include someone who had not been involved in the process to bring a new perspective to the team. Ms. Bolus asked if that individual would be a staff member or a patient. Mr. Siegel explained that a patient can serve in the role of "fresh eyes." Mr. Siegel stated that an HHC staff had served in the role of "fresh eyes" for the Post Discharge Coordination project at Metropolitan Hospital.

Mr. Siegel reported that the Reason for Action resulted from the fact that Metropolitan Hospital's 30-day readmission rate for heart failure had consistently remained at 30 percent. The hospital wanted to reduce that rate and improve patient care. He noted that, when a patient is readmitted within 30 days, this was not only a strike against the hospital, but it is also uncomfortable for that patient.

Mr. Siegel reported that the Target State focused on creating a series of flow cells that would lead to the provision of excellent care and all physicians following standard work. He explained that a key component of the Target State was the development of an education program where nurses, dieticians, and physicians worked with families and patients to improve their understanding of the medical condition, including triggers and ways to manage the condition within the community. Mr. Siegel described other critical components of the Target State which included good communication; a seamless process where patients are being followed in the community by Home Care; and the sustainment of patients within the community.

Mr. Siegel described the Gap Analysis that had been conducted. He stated that it is important to first understand the root cause of a problem in order to produce change. Mr. Siegel reported that the Gap Analysis identified the lack of:

- consistent education;
- a good process of managing the medical care;
- interdisciplinary collaboration in the hospital (no connection between substance abuse program and inpatient medical care); and
- a system to ensure that patients are discharged with their medications on weekends and after 5pm.

Mr. Siegel added that a key program goal was to create a care management program that reached out to patients shortly after discharge. Mr. Siegel informed the Committee that Ms. Lehrer would provide a description of the care management process in the community as part of her presentation. He added that care management was an essential component of the process, which had been very successful.

Mr. Siegel reported that the issue of substance abuse had to be addressed by the program because many patients from the East Harlem community also had a substance abuse problem in addition to their medical condition. The team worked to ensure that patients were connected with the care that they needed to address this issue as well.

Mr. Siegel reported that the Gap Analysis led to the creation of an education program for patients. He stated that the team worked to ensure that patients would be followed within a very short time frame in the clinic by cardiology. Mr. Siegel noted that Dr. Visco moved heaven and earth to ensure that every patient who was discharged from the hospital had a follow-up appointment in the clinic within seven days. Mr. Siegel reported that, in addition to the creation of an education program, a care management program was developed and standard work for all physicians was implemented.

Mr. Siegel informed the Committee that some experiments had been conducted, which were found to be effective in setting the stage for the program. He commented that, part of any good process is managing for daily improvement. He shared with the Committee some examples of the care management tools that are being used such as the team's processing flow boards; a sample of the daily e-mails from the care management team which provided a daily update on patients in problematic situations; and a sample of the Telehealth program's printout used to manage patient care in the community.

Mr. Siegel described the key components of the Completion Plan as including the following:

- Provide Alcoholic Anonymous (AA) representative with floor access (ID)
- Present heart failure program, including discharge criteria, to the Department of Medicine
- Track weekend discharges of heart failure patients without medication
- Home Care RN's access to documentation in Quadra-Med
- Create a Home Care algorithm
- Create a Home Care Form for calls
- Train Home Care staff
- Create and post data tracking charts

Mr. Siegel reported that the team had accomplished all of the goals of the Completion Plan with the exception of establishing a connection between Alcoholics Anonymous (AA) and patients. Dr. Michael Stocker, HHC's Board Chairman, asked if the difficulty was due to the lack of interest by the patients or lack of interest by AA. Mr. Siegel responded by stating that it was a little of both. He added that, it was requested that AA staff reach out to patients. Staff was informed by AA that the patient must make the call to AA. Mr. Siegel noted that, there had been some reluctance on the part of patients to initially admit their problem with substance abuse. Dr. Stocker asked if there is an AA group that meets at Metropolitan Hospital Center. Mr. Siegel stated that there is an AA group that meets at Metropolitan Hospital's Wellness Center. Notwithstanding, patients are reluctant to connect or join AA.

