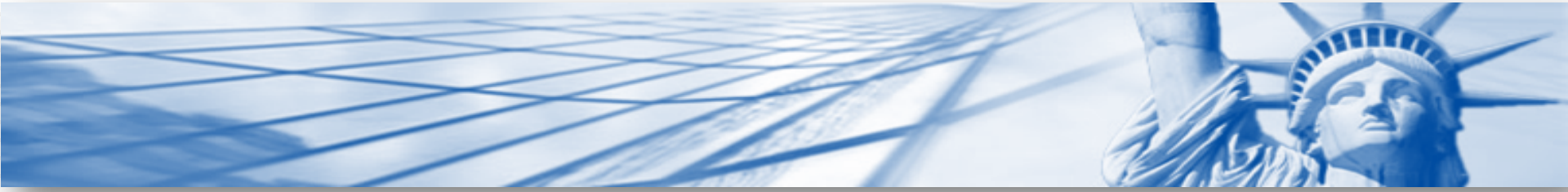


MEDICAID REDESIGN TEAM: HEALTH SYSTEMS REDESIGN

Brooklyn Work Group

September 21, 2011

Profitability

Greater New York Hospital Association

Karen S. Heller, Executive Vice President

2010 Financial Condition

The rule of thumb is that a 3% margin is needed for adequate capital formation.

$ in Millions	Total Operating Expenses	Total Operating Revenue	Total Margin
NY State	$45,432	$46,837	2.2%
NY City	$23,273	$23,959	2.1%
Kings County	$5,127	$5,071	1.1%
Beth Israel	$1,162	$1,226	5.3%
Brookdale	$520	$462	-12.7%
Brooklyn	$322	$352	1.7%
Community	$84	$85	1.1%
Interfaith	$254	$187	-30.7%
Kingsbrook	$252	$254	1.0%
LICH	$328	$316	-3.8%
Lutheran	$474	$479	1.1%
Maimonides	$941	$893	5.2%
Methodist	$512	$540	5.4%
Wyckoff	$278	$276	-0.7%

Source: New York State Institutional Cost Reports.
Note: 1. Margins for hospital groups are medians. 2. Beth Israel includes the Manhattan and Brooklyn campuses. 3. Interfaith has cut expenses to raise its margin to -18% so far in 2011.

Pending State Revenue Changes

- Losses
  - State budget cuts for SFY 2011-12
- Potential gains
  - Med mal relief from State's Medical Indemnity Fund
  - Extension of Medicaid managed care waiver
    - Hospital Medical Home Demonstration
      - Up to $325 million over 3 years
    - Potentially Preventable Readmissions Demonstration
      - Up to $20 million over 3 years
  - Potential new Medicaid waiver to reinvest Federal savings achieved through Medicaid redesign

Pending Federal Revenue Changes

- Affordable Care Act
  - Medicare inflation offsets, quality-related cuts
  - Medicare and Medicaid DSH cuts offset by new revenue
- Medicare inpatient cut, 3.9%, to offset case-mix growth
  - Administrative action
- Budget Control Act
  - Joint Select Committee to determine cuts by Nov. 23
    - White House proposed Medicare and Medicaid cuts on Sept. 19
  - Default is sequestration of 2% of all Medicare payments

Note: Medicare cuts apply to fee-for-service payments and flow through to Medicare Advantage (managed care) payments.

GNYHA Estimated Losses

Includes:

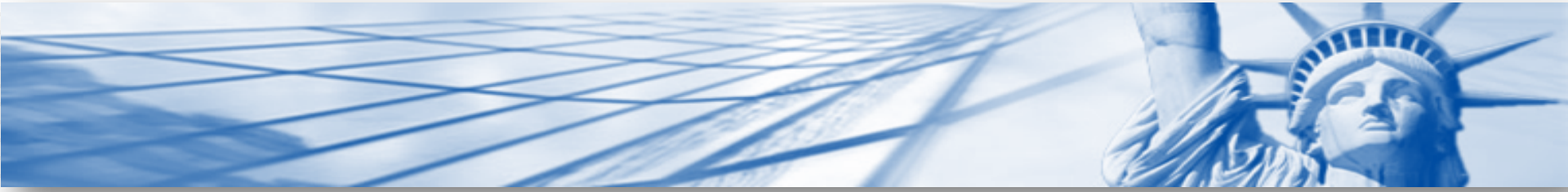
- SFY 2011-12 budget cuts
- ACA inflation update and quality-related cuts
- Medicare 3.9% inpatient cut to offset case-mix growth
- BCA 2% sequestration

$ in Millions	2011	2012	2013
NY State	($254)	($659)	($1,435)
NY City	($146)	($343)	($723)
Kings	($40)	($93)	($193)
Beth Israel	($8)	($19)	($40)
Brookdale	($4)	($8)	($15)
Brooklyn	($3)	($6)	($13)
Community	($1)	($3)	($7)
Interfaith	($2)	($4)	($7)
Kingsbrook	($2)	($5)	($11)
LICH	($2)	($6)	($12)
Lutheran	($3)	($8)	($16)
Maimonides	($8)	($19)	($39)
Methodist	($4)	($10)	($22)
Wyckoff	($3)	($6)	($12)

Note: Revenue changes are relative to 2010.

Dormitory Authority
State of New York

***Alfonso L. Carney, Jr.**, Chair*
***Paul T. Williams, Jr.**, President*



MRT HEALTH SYSTEMS REDESIGN BROOKLYN WORK GROUP

FINANCIAL OVERVIEW OF BROOKLYN HOSPITALS

September 21, 2011

Hospital Balance Sheet

Assets

Current Assets

- Cash
- Patient Accounts Receivable
- Inventory
- Other Current Assets
  - Total Current Assets

Assets Limited as to Use

Property, Plant & Equipment

Other Non-Current Assets

- Total Assets

Liabilities

Current Liabilities

- Accounts / Salaries Payable
- Current Portion of LT Debt
- Other Current Liabilities
  - Total Current Liabilities

Long Term Debt

Other Non-Current Liabilities

- Total Liabilities

Net Assets

- Total Liabilities & Net Assets

Hospital Balance Sheet

Assets

Current Assets

- Cash
- Patient Accounts Receivable
- Inventory

Liabilities

Hospital Balance Sheet

Assets

Current Assets

- Cash
- Patient Accounts Receivable
- Inventory
- Other Current Assets
  - Total Current Assets

Assets Limited as to Use

Property, Plant & Equipment

Liabilities

Measure: Property, Plant & Equipment

- Average Age of Plant
  - Definition: $\frac{\text{Accumulated Depreciation}}{\text{Current Year Depreciation}}$
  - Purpose: Measure of average age in years of fixed assets. Higher ages generally indicate the need for future capital spending.

Measure: Property, Plant & Equipment

- Capital Spending Ratio

  - Definition: $\frac{\text{Capital Spending}}{\text{Current Year Depreciation}}$

  - Purpose: Measure of reinvestment in physical plant. Ratios below 100 percent indicate that a hospital is disinvesting – spending less in new capital than the depreciation of old capital.

Hospital Balance Sheet

Assets

Current Assets

- Cash
- Patient Accounts Receivable
- Inventory
- Other Current Assets
  - Total Current Assets

Assets Limited as to Use

Property, Plant & Equipment

Other Non-Current Assets

- Total Assets

Liabilities

Current Liabilities

- Accounts / Salaries Payable

Hospital Balance Sheet

Assets

Current Assets

- Cash
- Patient Accounts Rec'bl
- Inventory
- Other Current Assets

Total Current Assets

Liabilities

Current Liabilities

- Accounts / Salaries Payable
- Current Portion of LT Debt
- Other Current Liabilities

Total Current Liabilities

Measure: Current Assets to Current Liabilities

- Current Ratio
  - Definition: $\frac{\text{Current Assets}}{\text{Current Liabilities}}$
  - Purpose: A measure of liquidity. If Current Ratio exceeds 1.0, then all current liabilities could (theoretically) be retired using only current assets.

Hospital Balance Sheet

Assets

Liabilities

Current Liabilities

Accounts / Salaries Payable

Current Portion of LT Debt

Other Current Liabilities

Total Current Liabilities

Long Term Debt

Long Term Debt

- Bond / Mortgage Debt
  (including Dormitory Authority)
- Bank Loans
- Capital Leases / Equipment Financing
- Other

DASNY Bonds for Brooklyn Hospitals
TOTALS Nearly $700 million

- Secured Hospital Bonds — $265 million for 3 hospitals
  - Brookdale Hospital Medical Center
  - Interfaith Medical Center
  - Wyckoff Heights Medical Center
- FHA-Insured Mortgage Bonds — $385 million for 5 hospitals
  - Brooklyn Hospital Center
  - Kingsbrook Jewish Medical Center
  - Long Island College Hospital
  - Lutheran Medical Center
  - Maimonides Medical Center
- "Unenhanced" Bonds — $45 million for 1 hospital
  - The New York Methodist Hospital
- Non DASNY Debt
  - Beth Israel Medical Center (Commercial facilities)
  - New York Community Hospital (NYC IDA)

Secured Hospital Bonds

- Borrowed Capital Reserve Fund
  - One year's debt service
- Special Debt Service Reserve Fund
  - One-half year's debt service
  - Originally funded by New York State
- State Service Contract
  - State agrees to request annual appropriation for annual debt service on bonds
  - Subject to the appropriation, State agrees to pay annual debt service on the bonds if no other funds available

FHA-Insured Mortgage Bonds

- Mortgage note insured by FHA
  - Note and mortgage assigned to FHA upon claim
- Borrowed Debt Service Reserve Fund
  - Intended to cover debt service while FHA claim is being processed
- FHA Regulatory Agreement
  - FHA involved in all aspects of debt administration

Unenhanced Bonds

- Borrowed Debt Service Reserve Fund

- No financial institution backing the hospital's obligation to pay

Measure: Long Term Debt

- Long Term Debt to Bed

  - Definition: $\frac{\text{Total Long Term Debt}}{\text{Licensed Beds}}$

  - Purpose: A measure of relative leverage

Hospital Balance Sheet

- Assets

Liabilities

Current Liabilities

Accounts / Salaries Payable

Current Portion of LT Debt

Other Current Liabilities

Total Current Liabilities

Long Term Debt

Other Non-Current Liabilities

Other Non-Current Liabilities

- Post-Retirement Benefit Obligations
  - Pension
  - Health Insurance
- Medical Malpractice Liabilities

Hospital Balance Sheet

Assets

Current Assets

- Cash
- Patient Accounts Receivable
- Inventory
- Other Current Assets
  - Total Current Assets

Assets Limited as to Use

Property, Plant & Equipment

Other Non-Current Assets

- Total Assets

Liabilities

Current Liabilities

- Accounts / Salaries Payable
- Current Portion of LT Debt
- Other Current Liabilities
  - Total Current Liabilities

Long Term Debt

Other Non-Current Liabilities

- Total Liabilities

Net Assets

Balance Sheet Analysis
Comparison Groups

BROOKLYN HOSPITALS

SUMMARY OF LONG-TERM DEBT (LTD) OUTSTANDING

SECURED HOSPITALS	DASNY BONDS[1] ($ millions)	NON-DASNY DEBT [2] ($ millions)
Brookdale	59.3	10.2
Interfaith	118.9	
Wyckoff	87.1	
SUBTOTAL SECURED HOSPITAL BONDS	265.3	10.2
FHA-INSURED HOSPITALS		
Brooklyn Hospital	43.2	45.0
Kingsbrook Jewish	11.3	
Long Island College	152.7	
Lutheran	60.8	
Maimonides	116.8	27.4
SUBTOTAL FHA-INSURED BONDS	384.8	72.4
UNENHANCED		
NY Methodist	44.9	
PRIVATE /OTHER		
Beth Israel Medical Center (GE)		215.4
NY Community Hospital (IDA Bonds)		0.9
SUBTOTAL PRIVATE/OTHER		216.3
GRAND TOTAL	**695.1**	**298.9**

[1] Source: DASNY Bonds outstanding, June 30, 2011

[2] Source: Audited Financial Statements;. Table shows only Bond/Mortgage LTD (excludes capital leases, notes and other loans) and will not tie out to the LTD/Bed calculation which includes the current and LT portion of all debt on the Audited balance sheet.

OTHER GROUPS

- New York City Hospitals
  - ✓ Source: 2009 Audits ; medians calculated by DASNY
  - ✓ Sample: 31 Hospitals / Hospital Systems in the 5 boroughs
    - ✓ Excludes major publics, State and specialty hospitals
- New York State Hospitals
  - ✓ Source: 2009 Audits ; medians calculated by DASNY
  - ✓ Sample: 148 Hospitals /Hospital Systems
    - ✓ Excludes major publics, State and specialty hospitals
- Moody's Rated Hospitals
  - ✓ Source: Moody's: "Special Comment: U.S. Not-for-Profit Hospital Medians show Resiliency against Industry Headwinds but Challenges still Support Negative Outlook", August 30, 2011
  - ✓ Sample: 401 not-for-profit freestanding hospitals and single-state healthcare systems with an institutional rating by Moody's, across all rating categories
    - ✓ Excludes children's hospitals and certain specialty hospitals, hospitals with unique circumstances and those for which 5 years of data is not available.

Hospital Balance Sheet Metrics Comparison of Medians

	AGE OF PLANT (Years)	CAPITAL SPENDING[5] (%)	CURRENT RATIO (X)	LONG-TERM DEBT/BED ($ 000s)	NET ASSETS ($ million's)
Brooklyn [1]	17	82	1.09	210	27
NYC [2]	15	88	1.35	238	43
NYS [3]	13	99	1.48	141	24
Moody's [4]	10	140	1.90	n/a	273

Sources: Hospital Audited financial statements and DASNY supplemental survey

1 Includes 11 Article 28 hospitals in Brooklyn; excludes the public HHC hospitals and State hospital. 2010 Audit data unless otherwise noted. Audit data for Beth Israel Medical Center is from the consolidated audit which includes the Kings Highway division in Brooklyn.

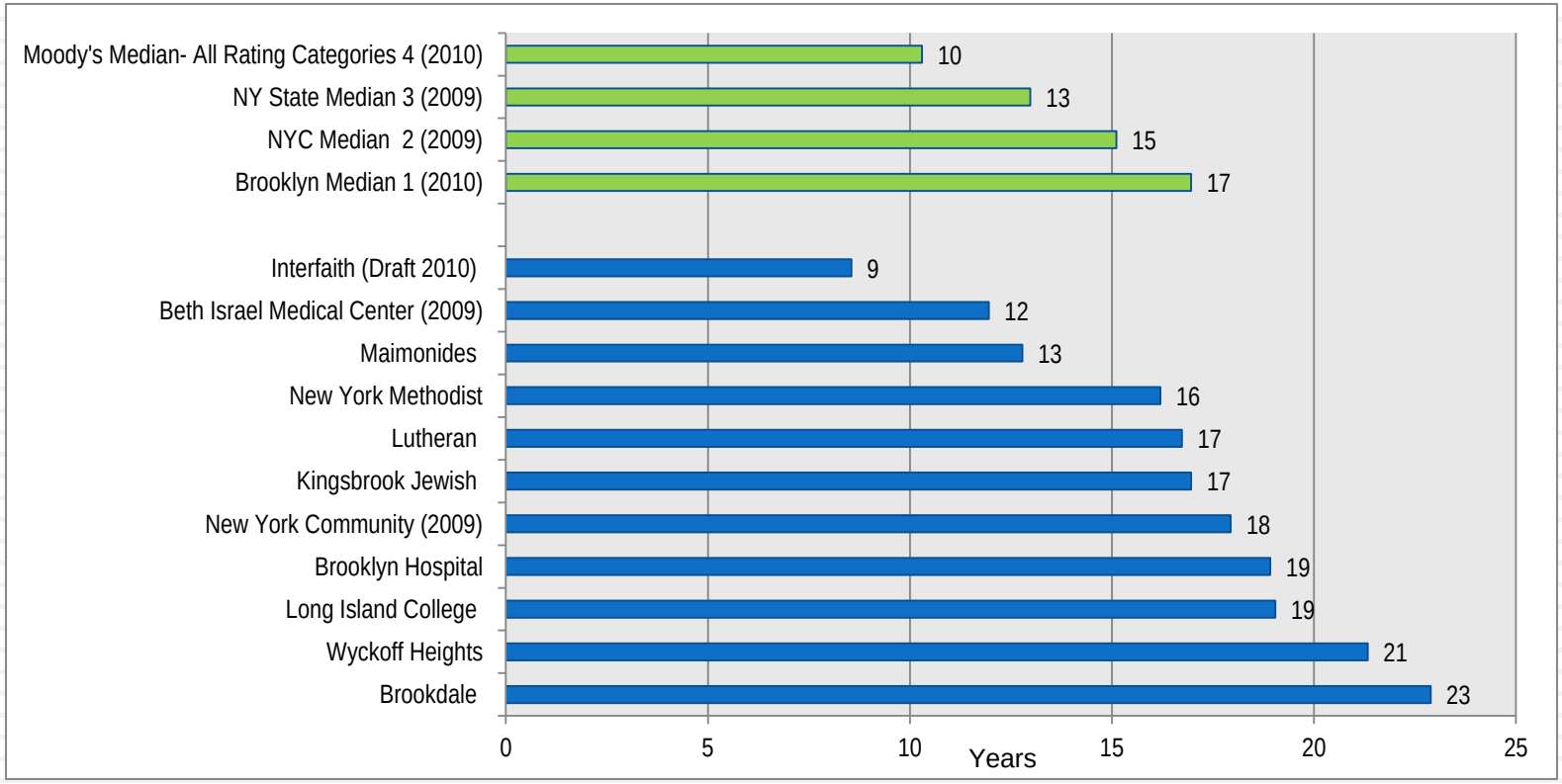
2 2009 Audit data. Includes 31 Article 28 hospitals/hospital systems located in the five boroughs. and excludes publics and specialty hospitals.

3 2009 Audit data. Includes 148 Article 28 hospitals/hospital systems in the State and excludes publics and specialty hospitals.

4 Moody's Fiscal Year 2010 Not-for-Profit Hospital Medians, August 2011. Includes 401 freestanding hospitals & single state systems that have an underlying rating from Moody's across all rating categories.. The Moody's Median for Net Assets of $273M is Unrestricted Net Assets only as a Total Net Assets Median was not available.

5 Five year averages: (2006-2010) for Brooklyn Hospitals and Moody's and 2005-2009 for NYC and NYS.

Age of Plant



Sources: Hospital Audited financial statements and DASNY supplemental survey

1 Includes 11 Article 28 hospitals in Brooklyn; excludes the three public Health and Hospital Corporation hospitals and State hospital. 2010 Audit data unless otherwise noted. Audit data for Beth Israel Medical Center is from the Consolidated Audit which includes the Kings Highway division in Brooklyn. Audit data for Interfaith is DRAFT. Audit data for Kingsbrook Jewish Medical Center only; excludes Rutland Nursing Home.

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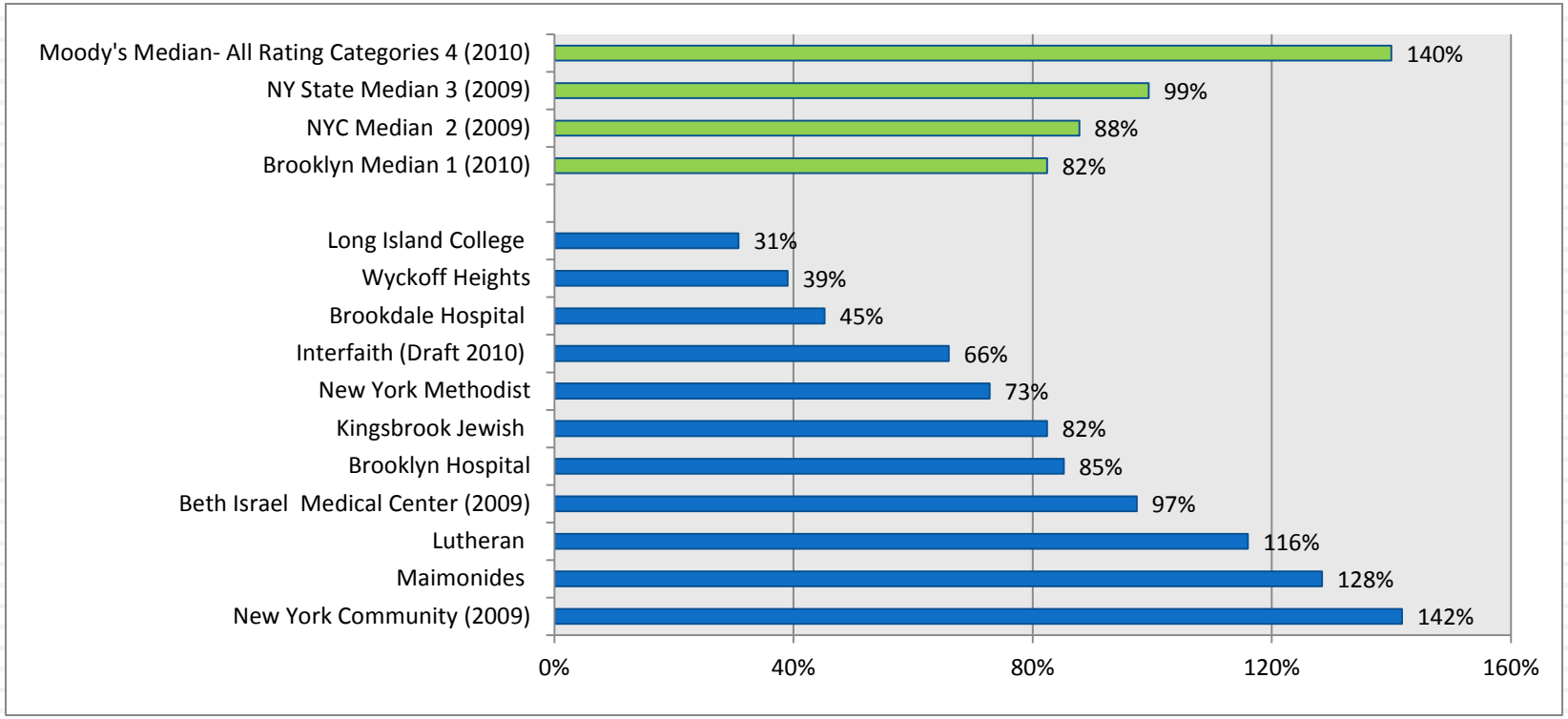
Capital Spending – 5 year averages



Sources: Hospital Audited financial statements and DASNY supplemental survey

1 Includes 11 Article 28 hospitals in Brooklyn; excludes the three public Health and Hospital Corporation hospitals and State hospital. 2010 Audit data unless otherwise noted. Audit data for Beth Israel Medical Center is from the Consolidated Audit which includes the Kings Highway division in Brooklyn. 2010 Audit data for Interfaith is DRAFT. Audit data for Kingsbrook Jewish Medical Center only; excludes Rutland Nursing Home.

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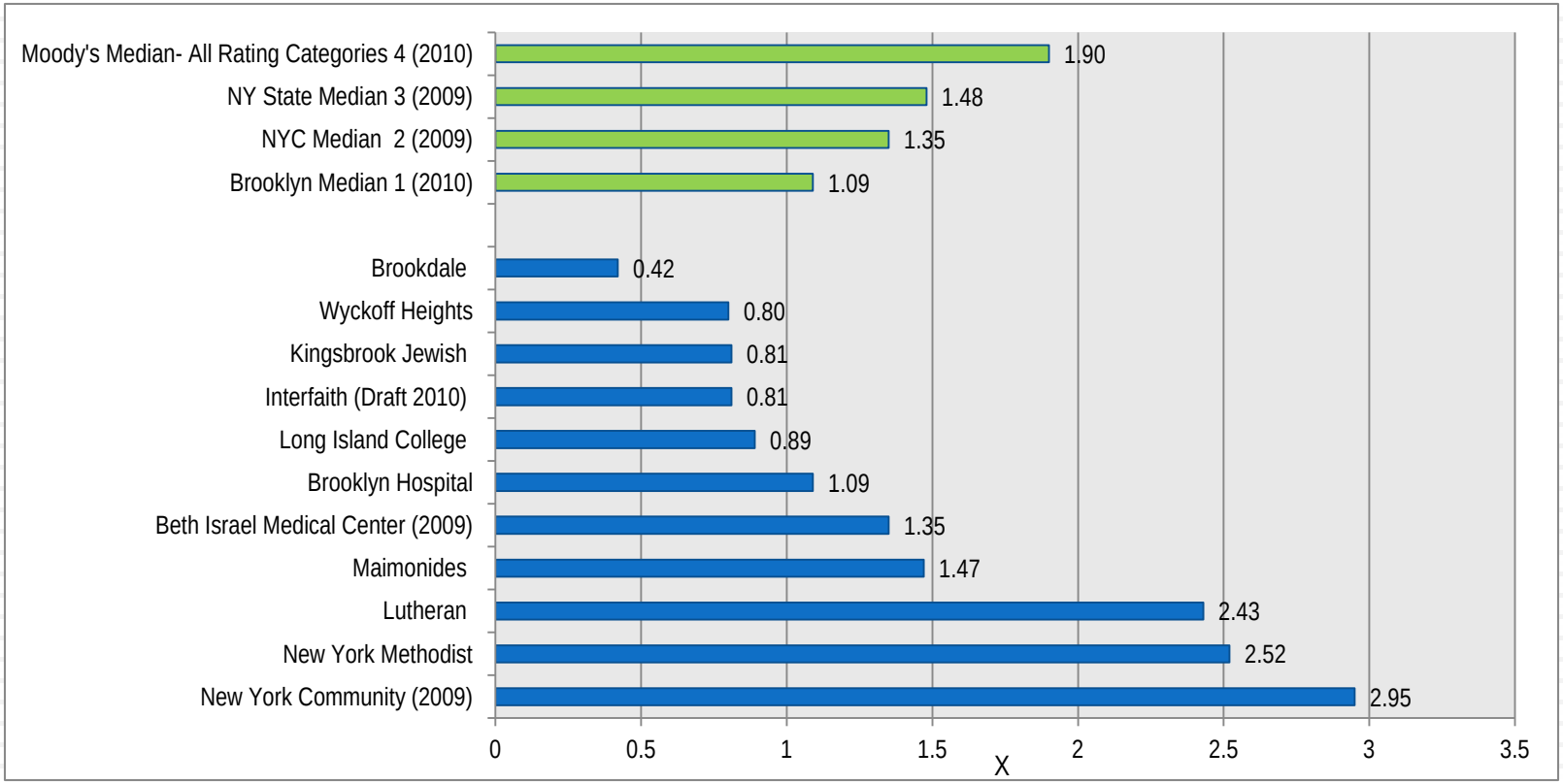
4 Moody's Fiscal Year 2010 Not-for-Profit Hospital Medians, August 2011. Includes 401 freestanding hospitals & single state systems that have an underlying rating from Moody's across all rating categories.