Mr. Siegel reported on the Confirmed State, 90 days following the rapid improvement event (RIE). He stated that, for all of the patients that had been involved in the program starting in July 2011, there had been no readmission within 30 days. He clarified that this result was not for all patients that came in for heart treatment, but for all the patients that had been enrolled in the program. That is, those patients who participated in education activities; those who returned for follow up care, and those who worked with Telehealth Care Management and the Health and Home Care program. Mr. Siegel reported that 66% of patients made the first follow-up appointment. He explained that Ms. Lehrer and her staff reached out to every patient and was able to reach a percentage of those patients. He reminded the Committee that, Metropolitan Hospital's patients are very transient and mobile. A mobile telephone that may work today doesn't work tomorrow. Additionally, a telephone number that is provided to the staff today may not be the best number to reach the patient. Mr. Siegel reported that the program is still struggling with achieving its goals relating to the substance abuse component of patients' medical condition.

Mr. Siegel concluded his presentation and turned the presentation over to Ms. Lehrer.

Ms. Lehrer began her presentation by stating that the information that she would be presenting related to the Confirmed State. That is, nine months after the RIE. Ms. Lehrer acknowledged Dr. Visco's leadership of the cardiology service at Metropolitan Hospital, characterized as relentless teamwork and problem solving. She stated that the program was a huge success, not only for the patients, but for staff who had begun to see the results of their hard work nine months post RIE. Ms. Lehrer informed the Committee that they had achieved success using Breakthrough methodology. She stated that the Breakthrough methodology enabled the team to develop and sustain a really good program that

significantly helped patients from admission through discharge, and also to decrease the readmission rate. She reported that standard work was being followed from inpatient through discharge and to the outpatient process. Referrals are made to HHC's Health and Home Care program during the time that a patient is hospitalized. Follow-up appointments are made during the patient's inpatient stay and are scheduled within seven days after discharge. Ms. Lehrer explained that, if the appointment is not made, Health and Home Care contacts cardiology to correct this issue. The entire team stays on top of the process. She added that patients are all started on essential medications before they are discharged from the hospital.

Ms. Lehrer reported that, for the patients who do not return for the follow-up visit within seven days, they are still on a baseline of medications. Telephone follow-up calls are made by Health and Home Care and the Telehealth Care Management program within 72 hours; these calls are usually made much quicker. Once patient contact is made by the care management team, the patient's medications are verified as soon as possible. Ms. Lehrer noted that care management staff has access to Quadra Med, which enables the staff to view the medications that a patient had been placed on at the time of discharge. This is done to verify that the medications are the same and to correct any discrepancies. Ms. Lehrer noted that, this process was reviewed by the entire team on a weekly basis, every Thursday at 2pm, at Metropolitan Hospital. This review is conducted under the direction of Dr. Visco.

Ms. Bolus asked if all patients' homes were equipped with scales to allow them to track their weight. Ms. Lehrer responded that scales are provided to patients before they are discharged from the hospital. She added that MetroPlus Health Plan had also offered to supply scales to their members.

Ms. Lehrer continued to describe the Confirmed State. She reported that a total of 153 patients were being tracked in Metropolitan Hospital's heart failure program database. Of that total, 122 patients was hospitalized at Metropolitan Hospital. The remaining 31 patients were referred from Metropolitan Hospital's clinic. Ms. Lehrer reported that the patients that had been included in the database represented a total of 174 admissions with a diagnosis of heart failure. Of the 174 admissions, a total of 34 were readmitted in less than 30 days. This result reflects a 20 percent readmission rate, compared to a 30 percent readmission rate of nine months earlier. Ms. Lehrer explained that this is a significant result for Metropolitan Hospital's heart failure program because many patients were difficult to reach and some were further challenged by substance abuse.

Ms. Lehrer reported that there were 91 patients that were being followed by the program. Of the 24 patients who returned to the clinic for a follow-up visit within seven days following discharge, only 8 percent had a readmission within 30 days. Ms. Lehrer noted that this result is significant because this statistic is the most telling with regard to a patient's ability to self-manage.