Current Ratio



Sources: Hospital Audited financial statements and DASNY supplemental survey

1 Includes 11 Article 28 hospitals in Brooklyn; excludes the three public Health and Hospitals Corporation hospitals and State hospital. 2010 Audit data unless otherwise noted. Audit data for Beth Israel Medical Center is from the Consolidated Audit which includes the Kings Highway division in Brooklyn. 2010 Audit data for Interfaith is DRAFT. Audit data for Kingsbrook Jewish Medical Center only; excludes Rutland Nursing Home.

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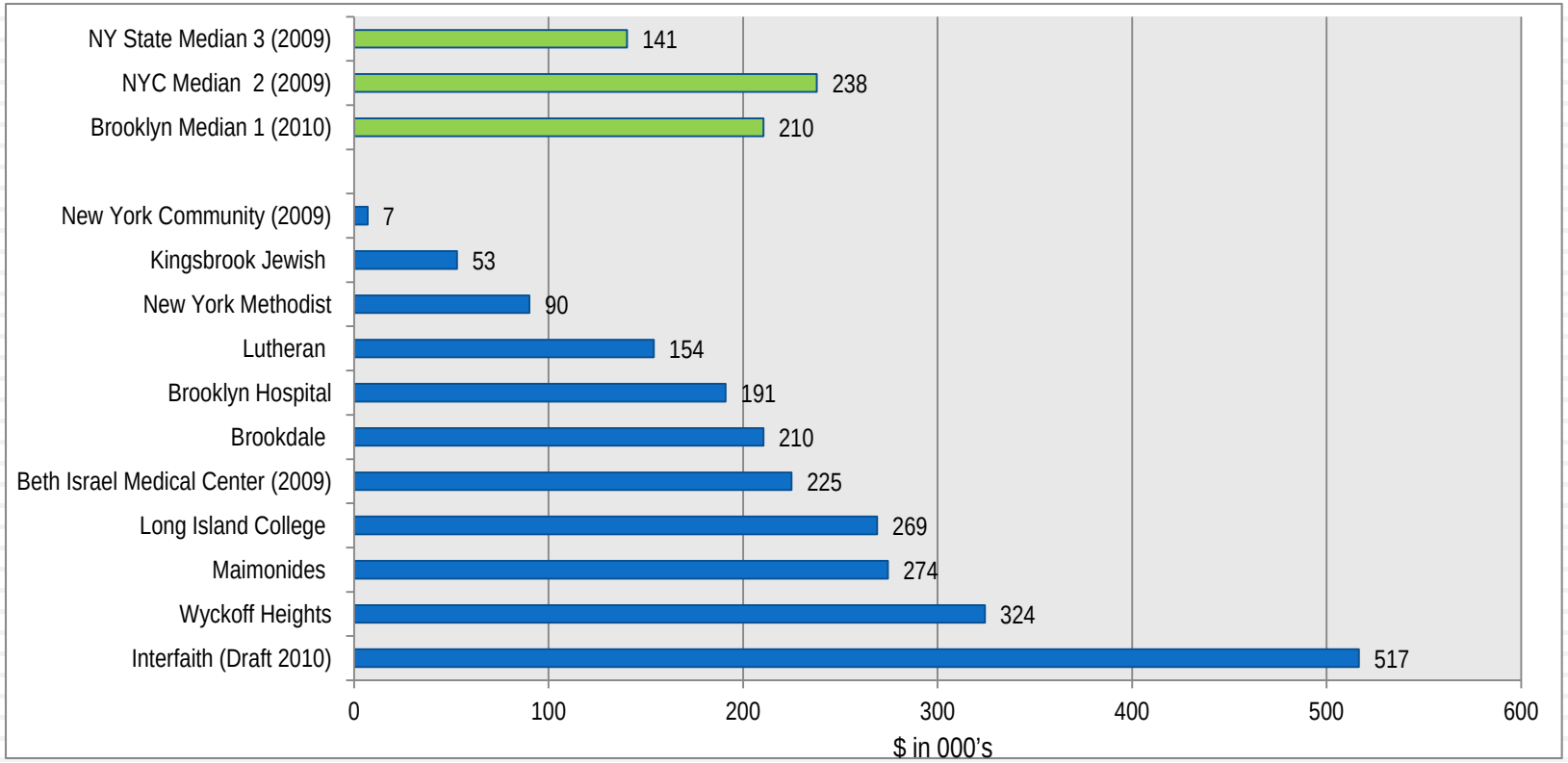
4 Moody's Fiscal Year 2010 Not-for-Profit Hospital Medians, August 2011. Includes 401 freestanding hospitals & single state systems that have an underlying rating from Moody's across all rating categories.

Long-Term Debt / Bed [4]



Sources: Hospital Audited financial statements and DASNY supplemental survey

1 Includes 11 Article 28 hospitals in Brooklyn; excludes the three public Health and Hospitals Corporation hospitals and State hospital. 2010 Audit data unless otherwise noted. Audit data for Beth Israel Medical Center is from the consolidated audit which includes the Kings Highway division in Brooklyn. 2010 Audit data for Interfaith is DRAFT. Audit data for Kingsbrook Jewish Medical Center only; excludes Rutland Nursing Home.

2 2009 Audit data. Includes 31 Article 28 hospitals/hospital systems located in the five boroughs. and excludes major publics and specialty hospitals.

3 2009 Audit data. Includes 148 Article 28 hospitals/hospital systems in the State and excludes major publics and specialty hospitals.

4 LTD / BED is defined as the Current and Long-term portion of debt from the Audit balance sheet divided by licensed beds.

Net Assets

Hospital	Total Net Assets ($ millions)	Total Assets ($ millions)	Total Long –Term Debt [2] ($ millions)	Total Other Liabilities ($ millions)
Brookdale	(285)	184	112	357
Long Island College	(78)	308	136	250
Interfaith (Draft 2010)	(126)	184	148	162
Wyckoff Heights	(91)	140	114	117
Kingsbrook Jewish	16	115	17	82
New York Community (2009)	27	60	1	32
Brooklyn Hospital	59	255	89	107
Lutheran	69	289	72	148
New York Methodist	135	491	53	303
Maimonides	185	759	195	379
Beth Israel Medical Center (2009)	350	969	263	356

Sources: Hospital Audited financial statements and DASNY supplemental survey

1 Includes 11 Article 28 hospitals in Brooklyn; excludes the three public Health and Hospitals Corporation hospitals and the State hospital. 2010 Audit data unless otherwise noted. Audit data for Beth Israel Medical Center is from the Consolidated Audit which includes the Kings Highway division in Brooklyn. 2010 Audit data for Interfaith Medical Center is DRAFT. Audit data for Kingsbrook Jewish Medical Center only; excludes Rutland Nursing Home.

2 Total long-term debt includes the current and long-term portions of all debt including bond/mortgages, capital leases, notes and other loans.

United Hospital Fund

Emergency Department Use in Brooklyn by Neighborhood

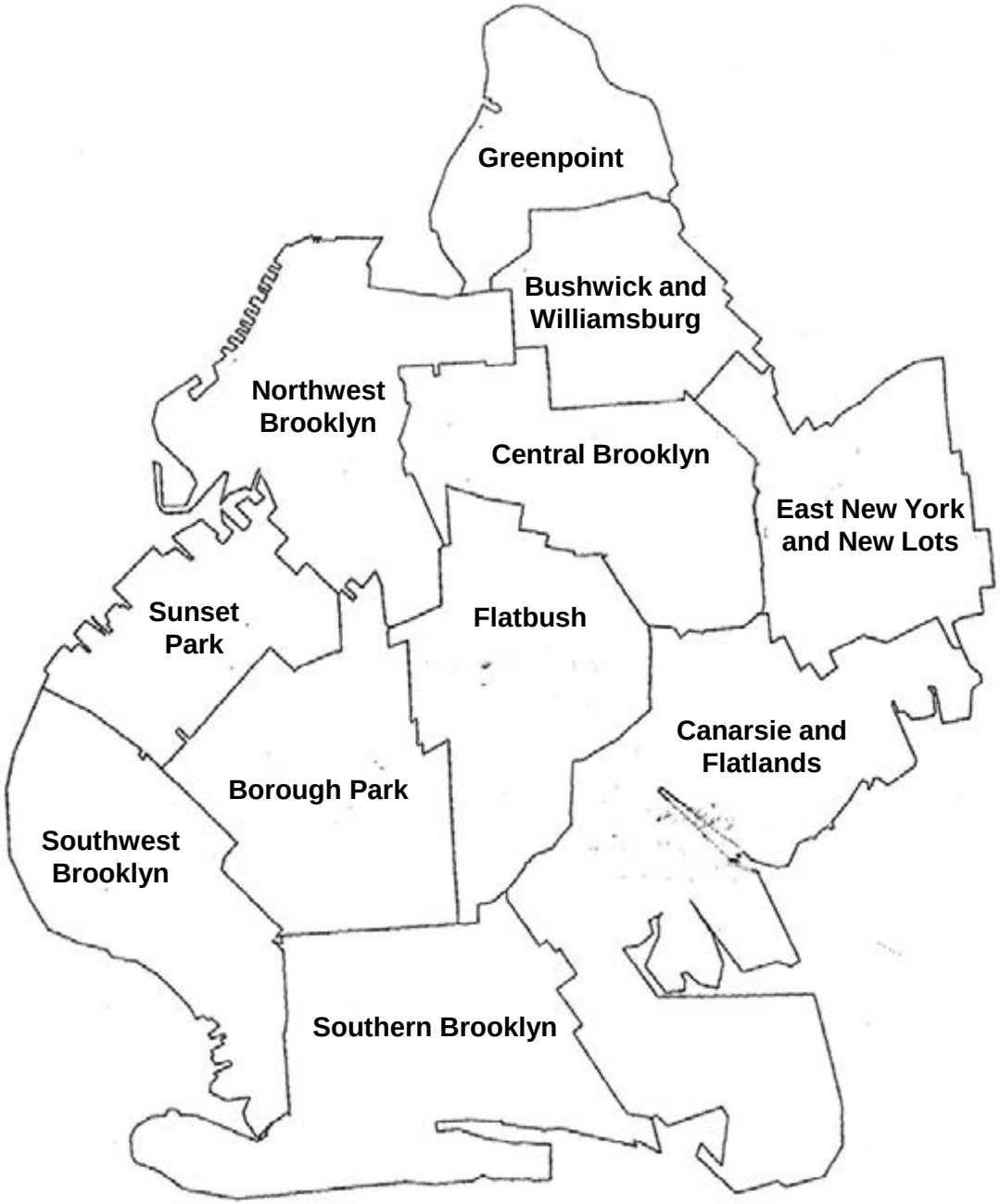
Michael Birnbaum
Vice President
United Hospital Fund

September 21, 2011

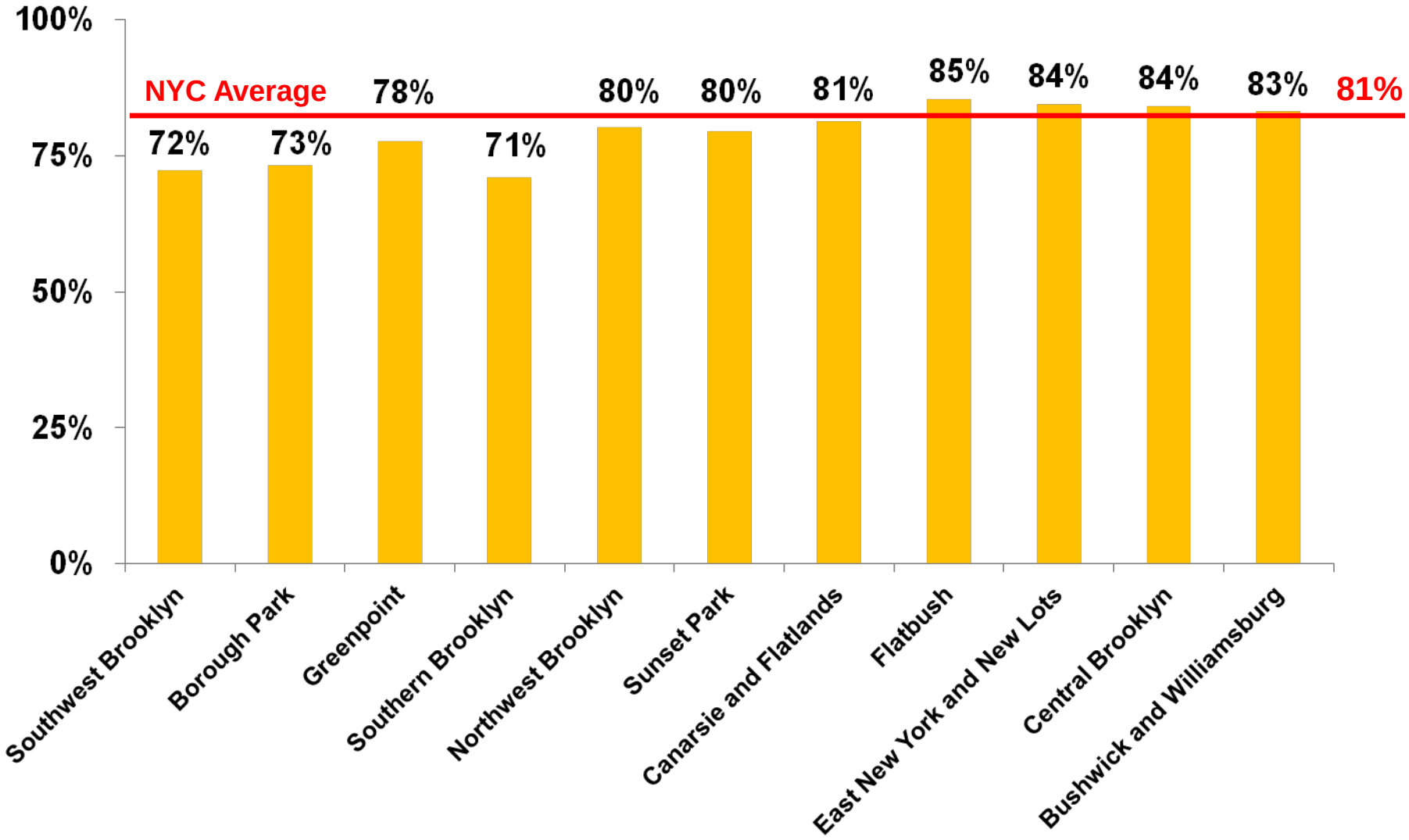
Study Parameters, Definitions, and Data Sources

- **Population**
  - **All Brooklyn residents**
- **Definition of emergency department (ED) visit**
  - **“Treat and release” visits (not resulting in admissions)**
- **Volume and types of ED visits and admissions**
  - **Source: Statewide Planning and Research Cooperative System (SPARCS) data up-weighted to reflect Institutional Cost Report (ICR) data**
- **Patient characteristics**
  - **Source: SPARCS data**
- **Neighborhood populations**
  - **Source: New York City Department of Health and Mental Hygiene Neighborhood Population Estimates**

Map of United Hospital Fund Brooklyn Neighborhoods



Share of ED Visits Not Resulting in Hospital Admissions (2008)

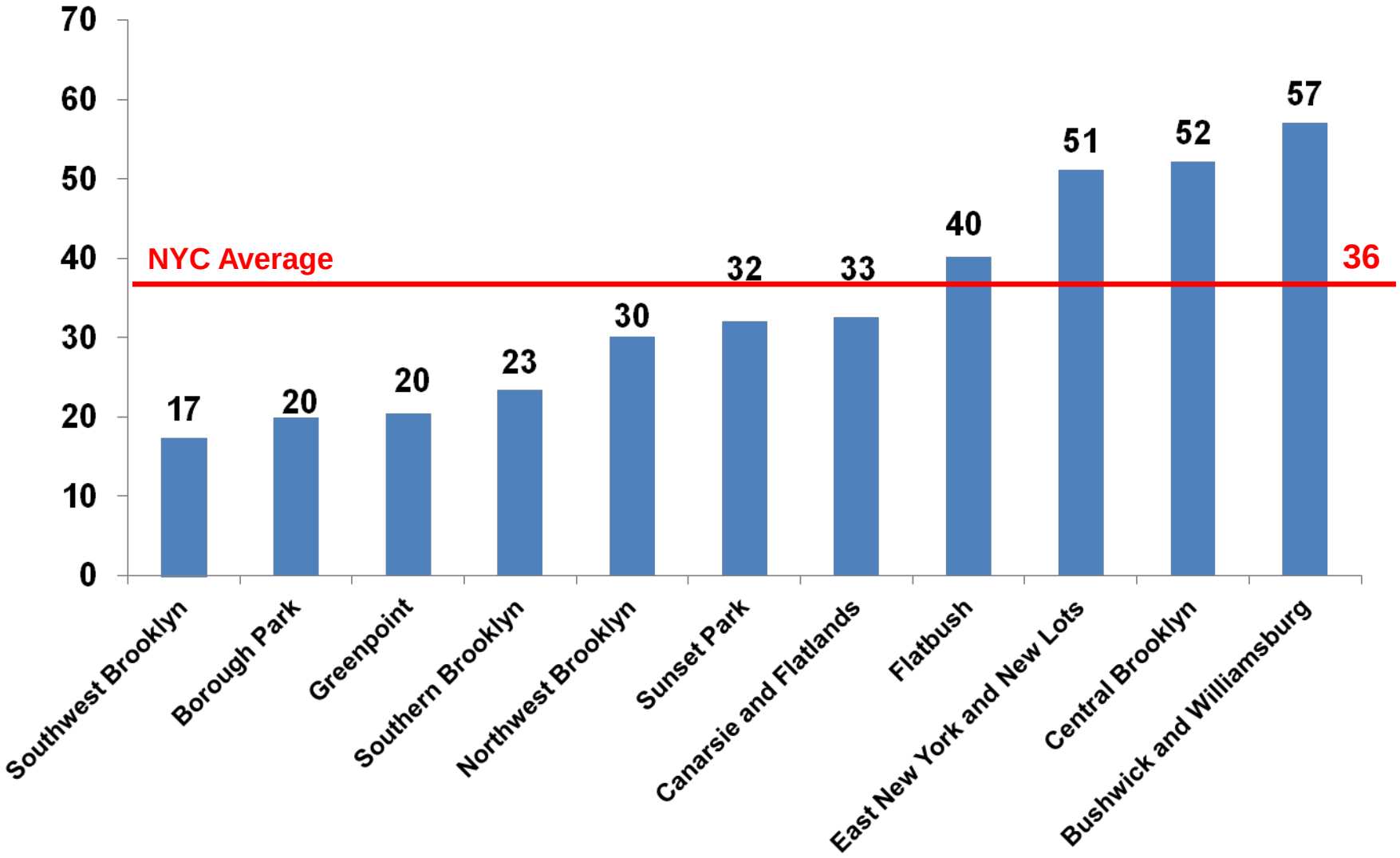


Source: United Hospital Fund analysis of SPARCS data and Institutional Cost Reports.

ED Use Among Brooklyn Residents by Neighborhood

- **ED Visits per 100 Residents**
- **Hospital Admissions per 100 Residents**
- **Share of Residents with at Least One ED Visit**
- **Share of Residents with Three or More ED Visits**
- **Share of ED Visits by Frequency of ED Use**

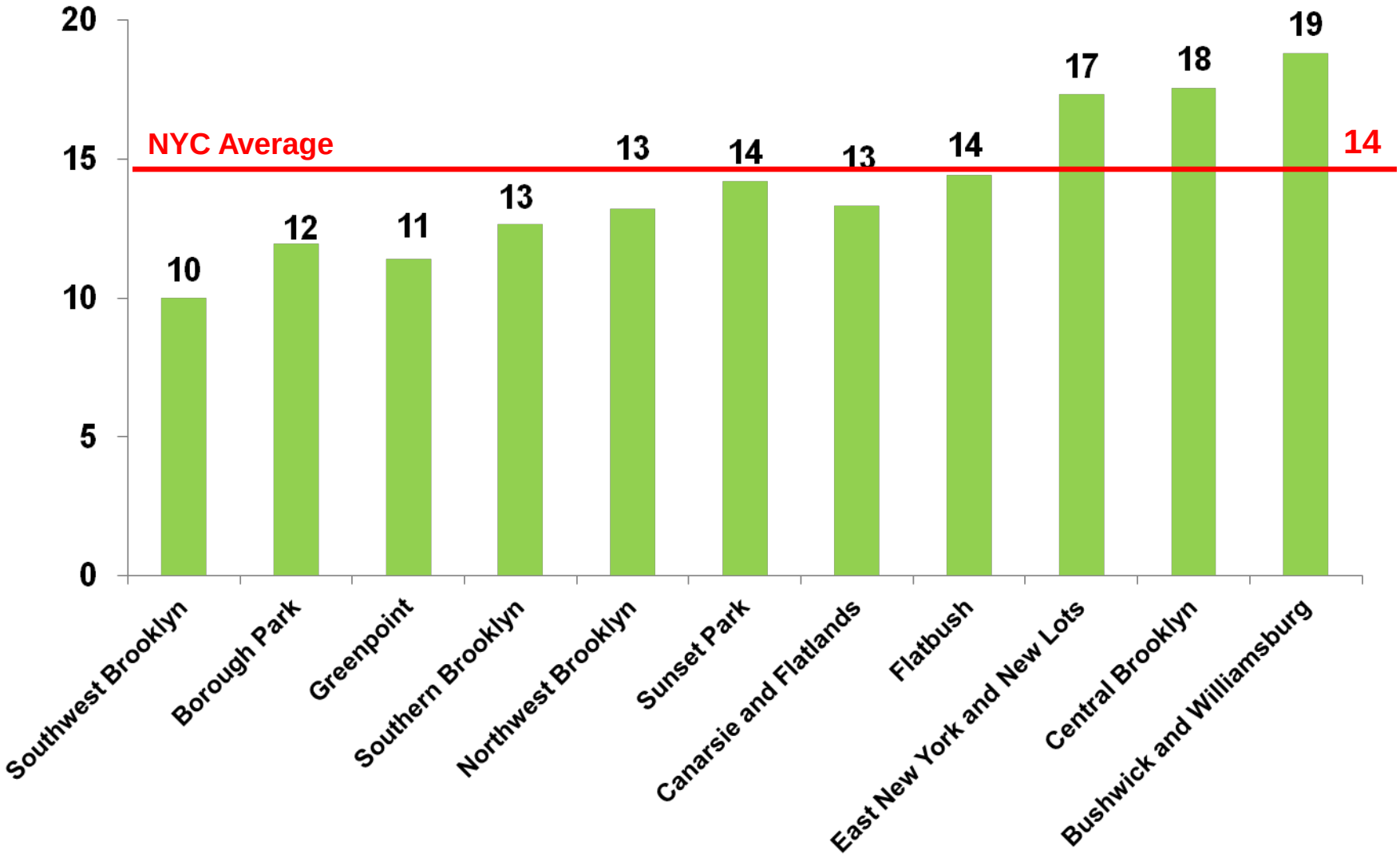
ED Visits per 100 Residents (2008)



Source: United Hospital Fund analysis of SPARCS data, Institutional Cost Reports, and NYC DOHMH Neighborhood Population Estimates.

Note: Rates are age- and sex-adjusted.

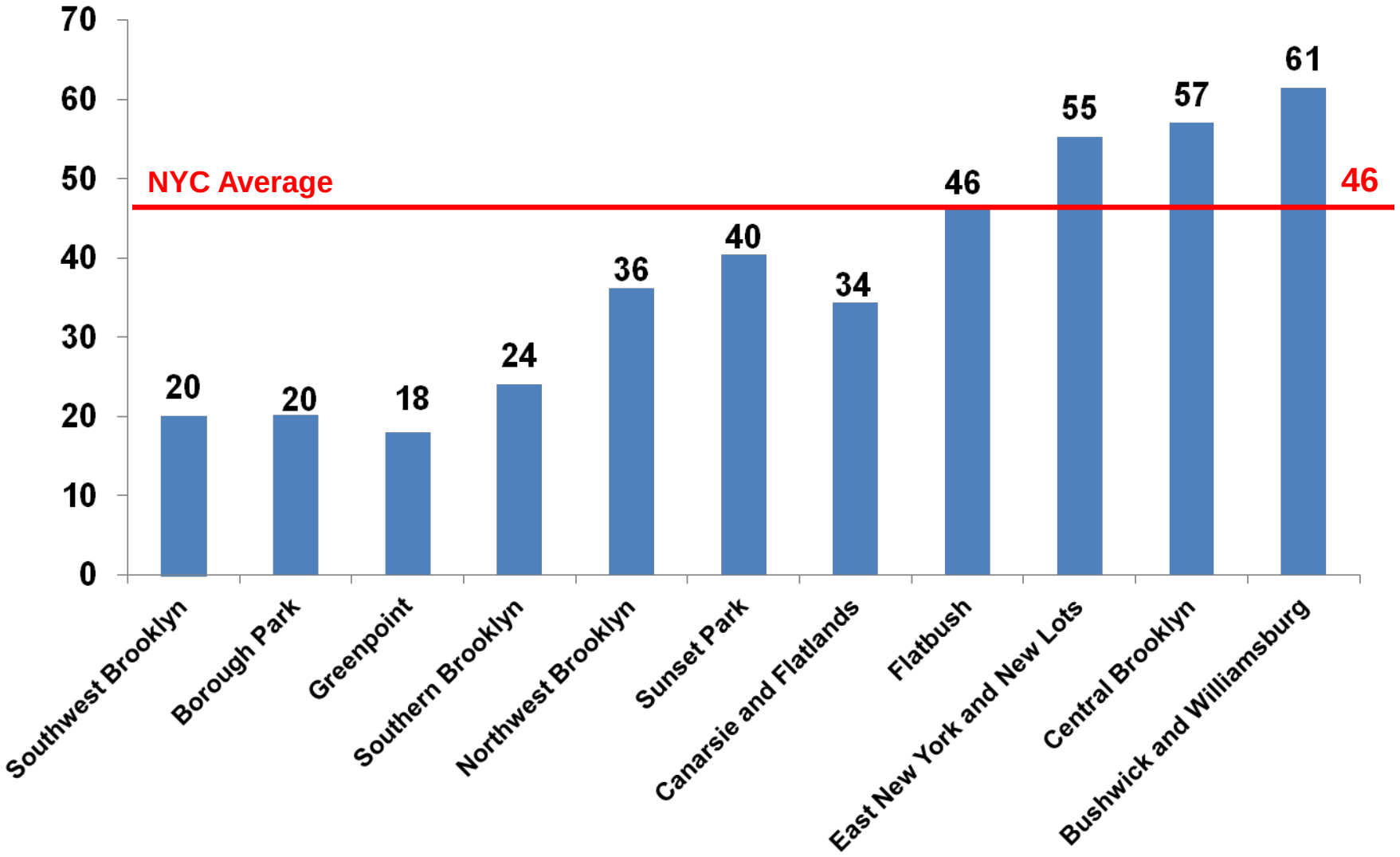
Hospital Admissions per 100 Residents (2008)



Source: United Hospital Fund analysis of SPARCS data, Institutional Cost Reports, and NYC DOHMH Neighborhood Population Estimates.

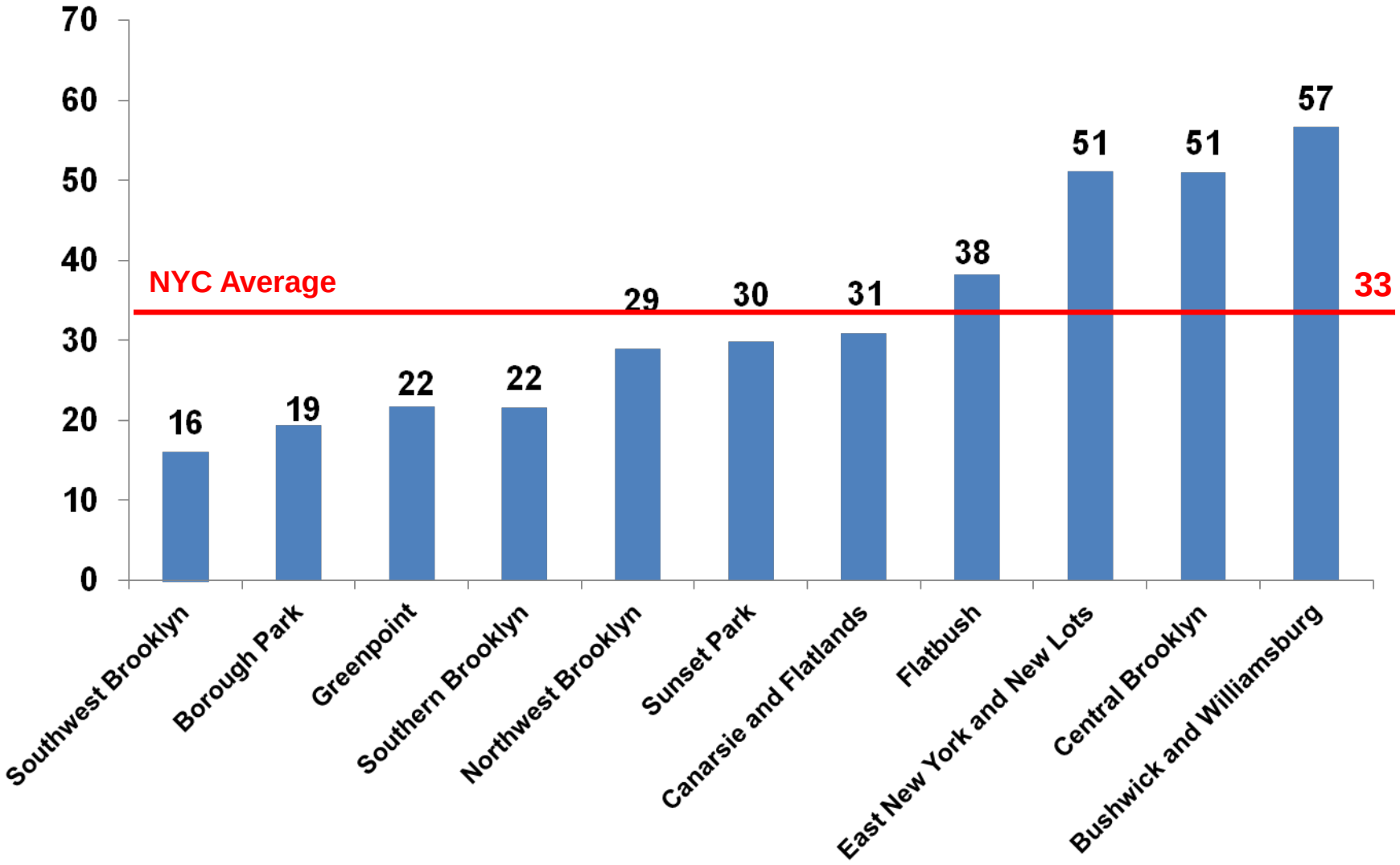
Note: Rates are age- and sex-adjusted.

ED Visits per 100 Children (2008)



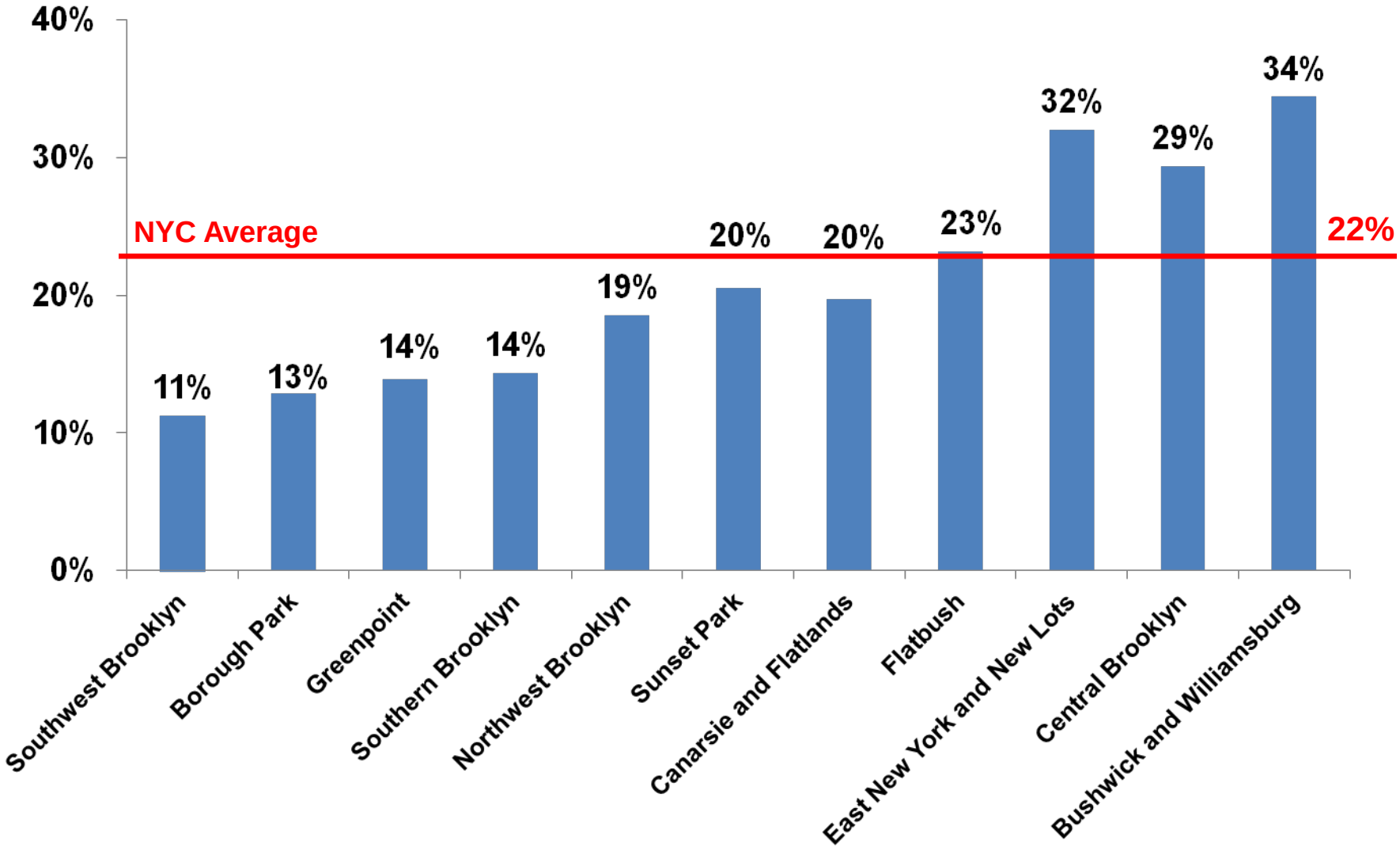
Source: United Hospital Fund analysis of SPARCS data, Institutional Cost Reports, and NYC DOHMH Neighborhood Population Estimates.

ED Visits per 100 Adults (2008)



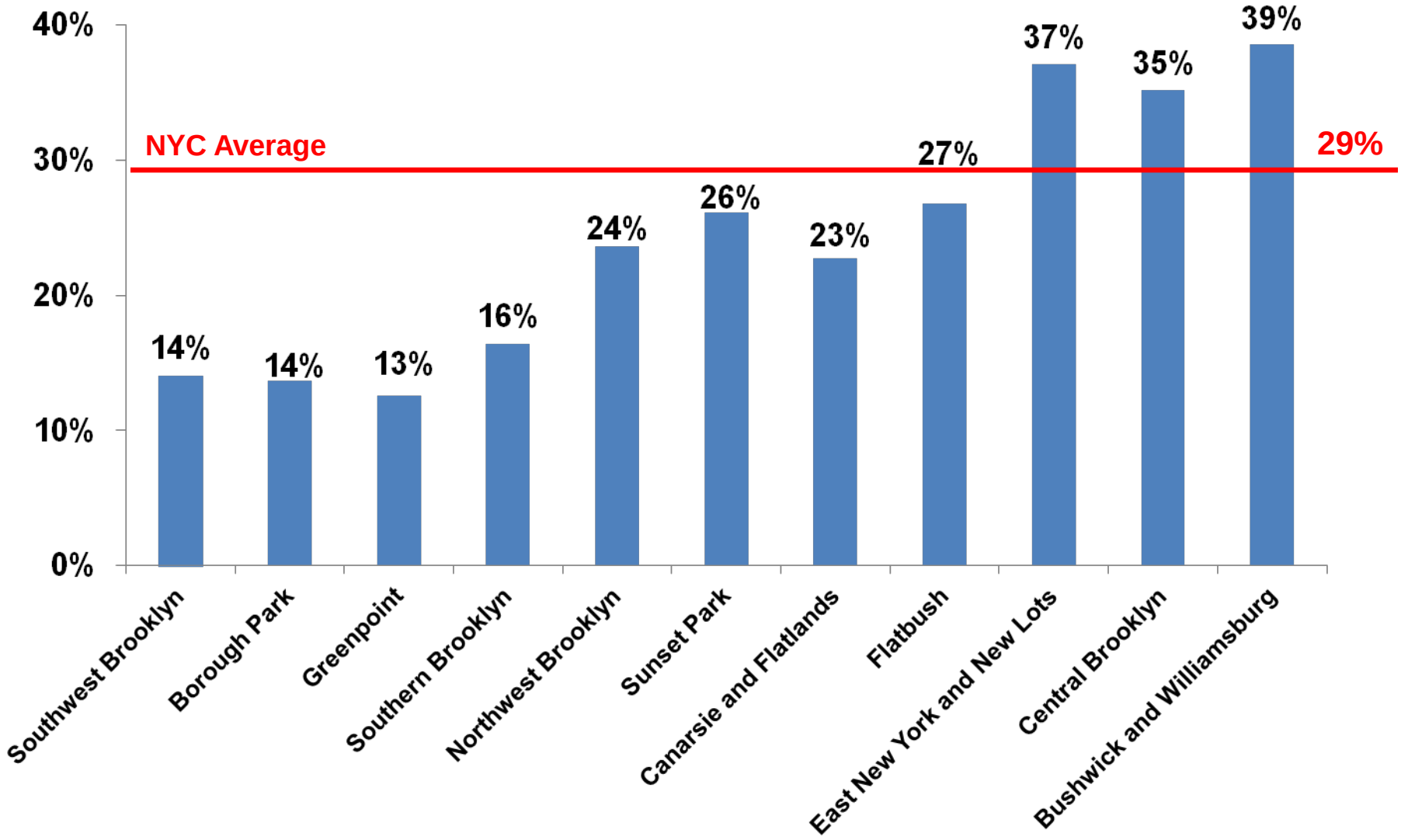
Source: United Hospital Fund analysis of SPARCS data, Institutional Cost Reports, and NYC DOHMH Neighborhood Population Estimates.

Share of Residents with at Least One ED Visit (2008)



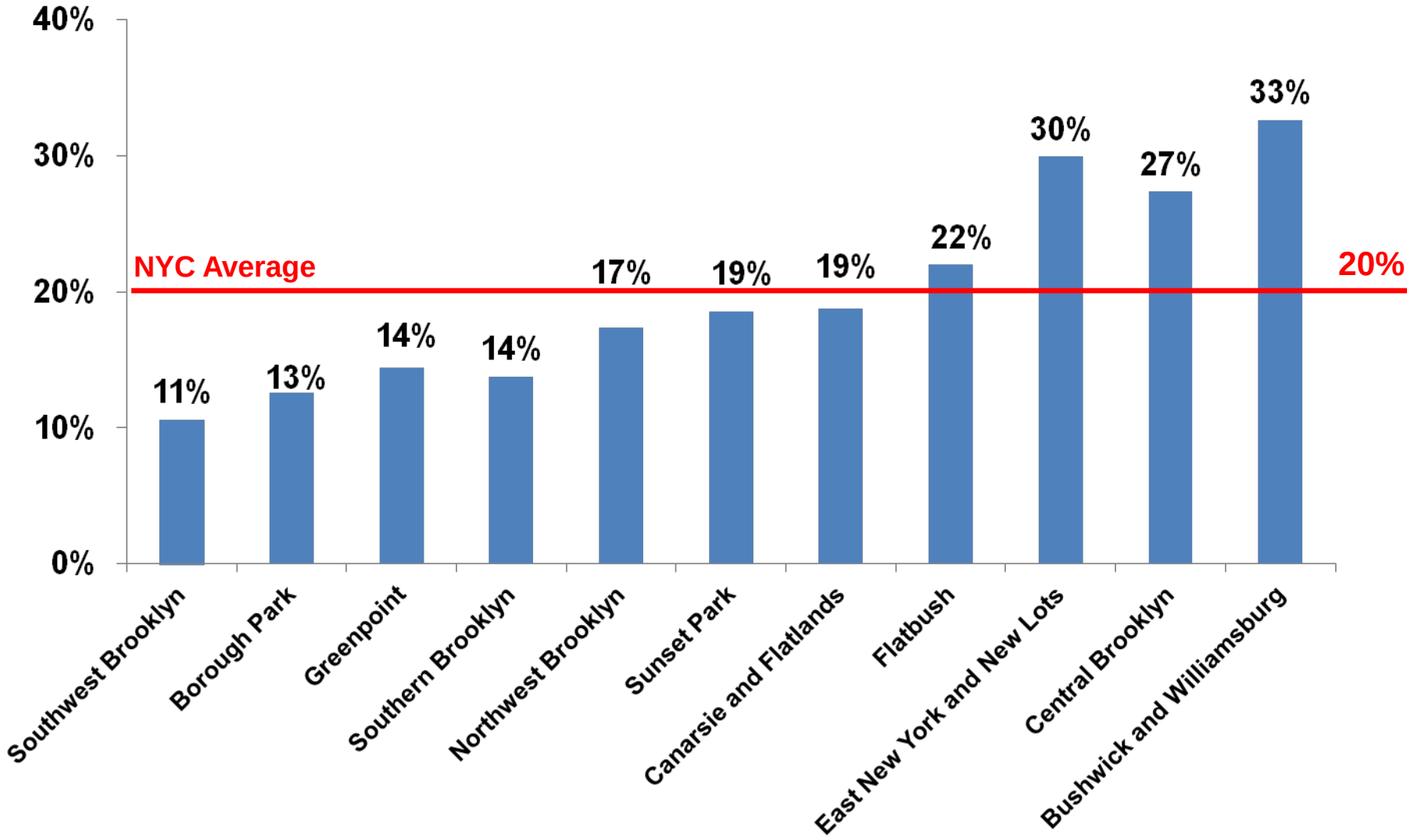
Source: United Hospital Fund analysis of SPARCS data and NYC DOHMH Neighborhood Population Estimates.

Share of Children with One or More ED Visits (2008)



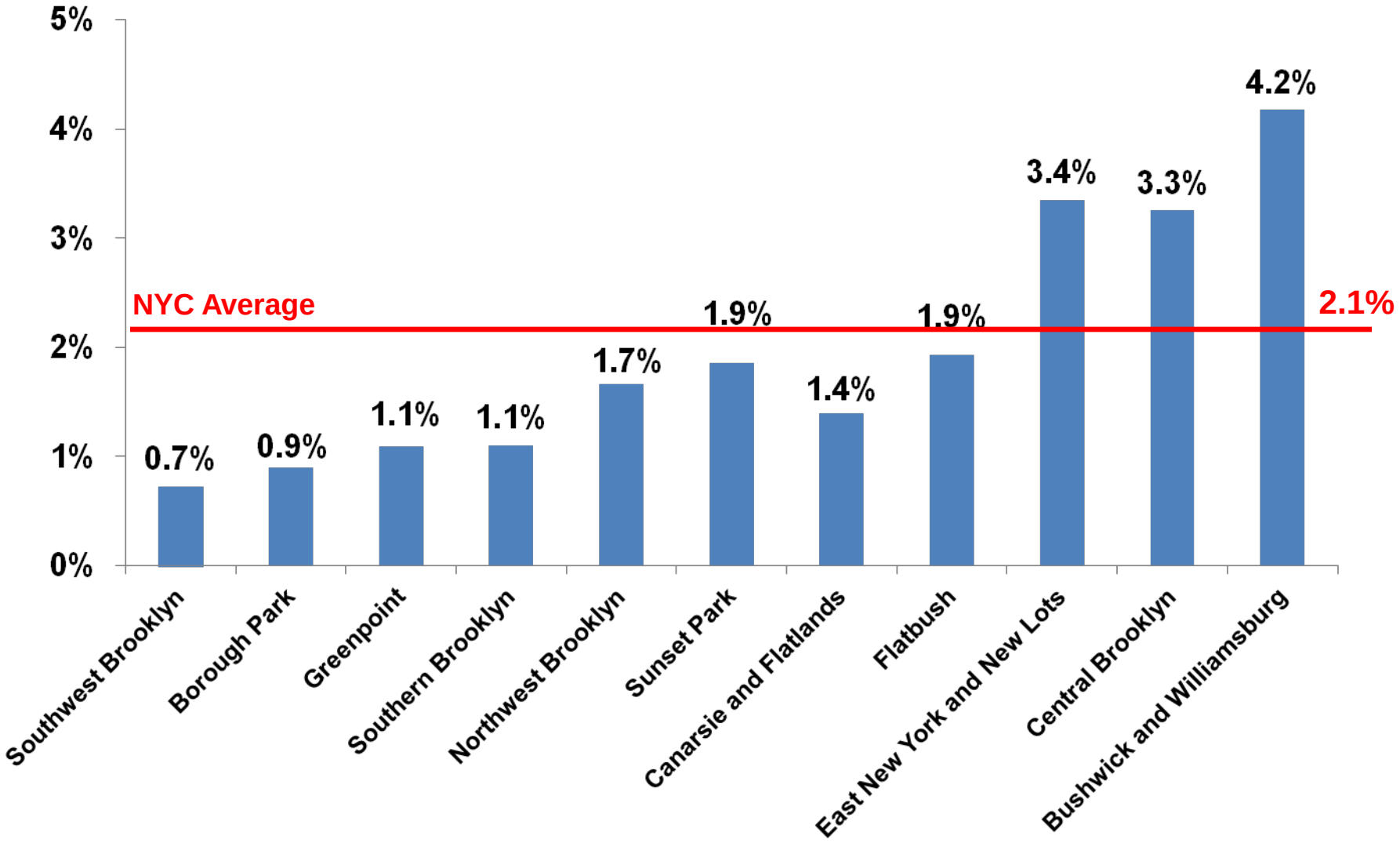
Source: United Hospital Fund analysis of SPARCS data and NYC DOHMH Neighborhood Population Estimates.

Share of Adults with One or More ED Visits (2008)



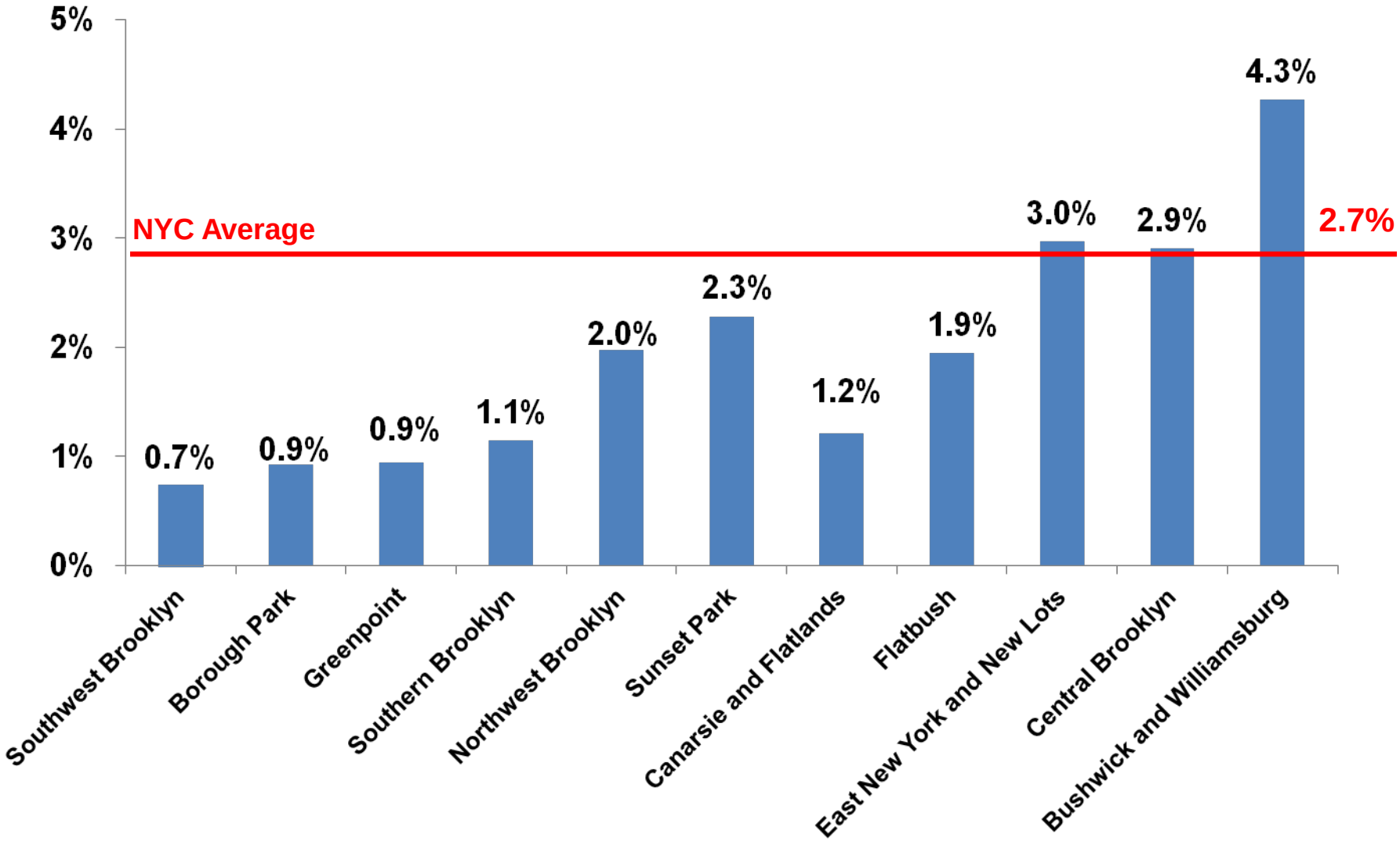
Source: United Hospital Fund analysis of SPARCS data and NYC DOHMH Neighborhood Population Estimates.