Ms. Lehrer explained that the real story was that the process that began in July 2011 had been refined and improved. The leadership that led the project in July 2011 has remained strong and focused. The team that started in July 2011 has remained together, and has worked through difficult issues by meeting every week and slogging through it. The patients who are enrolled in the program have had fewer re-hospitalizations and have received safer care.

Ms. Lehrer stated that the Breakthrough process had enabled Metropolitan Hospital, Health and Home Care, the Telehealth Care Management and MetroPlus Health Plan to work together across the care continuum. She added that this work is a model of accountable patient-centered care that the Corporation is now seeking. She noted that the team worked together using best practice instead of available practice. She added that the team had the added benefit of a mentoring type of leadership and support from both the clinical and administrative offices at Metropolitan Hospital and Health and Home

Care. She stated that it was her hope that this project would serve as a best practice model at other HHC facilities.

Ms. Bolus commented on the amount of that had been conducted by the team. Ms. Lehrer responded that, it is now standard work. It was a lot of work going through it, but once the work is standardized it is like hybrid health care. That is, when you need to use the gas, it is there and available. She added that the care management nurses were able to provide care to patients without delay or having to make six calls to reach a person. The team has direct lines of communication, and it is frequent.

Ms. Bolus asked if the two readmissions were unavoidable. Ms. Lehrer responded that, a lot of the patients were hard to reach. However, the data includes all patients whether they were in the program or not. Specifically, the data reflects those patients who couldn't be reached, those who could not be included in the program and those who did not return for the seven day follow-up visit following discharge.

President Aviles asked for clarification on the total universe of patients who had met the criteria of the target population and the number of patients who were included in the database. Ms. Lehrer explained that Metropolitan Hospital maintained a database of patients with heart failure. Anyone who is hospitalized at Metropolitan Hospital with heart failure is included in that database. The database includes a subset of patients who are in the heart failure program, because they are being care for by the health failure program at Metropolitan Hospital. Ms. Lehrer explained that, if the patient is being followed by a non Metropolitan Hospital provider, that patient would not be placed into the heart failure program. President Aviles asked if the 20 percent readmission rate related to all patients that had been included in the database. Mr. Hixson clarified that the data was aligned with the corporate metric relating to heart failure. So, all heart failure hospitalizations are tracked in the database and 20 percent is the readmission rate.

Ms. Lehrer commented that, the team would be looking specifically at the universe of patients who are in the program and getting care management, and would determine the hospitalization rate. She noted that the improvement in care had been spread across all patients with heart failure, even if the patient was being cared for by an external provider. She explained that all patients benefited from staff who followed them closely and who coordinated their care. Patients were provided scales and benefited from the education efforts. President Aviles asked how many patients were under care by the heart failure clinic. Ms. Lehrer responded that a total of 91 patients were being cared for by the clinic.

Dr. Stocker asked if the program is replicable and can it thrive in lots of different places, and over a longer period of time. Mr. Siegel responded affirmatively. He added that, in a program like this, a physician champion would be required. Dr. Visco's reason for coming to work every day is to create a center of excellence; and having a physician who is willing to manage the program on a daily basis is a start. He added that using Health and Home Care as a locus of some of the care coordination is a model that is very doable. Mr. Siegel commented that, initially, staff purchased the scales at Target and were reimbursed. He added that a system is now in place and the scales are now secured through the Corporation. Dr. Stocker asked if scales were given to patients. Mr. Siegel responded that, if a patient doesn't have a scale, a scale is provided to that patient. Patients are first asked if they have a scale before one is provided. It is not an entitlement. Dr. Stocker asked if there is a way to digitally transmit the information to staff when the patient weighs him/herself. Ms. Lehrer responded that this is being done for patients who need a digital scale and for those patients who are not able to share their weight every day. She explained that the digital scale used by the Telehealth program is being used at all HHC facilities.