Share of Residents with Three or More ED Visits (2008)



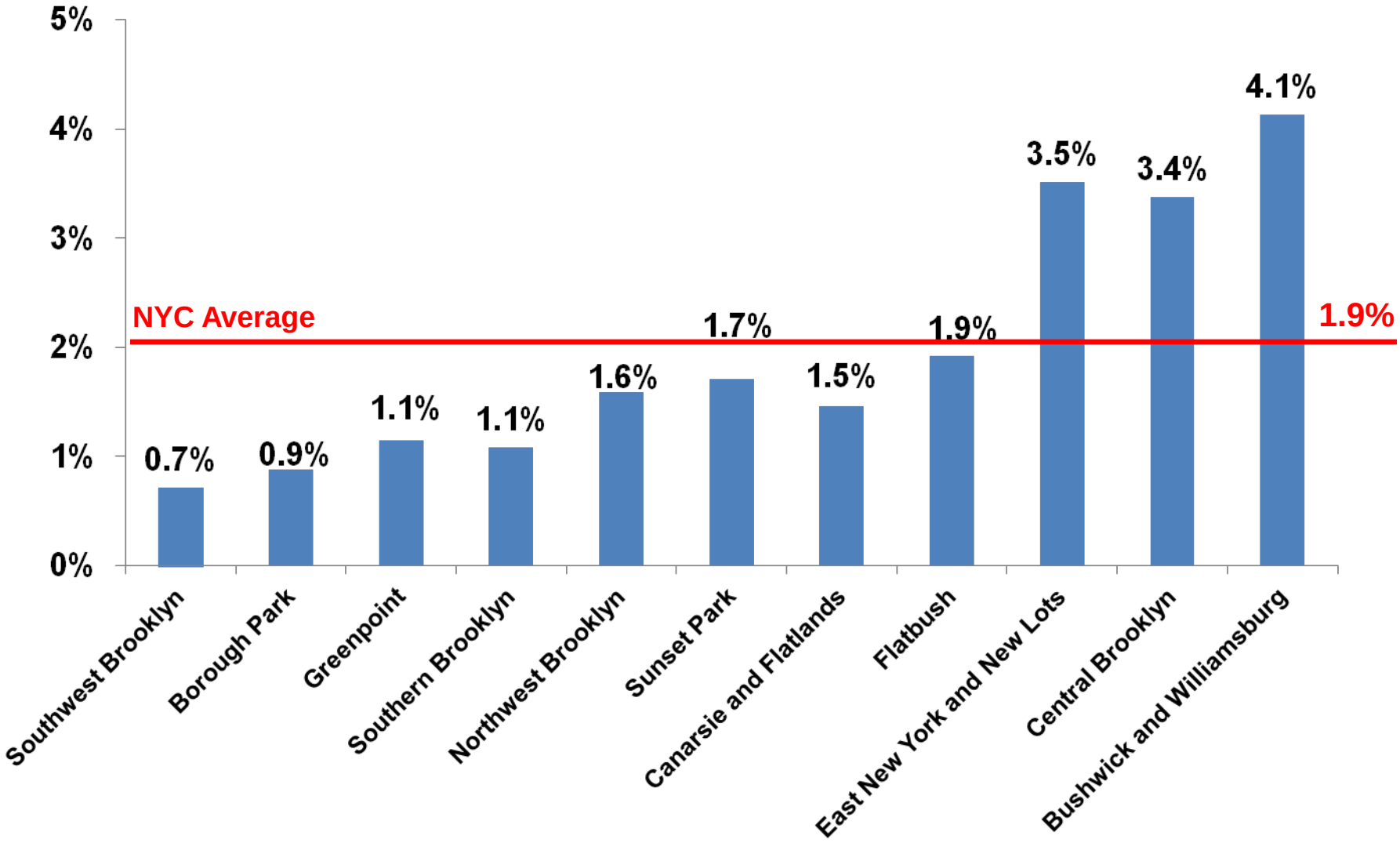
Source: United Hospital Fund analysis of SPARCS data and NYC DOHMH Neighborhood Population Estimates.

Share of Children with Three or More ED Visits (2008)



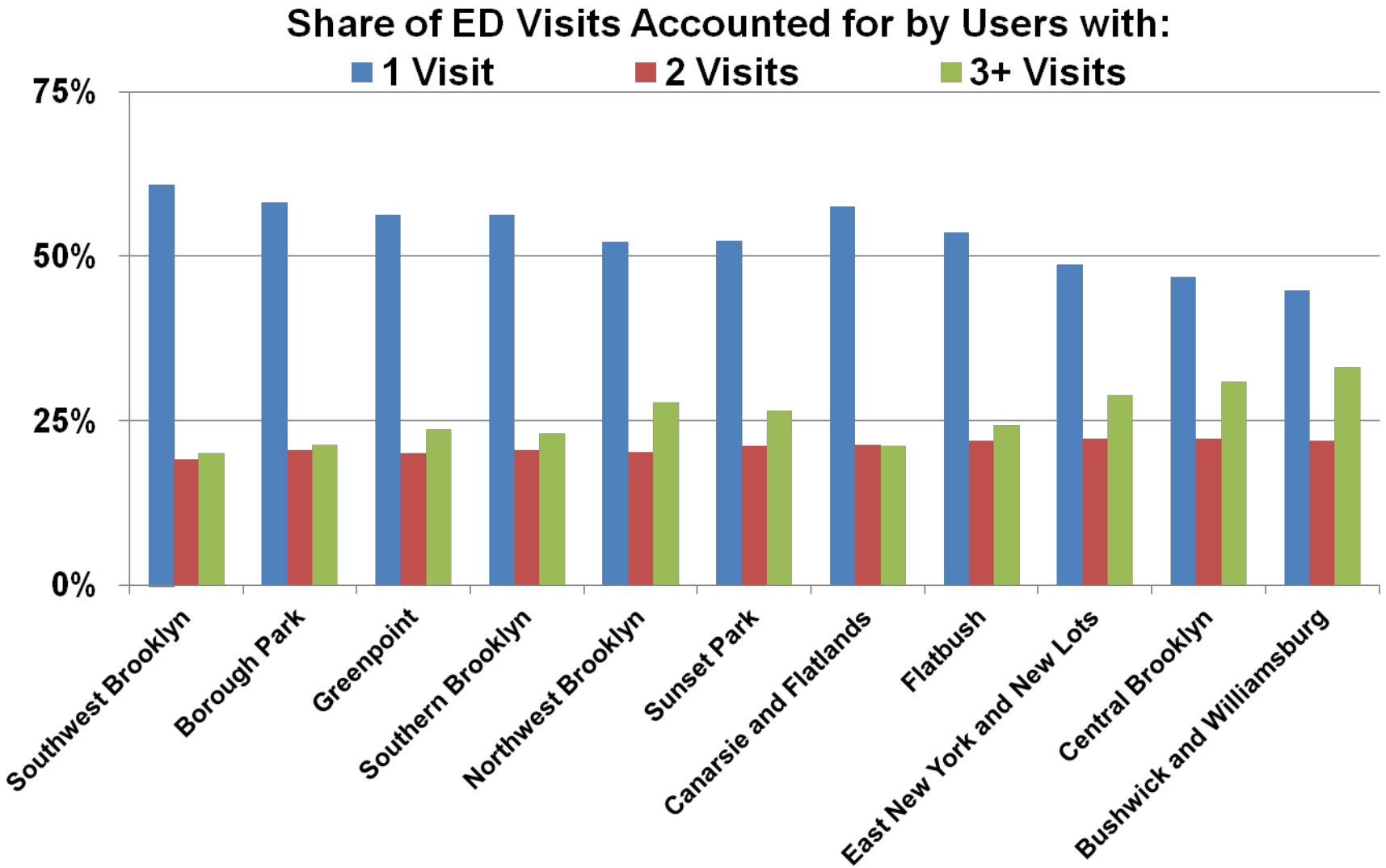
Source: United Hospital Fund analysis of SPARCS data and NYC DOHMH Neighborhood Population Estimates.

Share of Adults with Three or More ED Visits (2008)



Source: United Hospital Fund analysis of SPARCS data and NYC DOHMH Neighborhood Population Estimates.

Share of ED Visits by Frequency of ED Use (2008)



Source: **United Hospital Fund analysis of SPARCS data.**

Findings

- **Residents in certain Brooklyn neighborhoods have much higher rates of ED use than those in others.**
- **Variation in ED use among neighborhoods is greater than variation in hospital admissions.**
- **Children are more likely than adults to use the ED.**
- **Variation in ED use among neighborhoods is greatest for residents with 3 or more visits.**

B - HIP

Brooklyn Healthcare Improvement Project

September 21, 2011

Grace Wong, MBA, MPH

Vice President – Managed Care & Clinical Business

Assistant Professor – School of Public Health

SUNY Downstate Medical Center

Goals

- Development of a comprehensive community health planning process with a broad coalition representing all segments of the public, private, and corporate sectors. Articulate healthcare vision for Central & Northern Brooklyn, which covers more than one million lives, and build roadmap for implementation
- Study of Issues influencing ED usage
- Analyze primary care service model, capacity, availability and utilization in Brooklyn neighborhoods with high rates of ambulatory care sensitive hospital admissions (ACS).
- Develop a dynamic, cutting edge information reservoir for future planning needs.

Coalition Membership

Community Based Organizations
- Brooklyn Chamber of Commerce
- Church Ave Merchants Block Association
- Caribbean American Chamber of Commerce
- Christopher Blenman Senior Center
- St. Gabriel's Senior Center

Civic
- Brooklyn Borough President's Office
- Community Board 8
- NYC Department of Health & Mental Hygiene
- United Hospital Fund

Community Based Health Organizations
- Bedford Stuyvesant Family Health Center
- Brownsville Multi-Service FHC
- Brooklyn Perinatal Network, Inc
- Caribbean Women's Health Association
- Coalition of Behavior Health Agencies, Inc
- Primary Care Development Corporation
- Brooklyn Health DisparitiesCenter
- SUNY Downstate School of Public Health

Hospital Partners
- Brookdale University Hospital & Medical Center
- Interfaith Medical Center
- Kingsbrook Jewish Medical Center
- Kings County Hospital Center
- University Hospital of Brooklyn
- Woodhull Medical & Mental Health Center

Health Insurers
- 1199 National Benefit Fund
- Aetna
- EmblemHealth-HIP/GHI
- Empire Blue Cross Blue Shield
- Healthfirst
- HealthPlus
- MetroPlus
- Neighborhood Health Providers
- United Healthcare

Pharmaceuticals
- Novartis

Mission/Vision

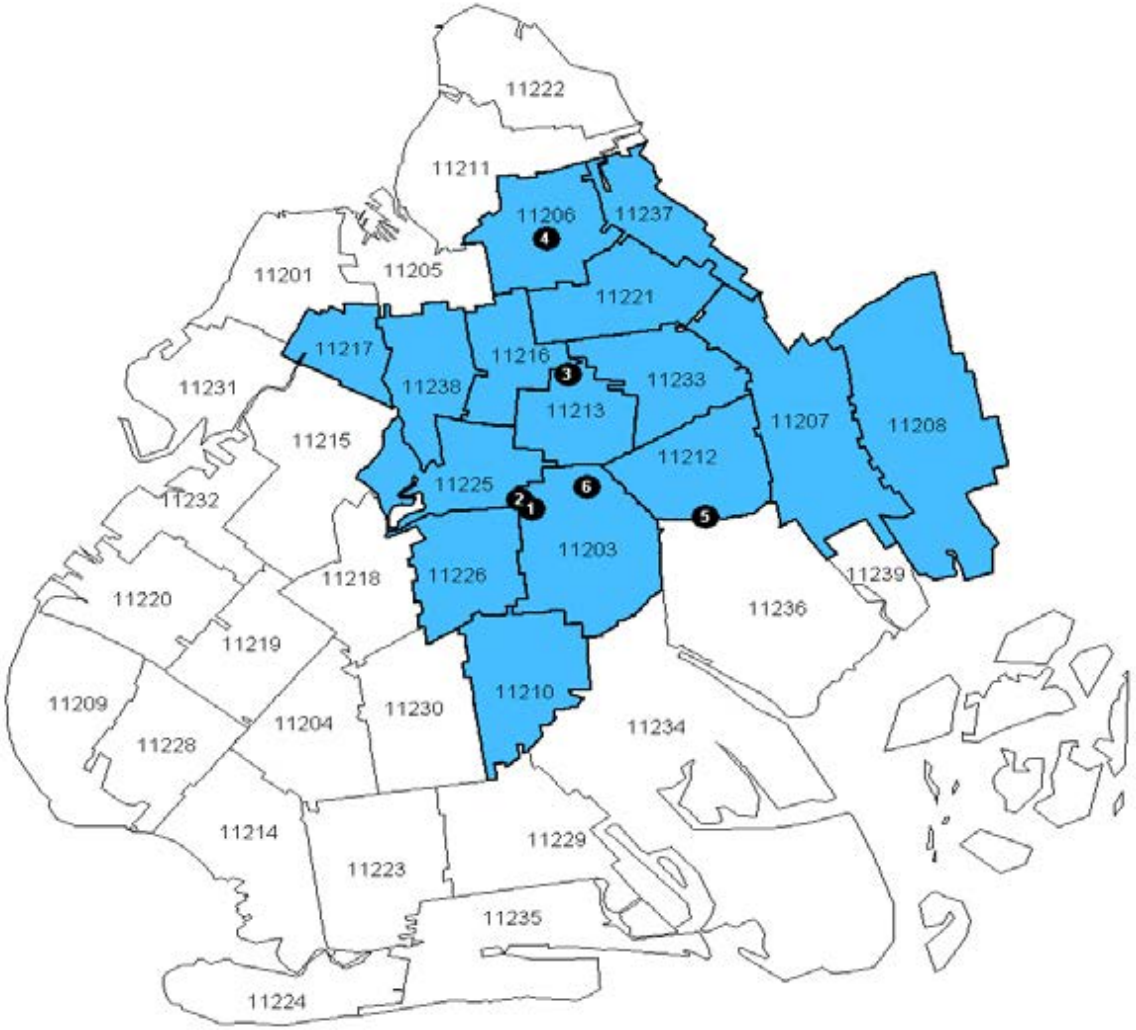
Mission Statement:

Our mission is to improve the wellness of our population by addressing access, quality, and cost of health care in Northern and Central Brooklyn

Vision Statement:

BHIP seeks to ensure access to affordable, quality, and timely care for all residents in Northern and Central Brooklyn, effectively eliminating disparities in health outcomes, through a coordinated health systems planning process that engages and fosters collaboration among multiple stake holders.

Target Area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Hospitals
1. UHB
2. Kings County
3. Interfaith
4. Woodhull
5. Brookdale
6. Kingsbrook Jewish

Target Area Statistics

	Age Adjusted per 1000		
SPARCS Data from 2006 - 2008	Discharges	ACSC*	% ACSC
NYC	150	24	16%
Brooklyn	151	25	16%
Brooklyn without Study Area Zip Codes	139	21	16%
Study Area Zip codes	180	34	18%
Examples within Study Area			
11206 (Williamsburg/Bushwick)	226	43	18%
11210 (Vanderveer)	124	19	14%

* ACSC – ***Ambulatory Care Sensitive Conditions*** are those for which hospitalization is considered potentially avoidable through preventive care and early disease management, usually delivered in an ambulatory setting, such as primary care. Examples include: Diabetes Complications, Dental Conditions, Asthma and Urinary Tract Infections

Studies

- Canvassing Survey of Healthcare Resources
- Emergency Department Studies
  - 6 Hospitals
  - Survey of ED Patients
  - Survey of ED Staff
  - Pilot – ED Admissions Review
- Analyses of SPARCS Data – Geocode by Census Tract
- Longitudinal Analyses of Insurance Encounter Data

Our Coalition & Canvassers

Canvassing Results

Community PCPs

Zip Code	Canvassing Data**		SPARCS 2006-2008
	Count: PCPs, IM, FP, Ob/Gyn, Ped	PCP FTE's @ 40 hr/wk	ED Visits (per 1,000)
Study Area Zip codes (15)	707	479	441
Sample Disparity			
11217 (Gowanus/Park Slope)	62	37	293
11226 (Flatbush)	71	52	378
11206 (Williamsburg/Bushwick)	31	11	611

**** Excludes Institutional PCPs**

ED Patient Survey
Captured

B - HIP

	All Visits	Asked	% Asked of All	Surveyed	% Surveyed of All
Brookdale	7,088	2,951	42%	1,819	26%
Downstate	5,323	3,257	61%	2,410	45%
Interfaith	3,800	2,287	60%	1,598	42%
Kings County	10,091	4,134	41%	2,799	28%
Kingsbrook	2,950	2,249	76%	1,498	51%
Woodhull	5,849	2,428	42%	1,530	26%
Totals	35,101	17,306	49%	11,654	33%

- Woodhull, Round 1- unable to survey 24/7

ED Patient Survey

Characteristics - Race

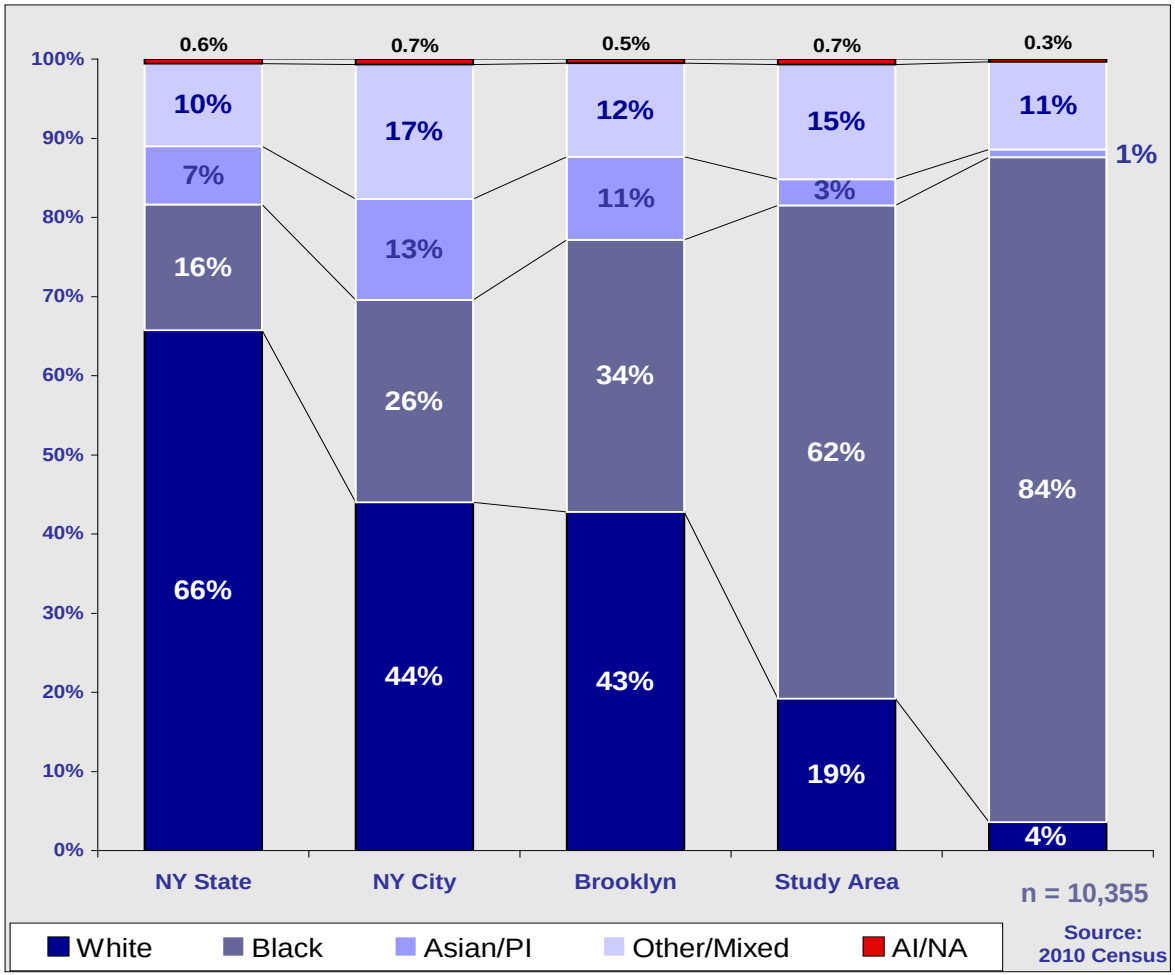
B - HIP

- NYC: 8.2mil
- Bklyn: 2.5mil
- Study Area
  - 1.05mil
  - 42% of Brooklyn
  - 13% of NYC

- Asian/PI includes:
  Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, etc.

- AI/NA includes:
  American Indian, Native Alaskan, Native Hawaiian, Guamanian, Samoan.

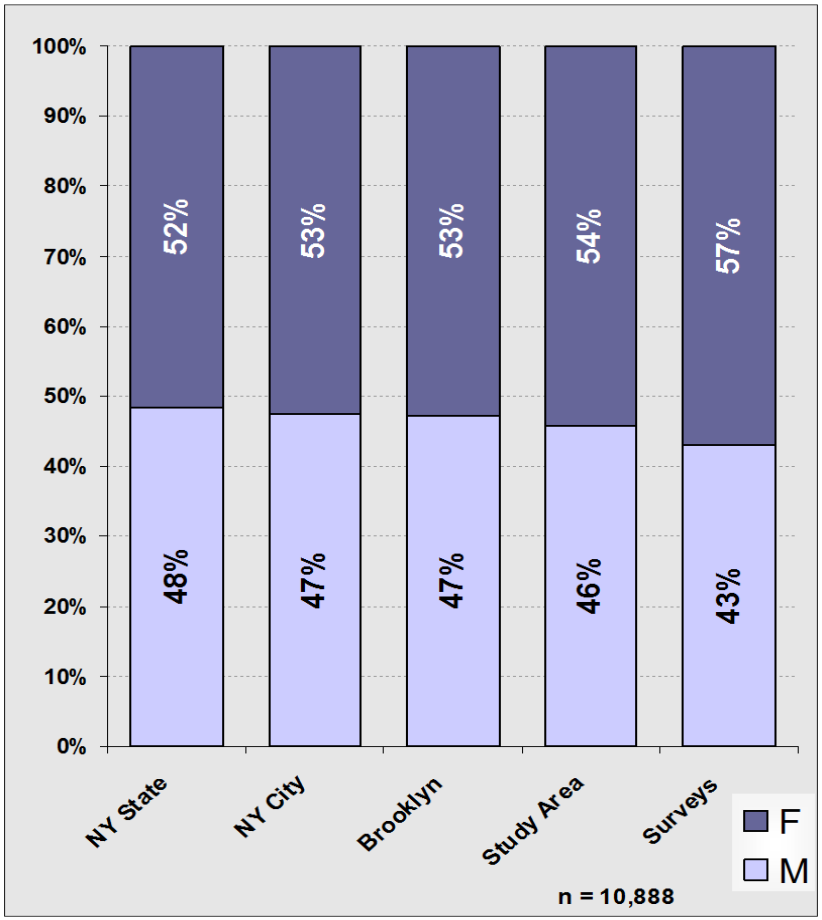
- Other/MIxed:
  Two or more Races or Some other self Identified Race

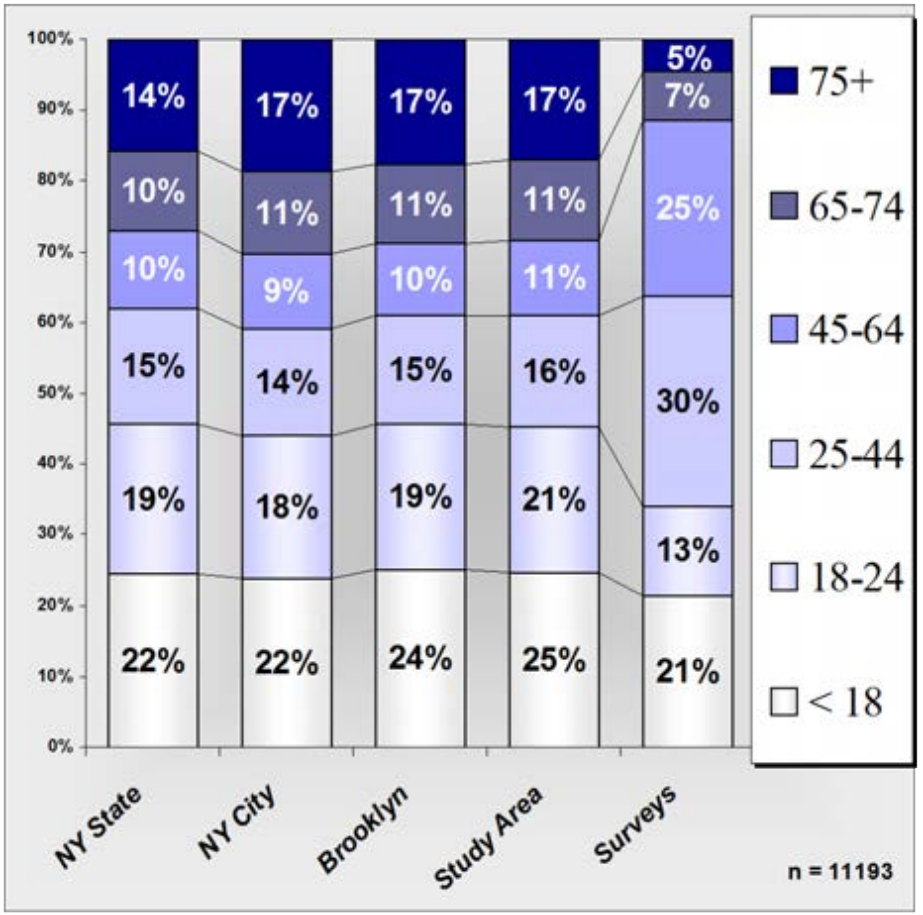


Source 2010 Census

ED Patient Survey

Characteristics – Gender & Age



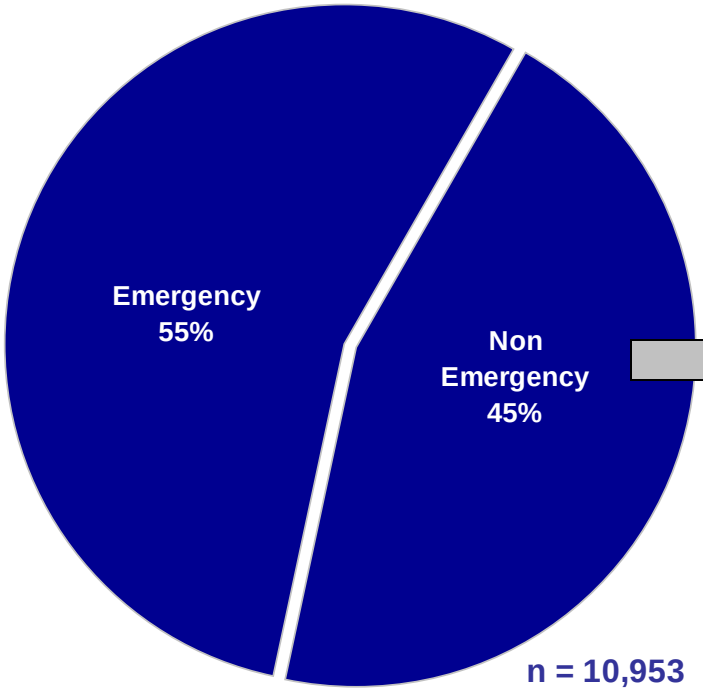


Source 2010 Census

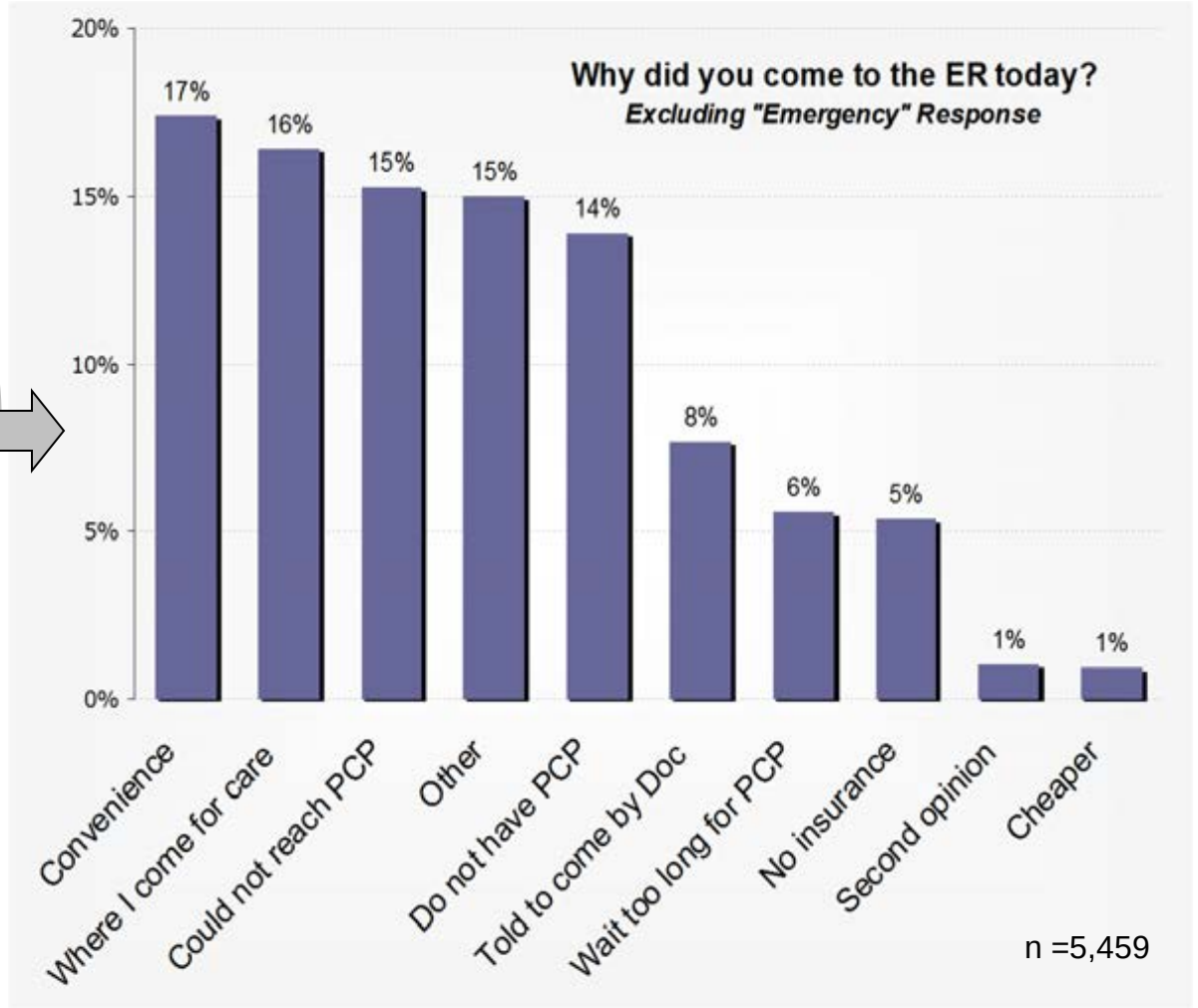
B - HIP

ED Patient Survey

Preliminary Data – Why did you come to the ER?



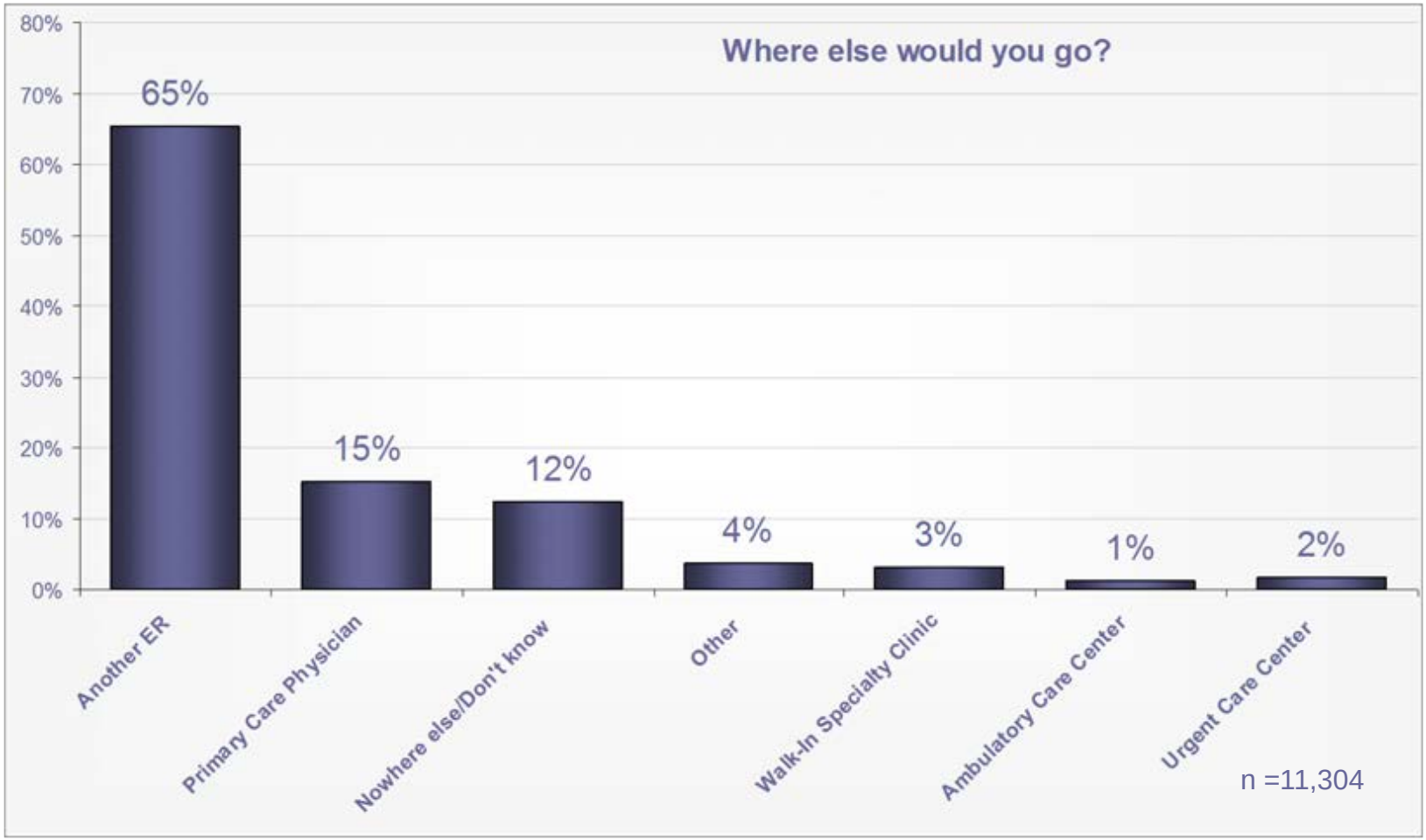
n = 10,953



ED Patient Survey

Preliminary Data – Where else would you go?

B - HIP



B - HIP

ED Patient Survey

Preliminary Data – PCP & Insurance Status by Age

Under 18			
	Have a PCP?		
Health Insurance?	NO	YES	Total
NO	4%	2%	7%
YES	10%	84%	93%
Total	14%	86%	2,222

25 - 64			
	Have a PCP?		
Health Insurance?	NO	YES	Total
NO	20%	4%	24%
YES	20%	56%	76%
Total	40%	60%	5,516

18 - 24			
	Have a PCP?		
Health Insurance?	NO	YES	Total
NO	21%	3%	24%
YES	26%	50%	76%
Total	47%	53%	1,251

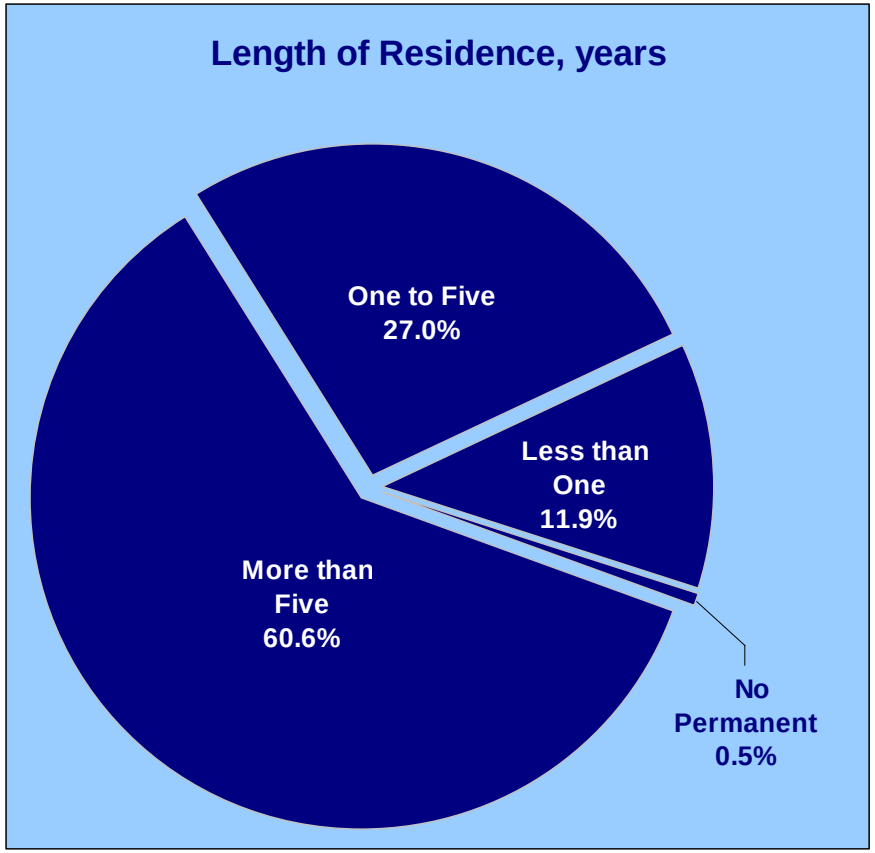
65 +			
	Have a PCP?		
Health Insurance?	NO	YES	Total
NO	8%	1%	9%
YES	11%	80%	91%
Total	19%	81%	1,165

- The Under 18 and Medicare eligible populations report significantly higher rates of insurance and of having a PCP

ED Patient Survey

Preliminary Data – Transience

B - HIP

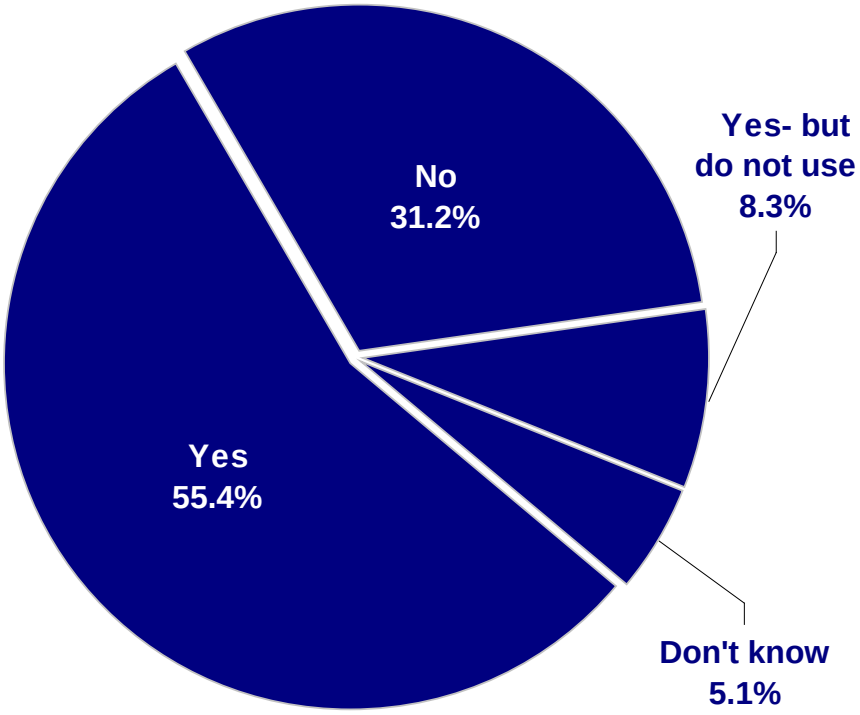


Length of time at current address, years				
Group	No. of Responses	% Insured	% with a PCP	% of Respondents with PCP that Do not use PCP
More than Five	6,676	82%	64%	13%
One to Five	2,976	80%	63%	12%
Less than One	1,312	72%	50%	14%
No Permanent	54	35%	24%	8%
Totals	**11,018**	**80%**	**62%**	**13%**

B - HIP

ED Patient Survey

Preliminary Data – Do you have a PCP?

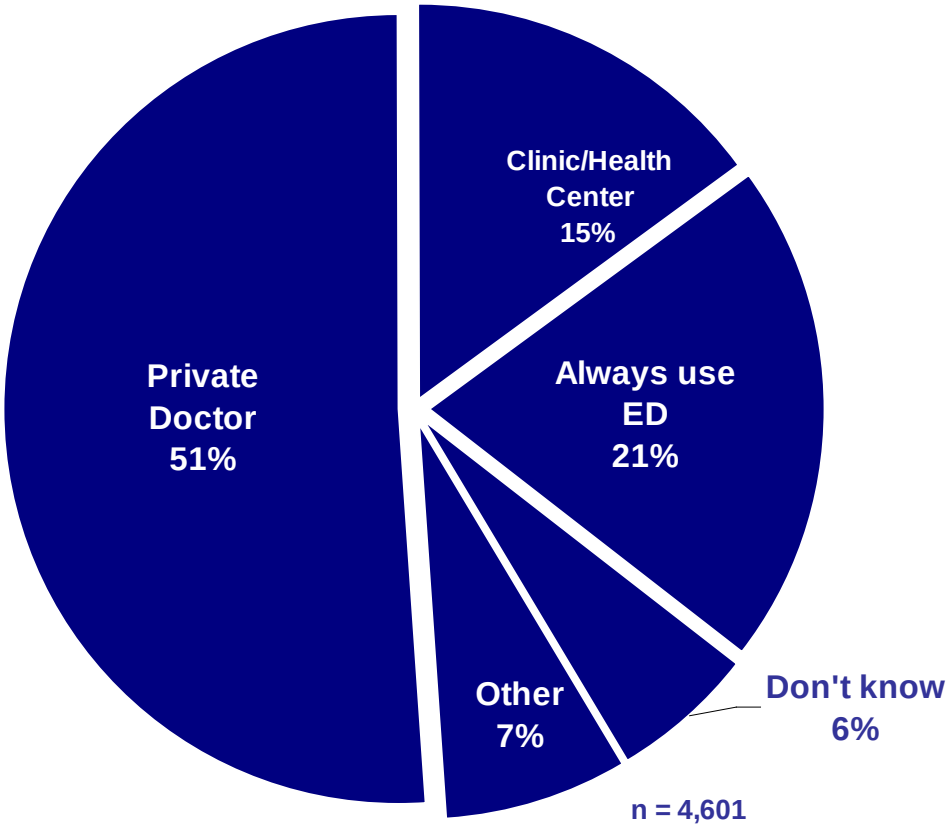


Have a PCP? (% by Ins Type)				
Ins Type	I don't know	No	Yes (incl. DNU)	*Total*
Commercial	3%	17%	81%	31%
Medicaid	8%	28%	64%	46%
MMC/CHP/FHP	3%	14%	83%	33%
Medicare	7%	18%	76%	16%
Uninsured	2%	80%	17%	28%
Other	10%	28%	62%	1%
Total	5%	31%	64%	10,693

B - HIP

ED Patient Survey

Preliminary Data – Last get your care outside of an ER



Always Use Emergency Room (951 respondents)	
Have a PCP?	
No	71%
I don't know	12%
Yes *(incl. 4% that do not use)*	15%
Insurance Status?	
Insured	56%
Uninsured	42%

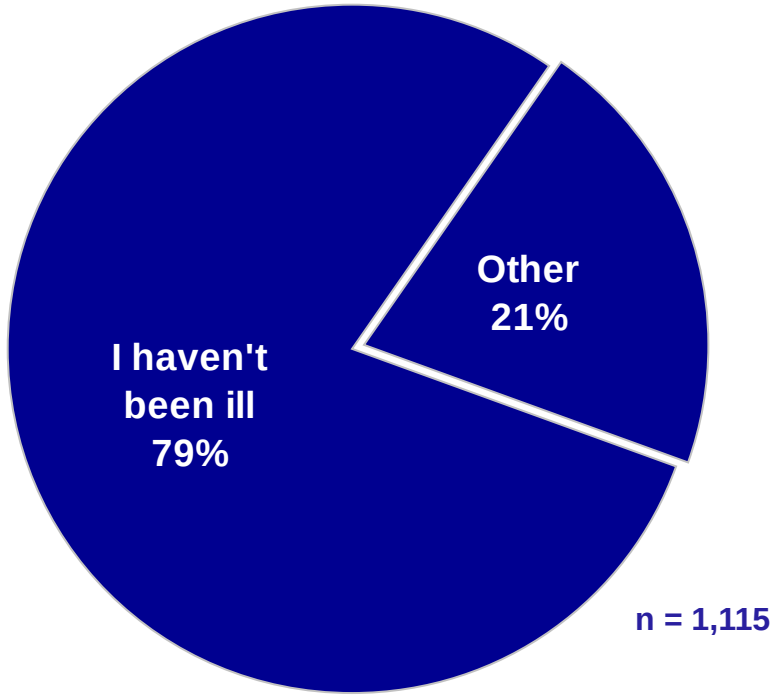
Gender	All Responses (n=10,888)	Always Use ED (n=951)
Female	57%	48%
Male	43%	52%

B - HIP

ED Patient Survey

Preliminary Data – Why haven't you seen your Doc?

Why haven't you visited PCP in the last year?