Dr. Stocker asked if it would be easier to reach patients using text messaging rather than repeated telephone outreach calls. Dr. Stocker noted that there had been a lot written about adolescents using

text messaging technology rather than telephones. He asked if the percentage of patients with smart phones in this population was known. Ms. Lehrer responded that roughly 30 to 40 percent of patients have phones but do not use it for their health care. She stated that patients are routinely asked if they would prefer to be reached via their smart phone. Ms. Lehrer commented that the average age of Metropolitan Hospital's heart failure patients is under the age of 65. Dr. Visco added that the age of patients ranged from 16 to 99. Ms. Lehrer commented that, a few weeks ago, a 23 year old patient presented to Metropolitan Hospital with heart failure.

## **ADJOURNMENT**

There being no further business, the meeting was adjourned at 10:52 a.m.

## **Dominic F. Perella**

Associate, Hogan Lovells, Washington, D.C.

[dominic.perella@hoganlovells.com](mailto:dominic.perella@hoganlovells.com)

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 Communications Commission.

Before joining Hogan Lovells, Mr. Perella served as a judicial clerk to The Honorable Sandra L. Lynch, Chief Judge of the U.S. Court of Appeals for the First Circuit. Mr. Perella graduated *summa cum laude* from the New York University School of Law, where he was named a Butler Scholar and received the Law Review Association Award for second-highest GPA in the graduating class of 2005.

### REPRESENTATIVE EXPERIENCE

- Successfully argued an appeal in the U.S. Court of Appeals for the District of Columbia Circuit regarding the Establishment Clause's application to the presidential inauguration.
- Successfully argued a pair of contract-law cases before the D.C. Court of Appeals.
- Successfully briefed a high-profile white-collar appeal before the U.S. Court of Appeals for the Second Circuit. Client's conviction was reversed.
- Briefed a merits Supreme Court case for a major client.
- Led the briefing for a consortium of hospital association amici in a series of appeals relating to the Patient Protection and Affordable Care Act.
- On behalf of a major client, filed a successful brief opposing certiorari in a case involving the scope of the Religious Freedom Restoration Act.
- Filed merits-stage amicus briefs before the Supreme Court on behalf of clients in several prominent cases, including one regarding the constitutionality of the Voting Rights Act and another regarding the Clean Water Act's application to mining techniques.
- Successfully briefed three consolidated appeals on statutory-interpretation issues on behalf of a cable industry client before the California Court of Appeal.

# The Health Care Case: Outcome and Potential Impacts

Dominic F. Perella

July 10, 2012



# Overview

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- Supreme Court's ACA decision is more complex than it appears at first glance. In a lot of ways, this is a decision friendly to conservatives and hostile to federal power.
- All sorts of potential ramifications for the Medicaid program and for the distribution of DSH funding.
- I'll walk through the decision and then turn to potential implications going forward.

# The ACA

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- Designed to solve crisis of uninsurance. Some 50 million uninsured Americans – more than five times the population of NYC.
- Two big ways coverage was to be expanded to 30+ million more Americans:
  - (1) individual mandate
  - (2) expanding Medicaid to new groups, including people up to 133 percent of the poverty level.

# The Supreme Court's Decision

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- As you know by now, the Court issued a long and complex decision that upheld most of the ACA.
- Chief Justice Roberts' opinion has been called the “majority” opinion. But in fact, parts of it were joined by no other Justices; parts were joined by the Court's liberals; parts were joined by the conservatives.
- We'll briefly unpack it and nail down what it means.

# The Decision – Commerce Clause

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- The challengers' main argument in the ACA case was that Congress could not enact the individual mandate using its authority under the "Commerce Clause."
- They argued that the Clause only authorizes Congress to regulate commerce, and here Congress was not doing so. Instead, it was *creating* commerce by forcing "inactive" people – those without insurance – to enter the market.

# The Decision – Commerce Clause (cont.)

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- There are good responses to that argument, and it was rejected by conservative judges in the lower courts.
- But five Supreme Court Justices (the five conservatives) accepted it. They said Congress could not enact the individual mandate using its commerce power.
- Roberts: “The individual mandate does not regulate existing commercial activity. It instead compels individuals to become active in commerce by purchasing a product. . . . 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.”

# The Decision – The Tax Power

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- On first glance, some news organizations read the Commerce Clause part of the decision and thought the mandate had been struck down. Not so.
- Roberts, now joined by the four Democratic appointees, accepted the federal government's alternative argument: The individual mandate is permissible under Congress's power to tax.