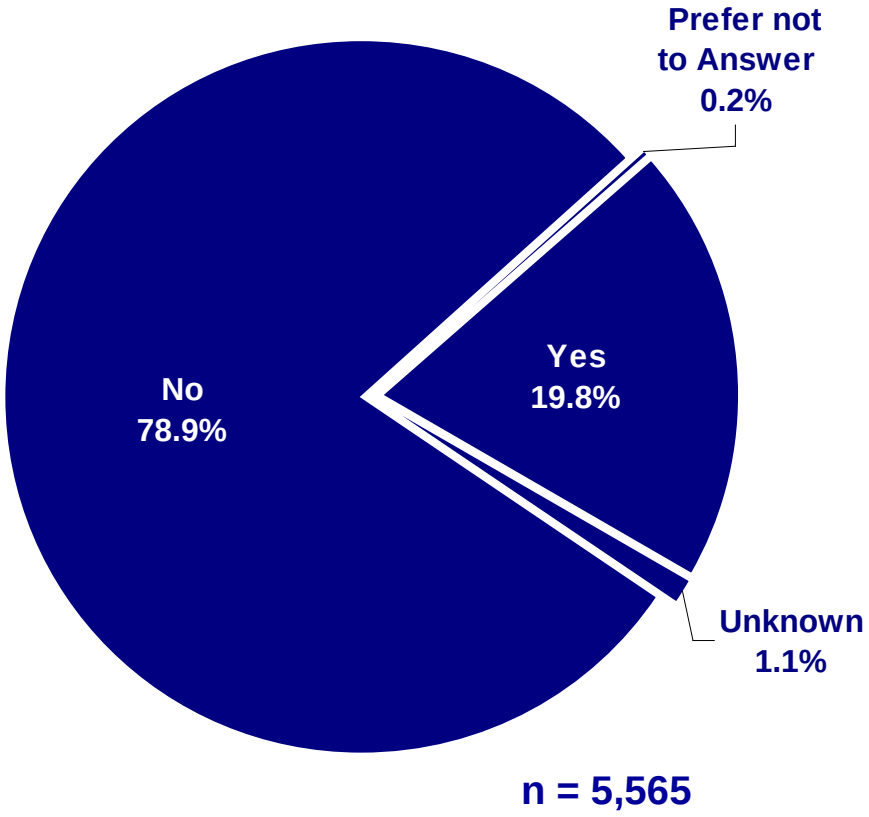


I haven't been ill (868 respondents)	
Insurance Status?	
Insured	78%
Un- Insured	22%

Insurer	Total	% Type
Commercial	134	15%
Medicaid	312	36%
MMC/CHP/FHP	146	17%
Medicare	77	9%
Other	7	1%
Total	676	78%

B - HIP

Admits in last 12 Months

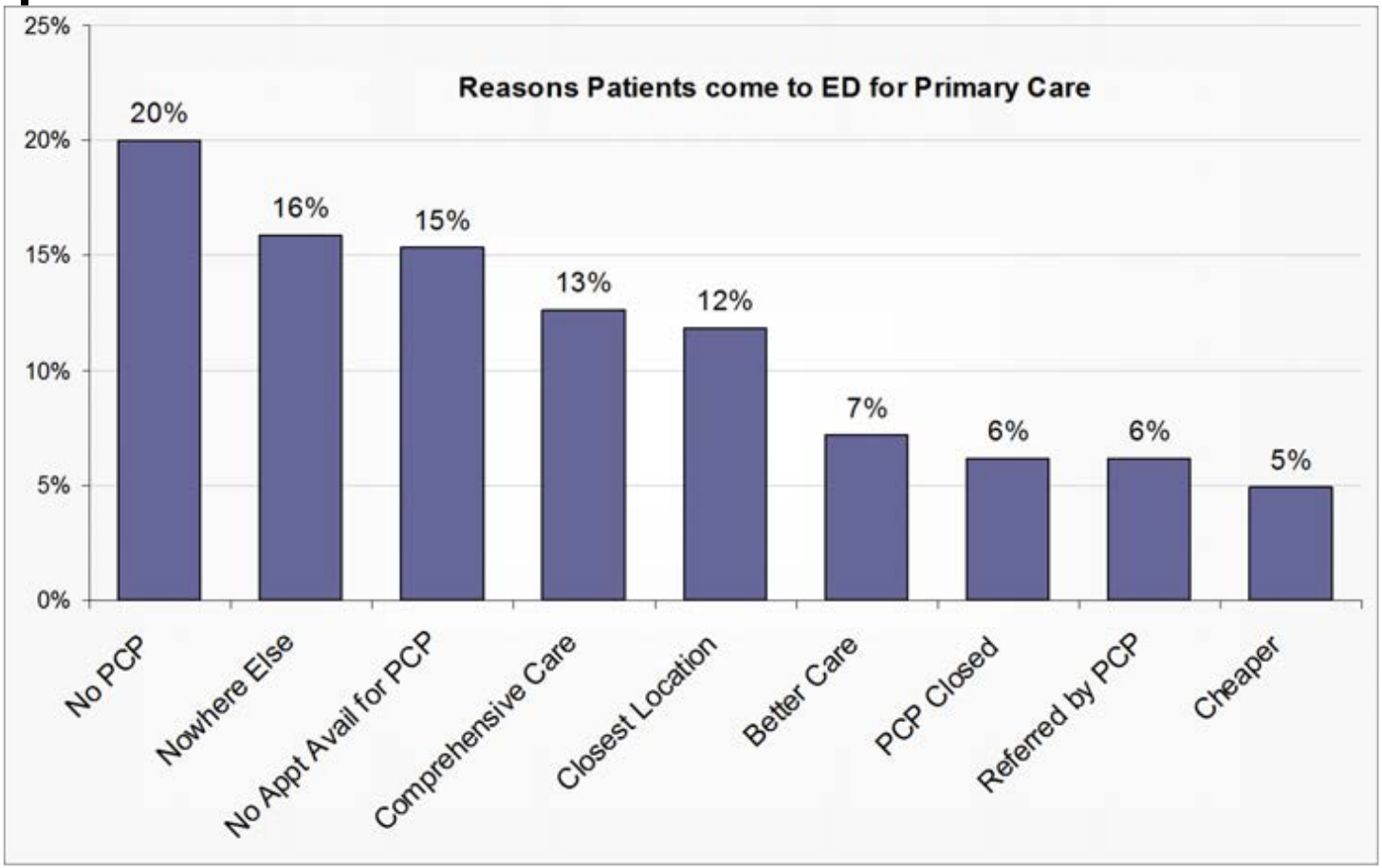


n = 5,565

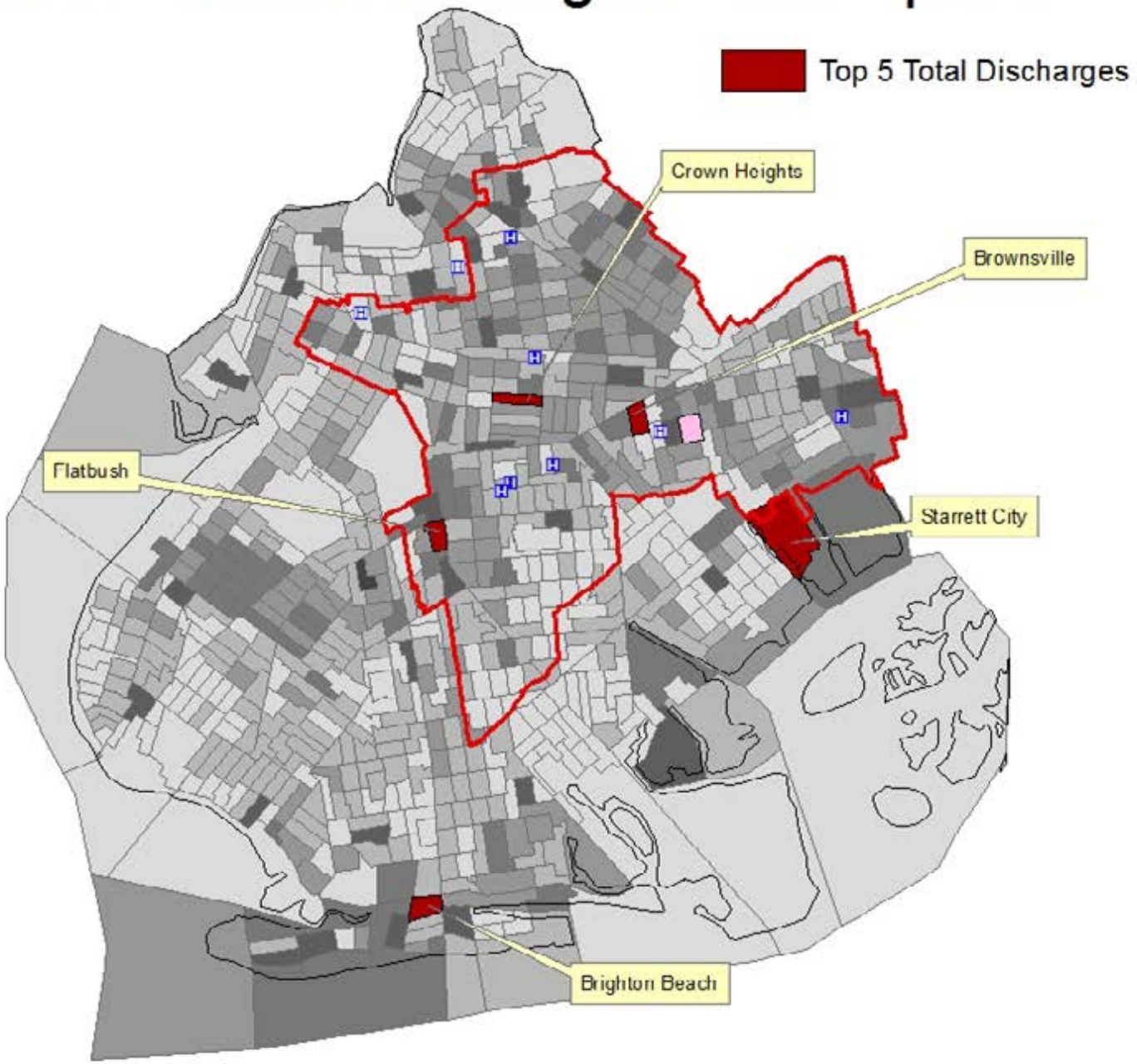
No. Times Admitted w/in Last 12 Months?	No. Respondents
Unknown no.	187
One	549
Two	216
Three	84
Four	30
Five	20
Six	10
Seven	2
> Ten	5
total	1103

* DATA ONLY AVAILABLE FOR ROUND 2

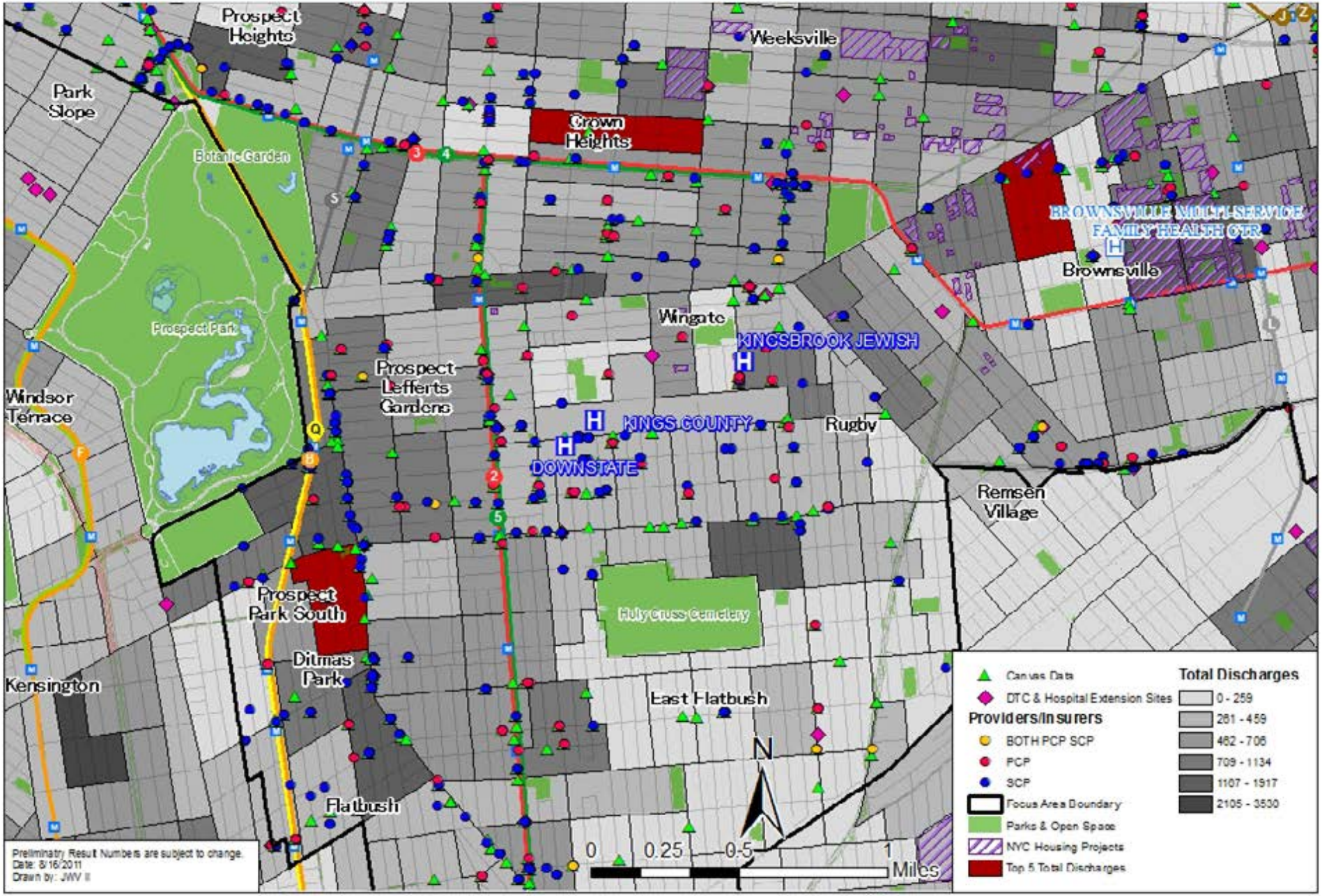
ED Staff Survey



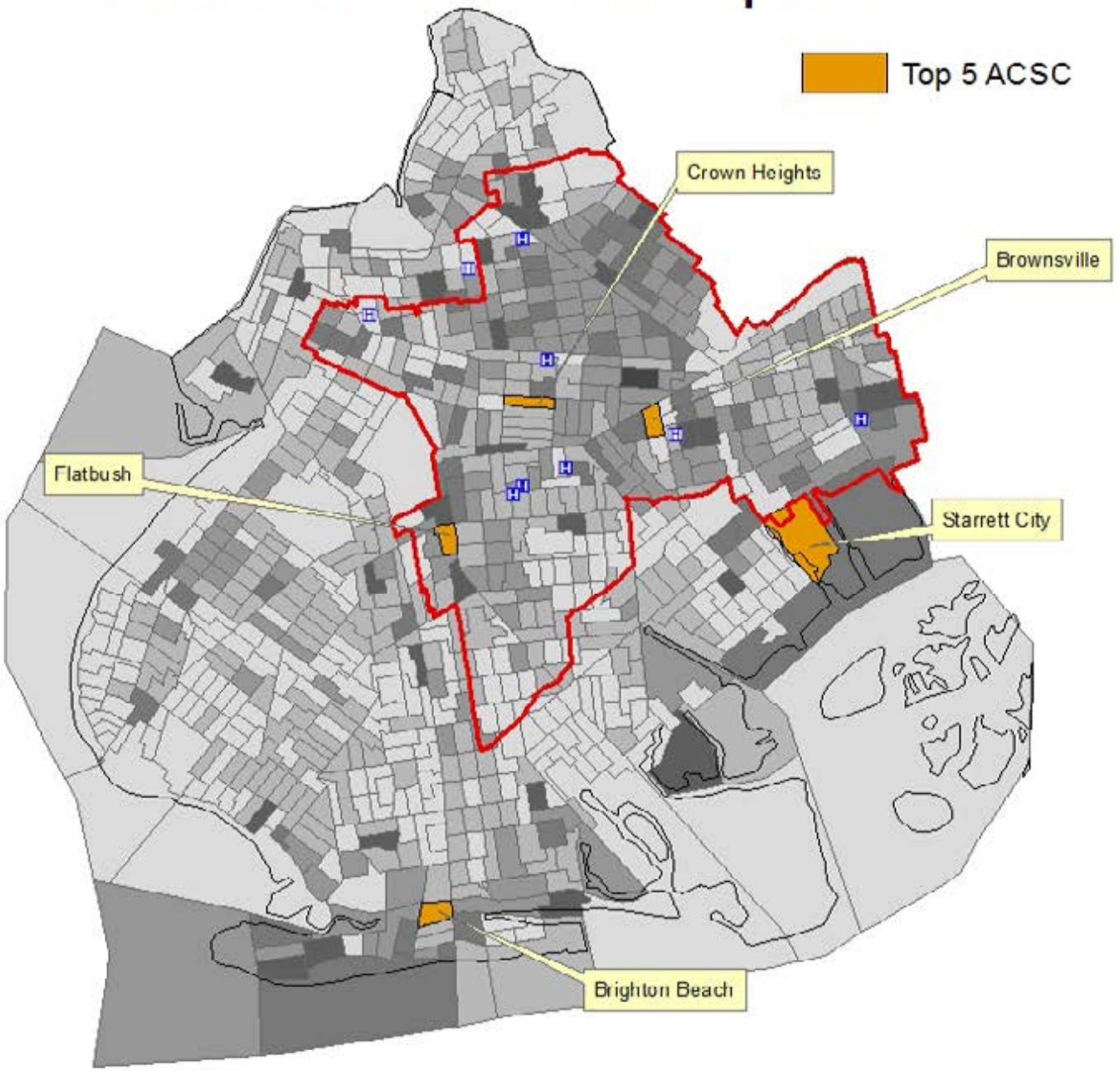
B-HIP Total Discharges - Hot Spots



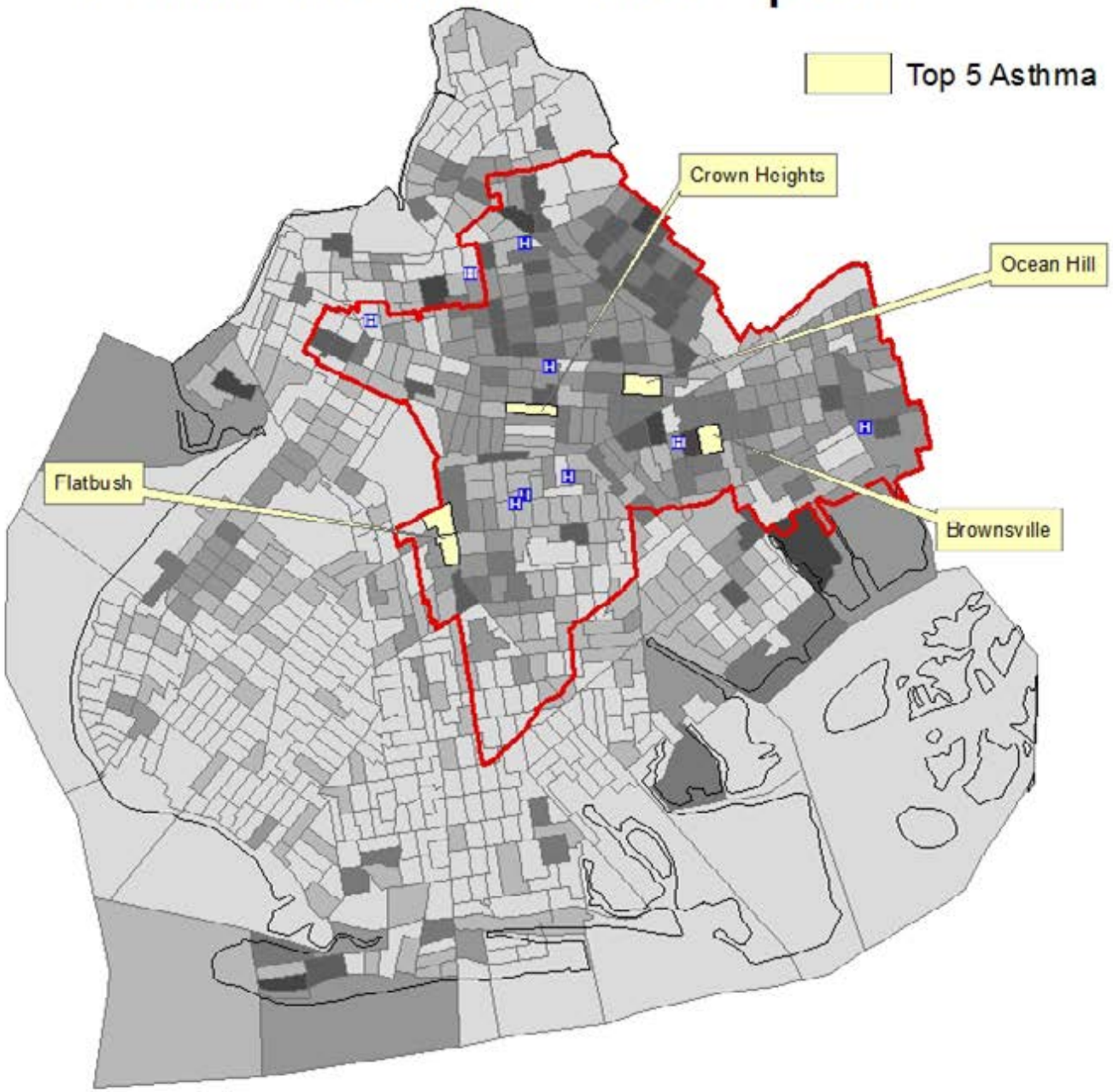
B-HIP Total Discharges, Hot Spot Focus Area #1



B-HIP ACSC - Hot Spots



B-HIP Asthma - Hot Spots



Preliminary Observations

General perception on ED patients is questionable

- No Insurance, no PCP, no check up

Reality check

- Most have insurance (over 80%), have PCPs, have check ups

ED patients are motivated to seek care:

- When needed
- Where they know they will be **comprehensively** serviced

This presents opportunities for further analysis and understanding of what the community needs are with regards to a health care delivery system that can respond to their needs.

More Analysis & data needed

- Availability and Accessibility to PCP– If yes, does it meet community needs with regard to access, convenience and perceived quality?

Preliminary Observations

B HIP sees opportunities to share this data to generate ideas for community/patient engagement strategies as well as ideas for health delivery system re-design to ensure that what is available to the community for their health care needs addresses the following:

- Accessibility
- Convenience
- Made known to the whole community at large and not just when seen by a medical provider
- Customization – one size doesn't fit all
- Impediments created by reimbursement rules

A Data Driven Approach –

Focus on Community Needs

- It is clear that there are huge disparities in the health status of residents in the B HIP study area compared to rest of NYS; NYC and Brooklyn county.
- Further exploration as to how the community is meeting their health care needs is needed – specifically, B HIP would like to assess how those who are not insured and/or how those not using area ERs are getting (or not getting) health care services.
- It is important to determine if and how the medical provider network within the target area is addressing these care needs (specifically, accessibility issues to care needs).
- Looking for quantifiable opportunities to make a difference and bear in mind that EDs are critical venues to obtain care from the patients' perspective.

NEW YORK state department of HEALTH

Redesigning THE MEDICAID PROGRAM

Medicaid Redesign Team: Brooklyn Redesign Workgroup

Obstetrical Services and Medical Malpractice

September 21, 2011

Total Newborn Deliveries 2009

Total Statewide: 241,200

- ✓ **New York City:** 116,128 — 48.2 % of State total
- ✓ **Rest of the State:** 125,072 — 51.8% of State total
- ✓ **Brooklyn:** 31,987 — 13.3% of State total (27.6% of NYC total)

Source: 2009 SPARCS data

New York Healthcare Liability System Landscape

- **Medical Malpractice premiums consume scarce health care resources.**
  - *OB physician premium downstate between $146,000-$200,000 and upstate between $53,000- $132,000.*
  - *On average, medical malpractice expense consumes 3-4% of a hospital budget.*
- **Obstetrical services drive increases in payouts.**
  - *Claims and payout growth for all cases over last 5 years have not increased markedly, except average payouts in OB have.*

New York Healthcare Liability System Landscape

- **Premiums continue to rise**
  - *Some reports of growth in premiums at 15-18% annually/Insurance Department approved growth at 5% on average for regulated carriers and 9.9% for MMIC.*
- **Limited number of underwriters of medical malpractice**
  - *No significant new entries into the market.*
  - *Captives and Risk Retention groups created.*

Malpractice Liability Cost is a Medicaid Problem

- Hospitals spend an estimated $1.6B on medical malpractice expense (3% of operating expenses).
- An estimated 35-50 % of medical malpractice premium is attributed to obstetrical cases.
  - *Of claims filed OB accounts for 18% of frequency of claims but account for 23% of the severity ($) of claims.*
- Medicaid pays for over 50% of the births in the State; higher in NYC.
- Expense has driven some providers to request closure of services creating access problems.

2011-12 Enacted MRT Legislation

- Medical Indemnity Fund (MIF) for birth related neurologically impaired infants that have received a settlement or jury award.
- Hospital Quality Initiative with an obstetrical safety workgroup.
- Hospital Quality contribution for the MIF and the initiative.
- County incentives for Medicaid lien recovery.
- Mandatory court settlement conferences for malpractice cases.

2010 AHRQ Grant

- **A three year AHRQ demonstration grant that DOH and Unified Court System are engaged in with five NYC hospitals .**

  - ***4 pronged demo that will:***

    - Further develop patient safety culture;
    - Implement specific clinical intervention;
    - Further develop in hospital disclosure and early settlement program;
    - Participate in judge directed negotiations with designated, trained judges.

The Future of Mental Health Services in Brooklyn

Bruce E. Feig

September 21, 2011

Current Mental Health System

- Over Reliance on Emergency & Inpatient
- Insufficient Functional Supports, (e.g. Housing, Employment, Schools.)
- Fragmented Care
- Poor Integration with Health Care
- “Casualty Model” Insufficient Early Intervention
- Lack of Accountability

Future Vision

- Consumers linked to accountable entities
- Health and Mental Health Integrated
- Emphasis on Outpatient Services, Functional Supports (e.g. peer wellness coaches)
- Engagement of Consumers not receiving services
- Early Intervention

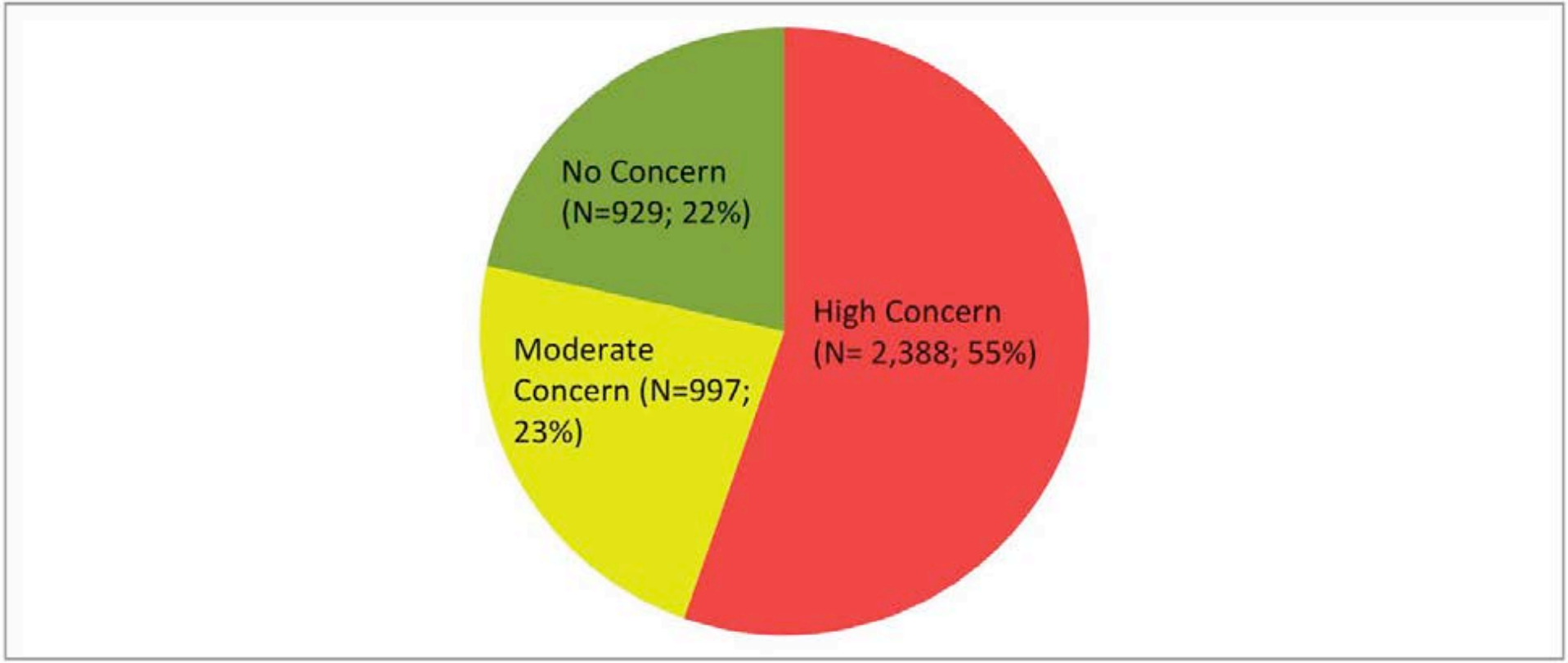
Brooklyn Care Management Initiative

- Started as Joint NYC/NYS Project
- Tracked High Needs Consumers Service Usage
- Results confirmed gaps in care
- Outreach to Providers

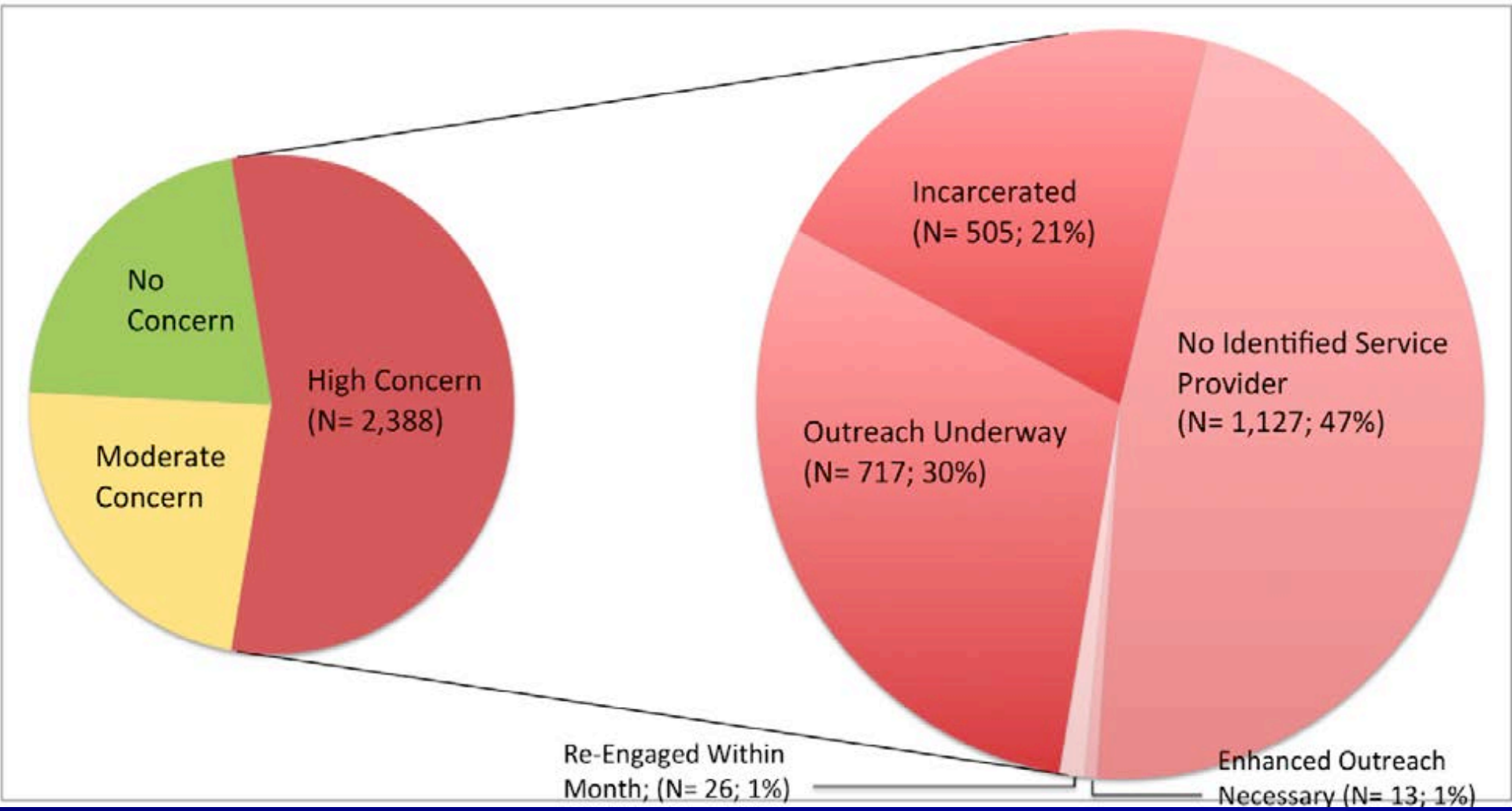
Care Monitoring Reviews, Brooklyn 2010

- 13,321 individuals in the high-need cohorts
- 10,118 (76%) met a notification at least once between Jan-Dec 2010
- Reviews were completed for 4,314 individuals

Category Assignments for 4,314 Completed Case Reviews, Brooklyn 2010



Classification of High Clinical Concern Cases



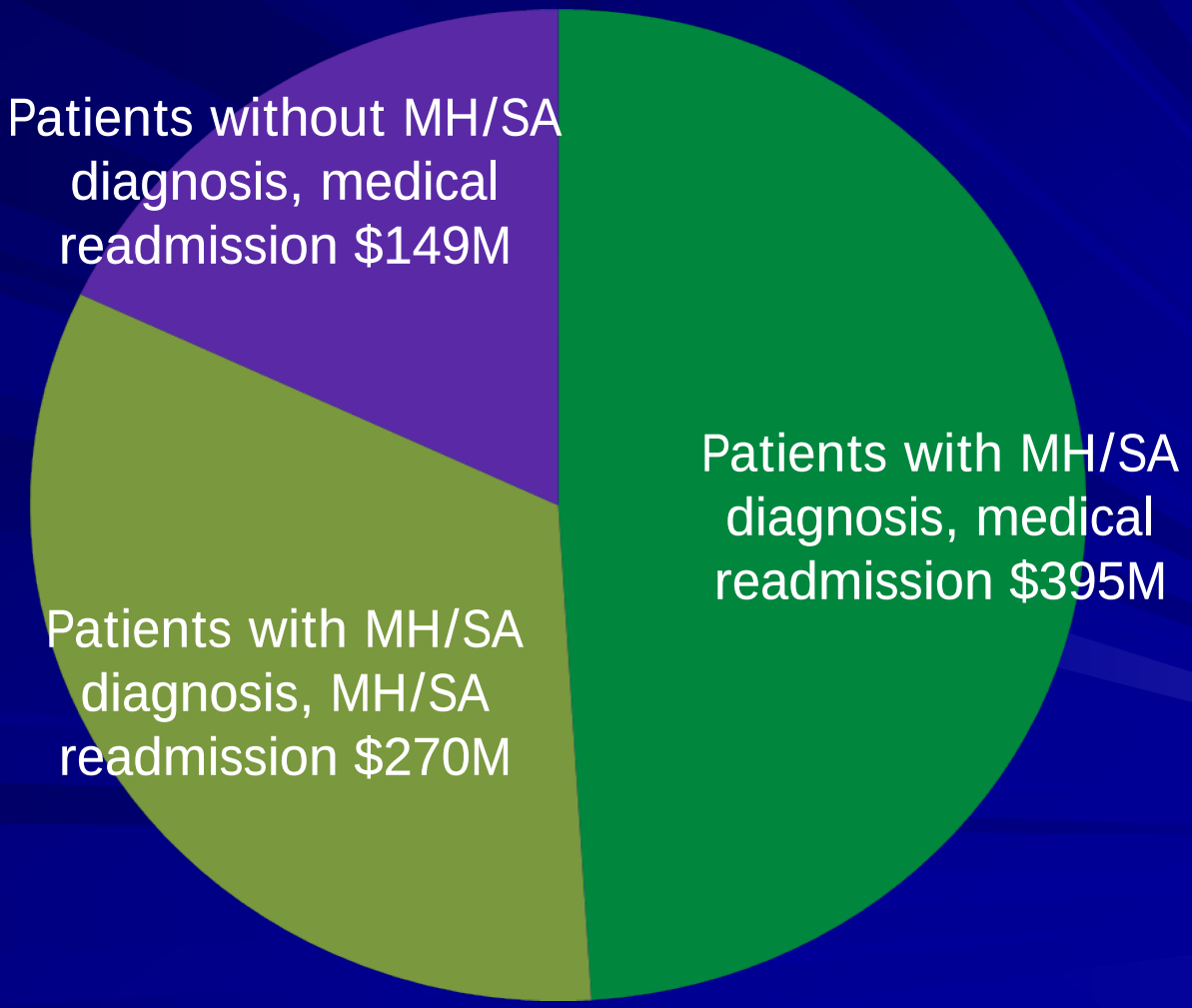
What have we learned?

- Medicaid claims data can identify individuals with SMI and high service needs who may need outreach and engagement.
- Many of those individuals are not engaged in adequate and appropriate services.
- Limits on cross-system information sharing impedes re-engagement and care coordination.
- Individuals enrolled in full-benefit managed care plans were just as likely to trigger notifications as those in fee for service.

Current MRT Initiatives

- Interim BHO Contracts
- BHO Task Force
- Health Homes

NYS Medicaid 2007:Absence of Care Coordination/ Potentially Preventable Readmissions (PPR's)



Example: Specialty Care Management Improves Utilization

(NYS Care Coordination Program—Erie, Monroe)

Better quality

- 46% decrease in emergency room visits per enrollee*
- 53% reduction in days spent in a hospital*
- 78% of enrollees report "dealing more effectively with problems" (2009 Enrollee Survey)

Better outcomes

- 31% increase in gainful activity*
- 54% decrease in self harm among enrollees*
- 53% reduction in harm to others*

Lower costs

•2008 Medicaid mental health costs for Care Coordination populations in NYCCP vs. comparison counties:

92% lower for inpatient services
42% lower for outpatient services
13% lower for community support

* 2009 Periodic Reporting Form Analysis

Interim BHO Contracts

- Single NYC Vendor
- Time Limited
- Focus on Inpatient Stay & Readmissions
- Facilitate Quality Discharges
- Develop Outcome Measures
- Engagement Activities Possible

BHO Task Force

- Recommend Approach to be Implemented in 2 years:
  - Enrolls all SMI & SED Individuals in Managed Care Approach
  - Integrates Behavioral & other Medical Care
    - Better Management of Common Behavioral Problems in Mainstream Health Plans/Settings
    - Integrated Care for People with Serious, Multiple Conditions – Health Homes
  - Emphasizes Quality Outcome Measures
  - Provides for Appropriate Care Coordination
  - Emphasizes Engagement
  - Supports Broader Range of Services
  - Consumer Oriented

Implications for Hospitals in Brooklyn

- Number of Beds Needed
- Emergency Services
- Role as Outpatient Provider
- Participants in Networks
- New Services in Managed Environment
- Role of State Psychiatric Center

MRT Health Systems Redesign
Brooklyn Work Group

September 21, 2011

Recommendation #5 of the Berger Commission Legislation

- Entity to have unified management with powers sufficient to compel the service mix provided at any of the individual institutions under its control

- Joined entity will utilize existing infrastructure to the extent possible to consolidate all necessary services into clinical centers of excellence, including teritary, quaternary, psychiatric and long term care services

Recommendation #5 of the Berger Commission Legislation

- Entity should develop new infrastructure in which to locate comprehensive heart and vascular services

- Entity to present to the State Legislature any necessary draft legislation in a time and manner sufficient to implement this recommendation

New Entity

- Currently referred to as Great Lakes Health System of Western New York (GLHWNY)
- 17 Member Board
- Robert Gioia, Chair
- James Kaskie, President and CEO

Great Lakes Health of Western New York Board of Directors

Board Mix

- Community Leaders
- ECMC
- Kaleida Health
- University at Buffalo
- Great Lakes Health CEO

Board Committees

- Finance
- Governance
- Professional Steering
- Strategic and Community Health Planning

Reserved Powers

- Approve and coordinate submission of CON applications
- Negotiate and approve any and all managed care contracts
- Develop operating budget for GLHWNY and approve and over see operating budgets for ECMC and Kaleida Health
- Approve and oversee the capital budgets of GLHWNY, ECMC and Kaleida Health
- Develop, approve and oversee the implementation of strategic plans for GLHWNY, ECMC and Kaleida Health
- Approve unbudgeted expenditures greater than $500,000 in any twelve month period or any contract or series of related contracts obligating ECMC or Kaleida Health to make unbudgeted capital expenditures greater than $1,500,000
- Approve the transfer or closure of a service

Reserved Powers

- Develop a system-wide consolidated quality improvement program
- Approve any new affiliation between GLHWNY, ECMC or Kaleida Health
- Coordinate and approve any physician recruitment activities of ECMC and Kaleida Health
- Approve the addition of any new regionalized health care services
- Approve any merger, consolidation or transfer of assets of ECMC or Kaleida Health, a change in governance structure or rules for ECMC or Kaleida Health or the dissolution of ECMC or Kaleida Health
- Approve the closure of any ECMC or Kaleida Health facility or of a major service of ECMC or Kaleida Health
- Approve borrowings by ECMC or Kaleida Health in excess of $1,000,000 per loan unless such borrowings are included in that organizations budget
- Approve the overall marketing and advertising plans for GLHWNY, ECMC, and Kaleida Health.

Great Lakes Health Overview

- Six Hospitals
  - 81,000 admissions
  - 200,000 Emergency Department Visits
- Five Long Term Care Facilities
  - Average Daily Census – 1195 residents
- Home Health Agency
  - 320,000 visits annually from eight counties
- Ambulatory Practices
  - 440,000 visits

Great Lakes Health Overview

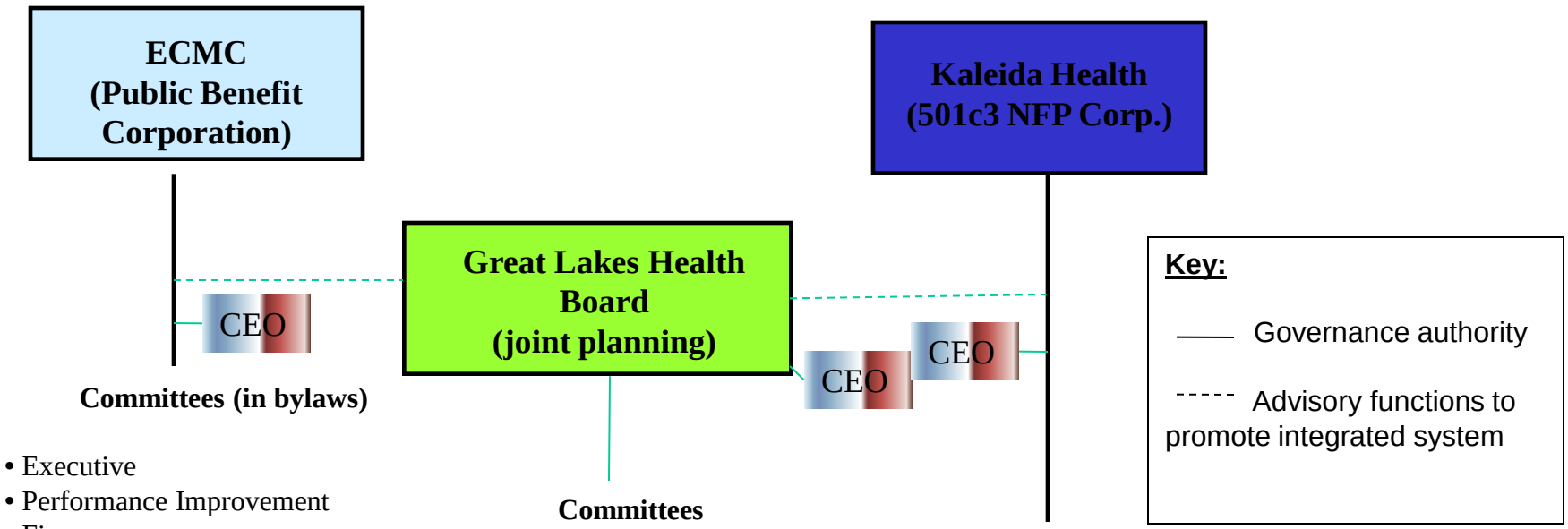
- $1.5B Net Patient Service Revenue
- Progressing towards a single operating platform
- 17 member volunteer board
- 12,500 employees
- 2,000 physicians
- 40% market share of eight counties of WNY

Campus Development: North End

Progress Report: GLHWNY/Kaleida Health/ECMC

- Alignment of the transplant programs with leadership named and the business model defined;
- Development of a coordinated replacement strategy for long term care facilities underway at the BNMC and Grider campuses where Kaleida supported the filing and approval of the CONs, HEAL dollars and other matters;
- Common consultants to advise the Professional Steering Committee process now resulting in a clearer roadmap to develop service lines and investments required;
- Use of Kaleida's General Physicians, PC to support and align physicians;
- Completion of one affiliation agreement with UB;
- Plans to introduce OB and Peds services under the WCHOB brand on the Grider Campus;
- Retained consultant to paint a road map for integration and begin to achieve value in purchasing goods and services;
- Ability to coordinate and decipher various clinical strategies to insure coordination and not competition in areas like wound care, behavioral health and cardio-vascular; and
- Full transparency across the boards and leadership teams building trust every day.

Current Governance Model (simplified)



Committees (in bylaws)

- Executive
- Performance Improvement
- Finance
- Audit and Compliance
- Building and Grounds
- Human Resources
- Joint Hospital/University Education
- Exec. Compensation/ Evaluation
- Ethics
- Cardiac Care
- Erie County Home/LTC QI
- Governance
- Investment
- Business Development (not in bylaws)

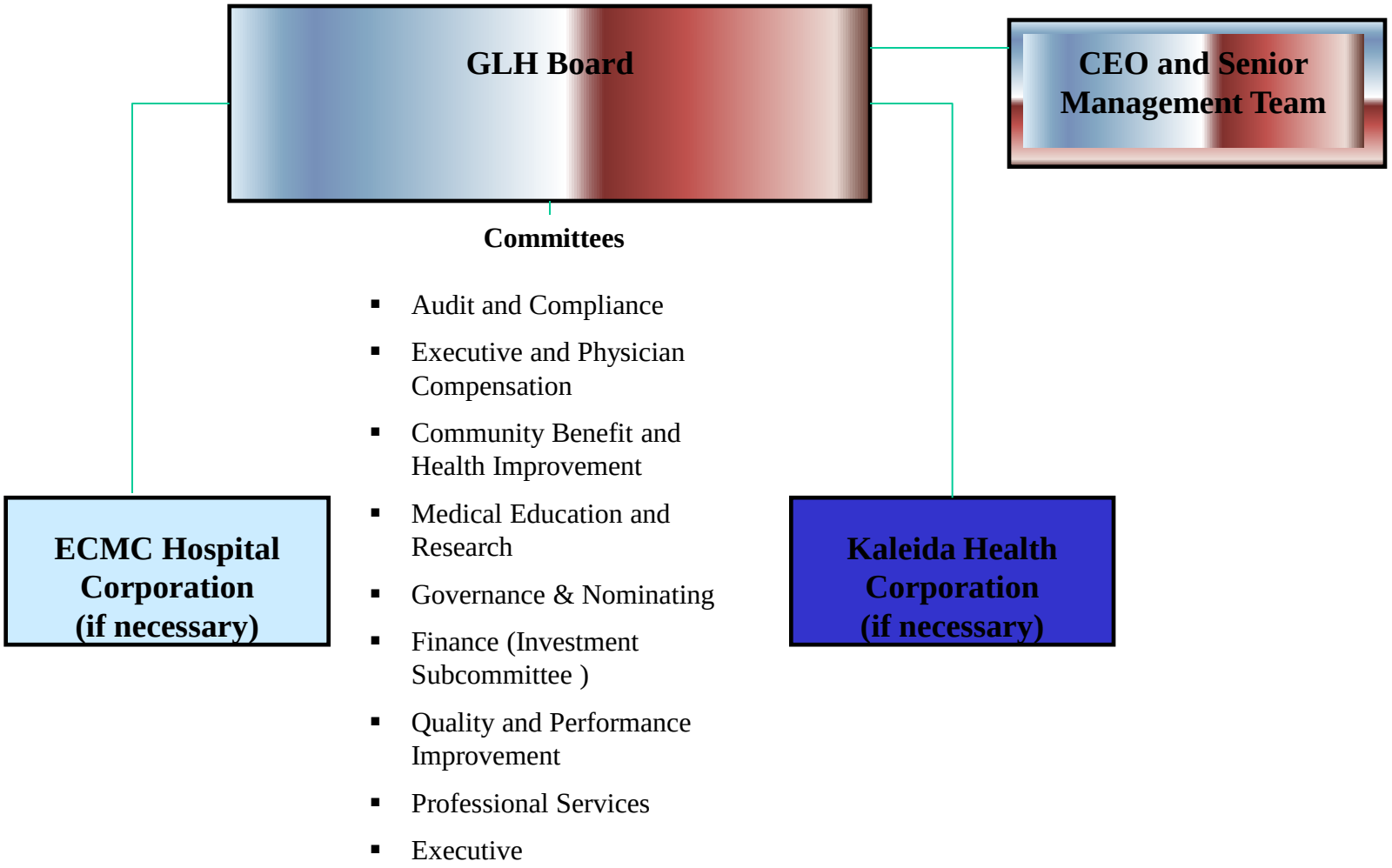
Committees

- Strategy and Community Health Planning
- Governance
- Finance
- Professional Steering
- Nominating

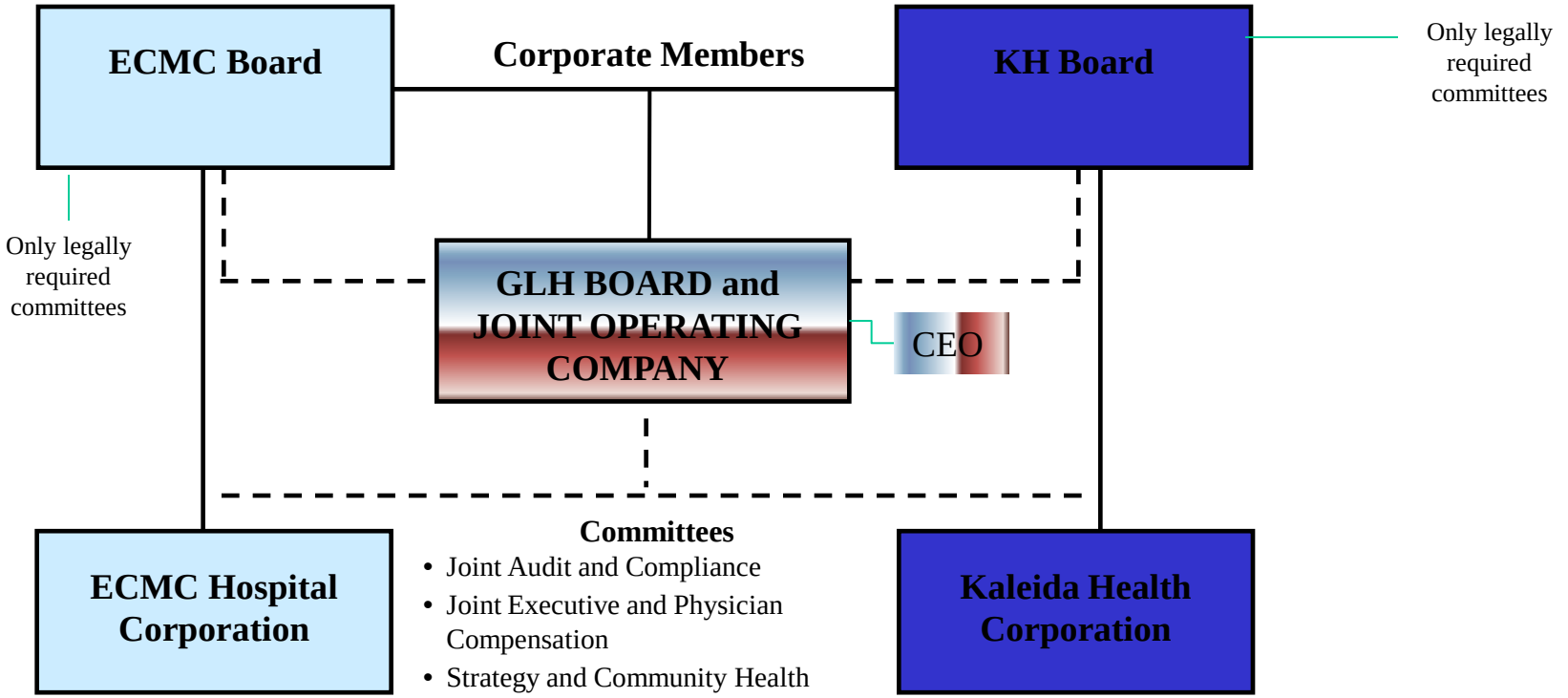
Committees

- Audit and Corporate Compliance
- Compensation
- Finance
- Investment Subcommittee
- Nominating and Corporate Governance
- Quality Improvement and Patient Safety