## The Decision – The Tax Power (cont.)

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- Roberts says the mandate can be upheld as a tax because (1) it looks a lot like a tax and (2) courts are required to give statutes benefit of the doubt to find them constitutional.
- Roberts: “The question is not whether that is the most natural interpretation of the mandate, but only whether it is a ‘fairly possible’ one. As we have explained, ‘every reasonable construction must be resorted to, in order to save a statute from unconstitutionality.’ The Government asks us to interpret the mandate as imposing a tax, if it would otherwise violate the Constitution. Granting the Act the full measure of deference owed to federal statutes, it can be so read.”

# The Decision – Divisions on the Court

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- Democratic appointees very unhappy with Roberts for even discussing the Commerce Clause – and for good reason. No reason to get into it, given the tax analysis.
- Conservatives very unhappy with Roberts for the tax holding. They otherwise had the votes to strike down the whole law.
- Did Roberts flip?

# The Decision– Severability

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- You may have heard prior to the decision about the concept of “severability” – i.e., what parts of the ACA the Court should leave in place if it struck down the mandate.
- Once the mandate was upheld, the severability issue disappeared. In other words: The law’s hundreds of other provisions remain in place and unchanged.

# The Decision – Medicaid

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- The one exception: Medicaid.
- The Medicaid argument was really about an obscure concept in constitutional law called the “coercion doctrine.”
- The doctrine goes like this: Congress can offer money to states with conditions (“you can have this \$100 million if you do X”). But it can’t directly command states to enact programs (“you must do X”).
- Court had suggested that if states ever have *no choice* whether to accept “voluntary” funds – i.e., if the offer amounts to “coercion” – then it’s an unlawful command, not a conditional funding grant.

## The Decision – Medicaid (cont.)

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- This is the first case in which the Supreme Court has ever actually found unlawful “coercion” to exist. 7-2 vote.
- Roberts: “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 Affordable Care Act’s expansion in health care coverage stands to lose not merely ‘a relatively small percentage’ of its existing Medicaid funding, but *all* of it.”

## The Decision – Medicaid (cont.)

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- But Roberts, joined by the four Democratic appointees, held that the Medicaid expansion need not be struck down.
- Instead, Medicaid expansion had to be made truly optional. States could not be punished with withdrawal of all Medicaid funds if they decline to expand their Medicaid offerings.
- Roberts: “Nothing in our opinion precludes Congress from offering funds . . . to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding.”

# The Decision – Takeaways & Implications

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- The biggest takeaway: The ACA is upheld, with some limits on Medicaid.
- All programs (except potentially Medicaid) remain in place and unchanged.
- States will push ahead with implementation. Agencies will push ahead with rulemakings.

# The Decision – Takeaways & Implications (cont.)

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- The big exception is Medicaid.
- The Court's decision appears to mean that states can decline to expand Medicaid to new populations.
- One big question: Which states will take the Court up on that offer? (Most likely, states that were plaintiffs.)
- Another big question: What can CMS do about it if states announce plans to refuse expansion?

# The Decision – Takeaways & Implications (cont.)

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- Question #3: What about DSH funds?
- The Medicaid DSH provision sets annual cuts and tells CMS to make two categories of states bear the brunt.
- One of those categories is states with “the lowest percentages of uninsured individuals.”
- Does this mean states that expand Medicaid – and thus have lower rates of uninsured – end up getting punished with less DSH funds than states that refuse to expand?
- Maybe not. Secretary has some discretion and may well find a way to address this situation. See statutory language of 42 U.S.C. § 1396r-4(f)(7)(B)(i).

# The Decision – Takeaways & Implications (cont.)

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- The last big question: What about politics?
- Highly unlikely that any change in law could occur between now and November.
- Instead, pre-election, CMS is likely to issue guidance to encourage establishment of health exchanges, expansion of Medicaid, etc. Full speed ahead to get as far as possible in case Obama loses.
- Some Republican Governors may refuse to implement ACA's Medicaid expansion, exchanges and even more.
- As far as a future repeal: Who can tell? But it almost certainly won't happen as long as Obama holds office.

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