Fully Integrated GLHWNY Governance and Management Model



Three-Board Joint Operating Company



Committees

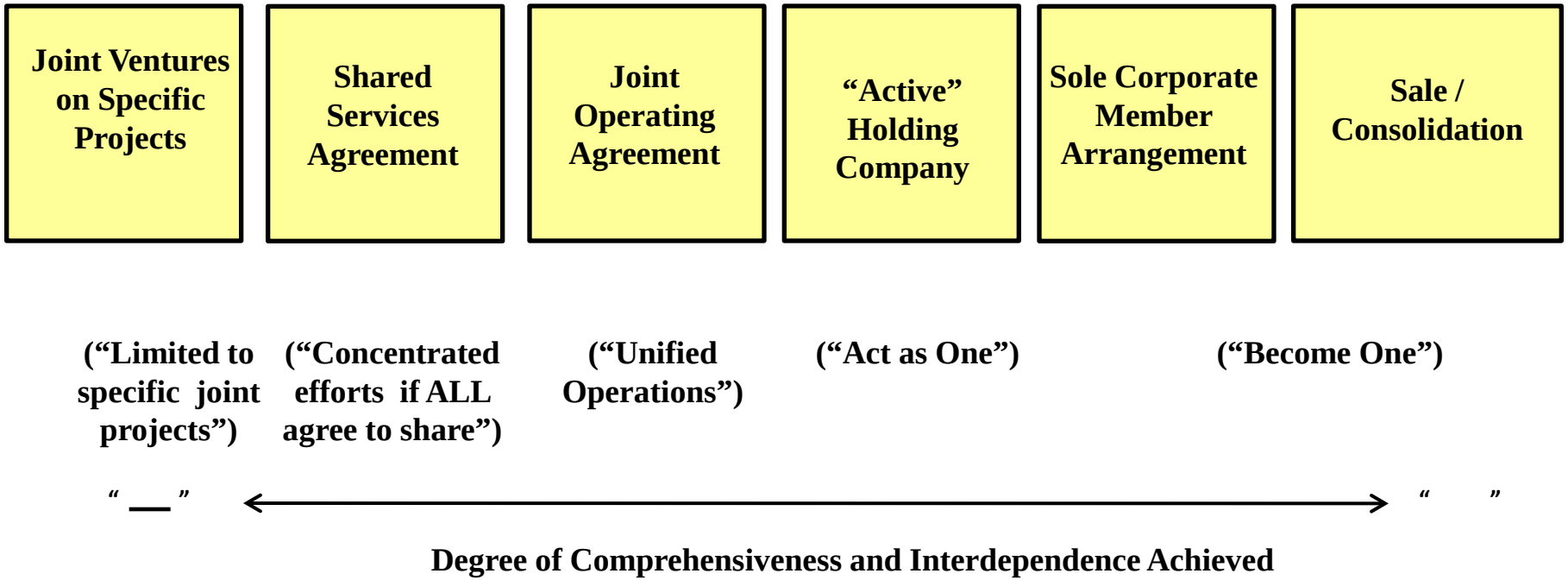
- Joint Audit and Compliance
- Joint Executive and Physician Compensation
- Strategy and Community Health Planning
- Joint Medical Education & Research
- Joint Governance and Nominating
- Joint Finance
- Joint Investment Subcommittee
- Joint Quality and Performance Improvement
- Professional Steering

Key:

Governance

Joint Operating Agreement

“Partnership” Structures



Guiding Principles for Affiliation Discussion

- We believe in local control for governance and decision-making
- Protect fiscal integrity of both parties
- Our strategy is to complement, not compete
- Our approach for level of involvement is flexible
- The relationship should bring value to both parties, and promote sustainability and viability
- We respect patient and physician choice
- We are committed to making an investment after a market assessment is completed, and both parties have an understanding of community need
- A shared vision is a fundamental element of success

Affiliation Models

- Contractual relationship for services
- Joint operating agreement
- Merger
- Each model varies with respect to:
  - Governance
  - Control
  - Capital

Clinical Service Line Planning

1. Initiate a planning process that engages physicians and is data driven
   - Complete a market assessment
   - Determine service expansion/consolidation
   - Identify revenue opportunities/cost savings
   - Identify opportunites to grow market share
   - Acquire and apply required resources
   - Implement and measure success
2. Drive investments in infrastructure and programs that create value

Freestanding Emergency Department

Fred Bentley, Managing Director,
Advisory Board Company

Brooklyn Redesign Work Group

Medicaid Redesign Team Directional Updates

Presented by:
Jason Helgerson, Medicaid Director
New York State DOH
September 21, 2011

Health Homes

What is a Health Home?

"The goal in building "health homes" will be to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses." - *CMS Medicaid Director Letter*

Health Homes Timeline

Phase 1 applications due October 5 with expected implementation in November

Complete roll out under development

Issues under consideration:

1. Roll out of CIDPs, TCMs, and MATS programs not in the identified Phase I counties.
2. Phase II application due date expected February 1; counties TBD based on preparedness and capacity.
3. Phase III TDB

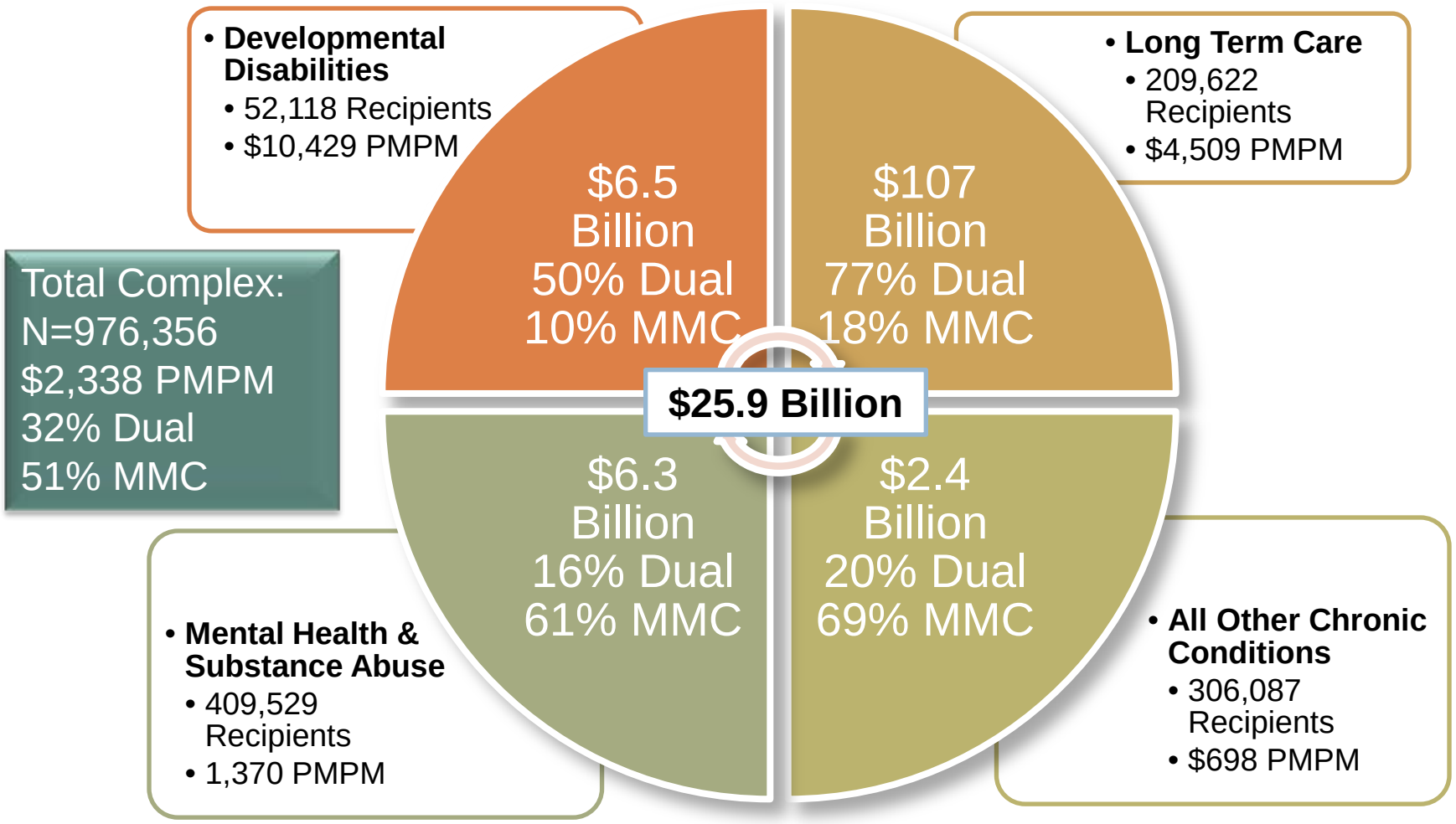
Health Homes Timeline

New timeline under development

Phase 1 Counties include:
Brooklyn, Bronx,
Nassau and Monroe

Assessing regional need and proposed network preparedness to determine additional counties for Phase I.

Health Home Populations



Proposed Quality Measures for Health Homes

** Many of these measures are targeted at reducing cost.*

Health Homes: Payment

- PMPM care management fee that is adjusted based on:
  - *Region*
  - *Case Mix (from Clinical Risk Group (CRG) method)*
  - *A volume adjustment may be used*
  - *Fee will eventually be adjusted (after the data is available) on patient functional status*

Health Homes: Payment

- A lower fee (80 percent of full fee) may be paid during outreach and engagement.
- A portion of the fee may be retained (10 percent) against achievement of core quality measures.
- Gainsharing on the state share will be at 30 percent of demonstrated State share savings (up from the preliminary 15 percent).
- Gainsharing on federal share of both Medicaid and Medicare is under discussion with CMS.

Health Homes:

A step toward integrated care and consolidated accountability

- Health homes provide a platform from which to study cost effective care management and network management design (including promising HIE models)– perhaps a precursor to ACO-type relationships with advanced provider networks to share risk and reward.

Payment Reform

MRT Approach to Payment Reform

- New York wants to eliminate fee-for-service.
- New York wants to convert to care management for all (capitation).
- Contracted plans must also move beyond fee-for-service.
- New York is exploring multiple reforms (ACOs, bundled payments, risk-sharing, etc.)
- Separate work group focused on payment reform.

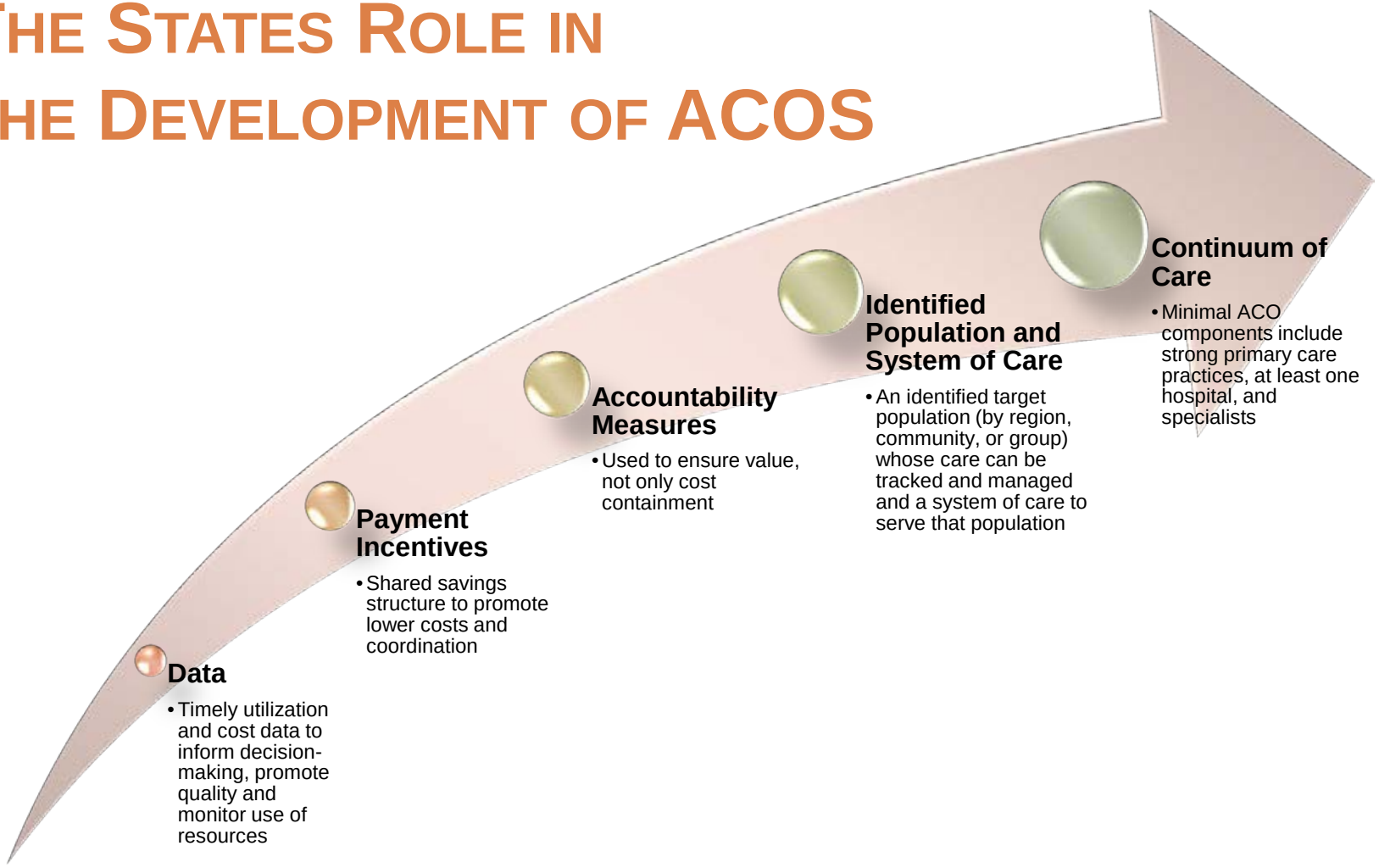
Payment & Quality Measurement Examples

Name	Payment Measures	Quality Measures
Brookings-Dartmouth	•3 potential incentive pools for distribution •Shared savings to offset lost revenue due to change in practice patterns •Shared savings for cost savings •Incentive pool for return of capital to the principle ACO investors	•Phase in of performance measurement to align with access to multiple data sources so that ACOs with a "basic" health IT infrastructure are phased in a different rate than ACOs with an "advanced" health IT infrastructure •4 categories of quality measures: care effectiveness/population health, safety, patient engagement, overuse/efficiency •Measures based on widely accepted and endorsed measures •Performance benchmarks to be met in order to earn points and become eligible for shared savings
Colorado	•Payers: Medicaid, dual eligibles after 15 months •Hospital inpatient & outpatient •Performance target: % improvement compared to regional historical baseline •Capitation payment with shared savings •Incentive payment: 66% to 100% of full amount •Regional shared savings expansion phase (7/1/2012)	

Payment & Quality Measurement Examples

Name	Payment Measures	Quality Measures
Massachusetts	•Global Payment: Blue Cross Blue Shield to cover all of the services and costs: hospital inpatient, outpatient, pharmacy & behavioral health •Based on risk adjusted average medical expense in geographic region •Performance Incentive based on aggregate performance across the set of ambulatory and hospital performance measures	•Requirements: 32 ambulatory measures and 32 hospital inpatient measures •3 categories of quality measures: processes, outcomes, patient experience •Each measure has designated performance thresholds ranging from low to high •Scores for all measures are weighted and summed to a total score
Vermont	•Multi-payer collaborative shared savings ACO pilot January 2012 •Primary care/physician based •Negotiated per capita benchmark based on its current provider contracts •Participation and shared savings models •May require medical home as the ACO center	•National Committee for Quality Assurance guidelines

The States Role in the Development of ACOS



NEW YORK state department of HEALTH

Redesigning THE MEDICAID PROGRAM

Medicaid Redesign Team:
Brooklyn Redesign Workgroup

Federal State Health Reform Partnership (F-SHRP)
and
Healthcare Efficiency and Affordability Law for New Yorkers (HEAL-NY)

September 21, 2011

Key FSHRP Facts

- Governor's Healthcare Reform Workgroup
  - Recommendations to right-size and restructure acute and long term care delivery and invest in HIT and ambulatory care
- State HEAL funding insufficient to meet full need
- Recognized benefits to both Federal and State
- Federal investment necessary; commitment of $1.5B
  - 1115 waiver savings as vehicle for federal investment
  - Federal approval received for 5 year waiver effective 10/1/06 through 9/30/11, **recently extended through 2014**.

FSHRP Goals and Objectives

- Promote the efficient operation of the healthcare system.
- Consolidate and right-size healthcare system by reducing excess acute care capacity.
- Shift emphasis in long-term care to from nursing homes to community settings.
- Expand use of e-prescribing, electronic health records and RHIOs.
- Improve ambulatory and primary care.
- Reform activities consistent with goals of HEAL-NY.

Healthcare Efficiency and Affordability Law for New Yorkers (HEAL-NY)

- Established by Chapter 43 of the Laws of 2004 (amended in 2006 and 2009) to invest up to $1 billion in state resources over 4 fiscal years.
- Provides grants to “match” F-SHRP funds to invest in:
  - Health information technology;
  - Restructuring of healthcare services;
  - Support for hospitals to transition to the new Medicaid FFS rates;
  - Capital access initiatives
- Sources of funding for HEAL-NY included Personal Income Tax state supported bond funding issued by DASNY and state capital appropriations

FSHRP and HEAL-NY Investments

- **$591M** for restructuring hospitals and nursing homes to reduce excess inpatient capacity.
- **$550M** to assist hospitals and nursing homes to implement Commission on Health Care Facilities in the 21st Century determinations.
- **$100M** in investment to clinics and hospitals to expand primary care services.
- **$397M** to support Health Information Technology.
- **$350M** for reconfiguration of nursing homes and development of alternatives.
- **$60M** in Queens and Manhattan to support community access due to hospital closures.
- **$15M** for local and regional planning.

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Private investment in community health systems for Medicaid redesign

September 2011

pwc

Concept

Need to create an environment that can attract private investment to support a sustainable, redesigned healthcare delivery model.

Why?

With the redesign of payor models to promote sustainable change in communities' health systems and their transformation to patient centered care models, additional sources of capital are required.

How?

Isolate bad assets and liabilities to create a more stable environment for investment

Healthcare stakeholders redesign and redevelop the current system to a new structure, which embraces two essential elements:

- An advanced patient centered care model that enhances quality and value: integrated care
- A redesigned payment structure: capitation which:
  - Services debt
  - Reinvests in the community
  - Provides a return on investment

Private investment brings needed capital to healthcare assets, facilitating a transition to more effective models of care

Capital is needed to:

Develop new infrastructure that focuses on preventive and primary care

Change/renovate existing infrastructure

Develop a health IT and technology foundation for care coordination and patient engagement

Invest in shifting the model of care

Reinvest in the community

Potential sources of capital:

Financial investors

State sponsored

Strategic investors

A Virtuous Cycle

Private investors realizing a return will be interested in reinvesting at higher levels ongoing

Redesigning today's model by creating an institutional structure

Remove bad assets and liabilities from balance sheets of providers

This will provide a clean slate for private investment to occur by making remaining assets more attractive for investment

This is the catalyst to begin the redesign process

By agreeing to remove bad assets and liabilities, providers commit to redesigning the care model and participating in the new payment structure

Integrated care model:

- Leads to savings and cash flow

Capitation

- Leads to predictability over the long term and a more stable investment environment

Private investors may be able to extend their investment horizon with confidence, adjusting their return expectations and investing at higher levels.

An integrated care model can deliver higher value at a lower cost than existing care delivery models

Key differences

Component	Existing Care Model	Integrated Care
Focus of health services	• Tertiary care	• Preventive & primary care & population health
Reimbursement	• Incentives encourage volume	• Incentives encourage care coordination & low volume
Accountability	• Fragmented	• Shared

Where are the savings?

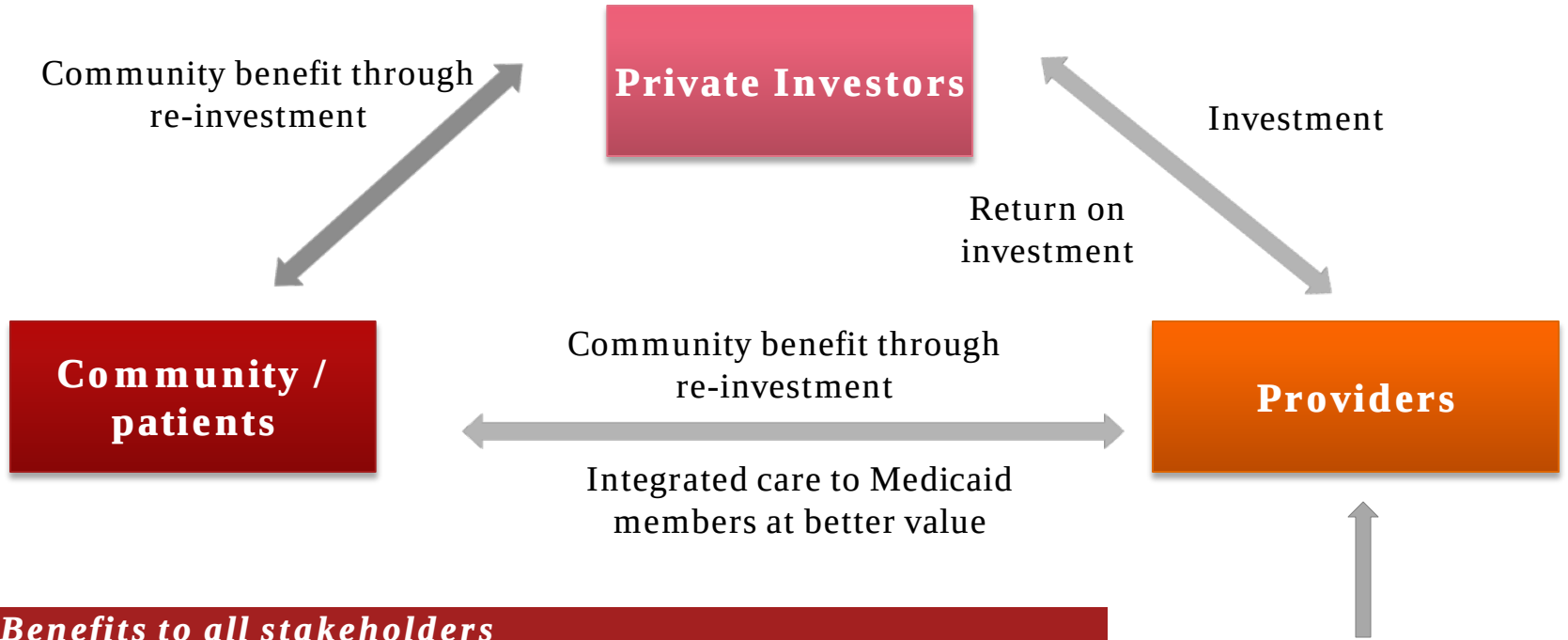
- Hospital reductions – 15-20%
- ER visit reductions – 15-20%

Sample pilots include:

- Geisinger Health System
- Intermountain Health
- Community Care of North Carolina
- Vermont BluePrint for Health
- Colorado Dept. of Health Care Policy

SOURCES Colorado Department of Health Care Policy and Financing; Geisinger Health System; Notes 12–15 in text; Care Management Plus; Community Care of North Carolina; and Vermont BluePrint for Health. NOTES Not all metrics reported. Unless indicated otherwise, data are based on as-reported outcomes, reduction from baseline. ER is emergency room. [a]$169 for all patients; $530 for patients with chronic conditions. [b]Change relative to control group. See Note 12 in text, p. 2998, for more detail. [c]4.8 percent for all patients; 19.2 percent for patients with complex illnesses. [d]No change for overall population; 7.3 percent for patients with complex illnesses. [e]Only for asthma patients. [f]Based on Aid to Families with Dependent Children (AFDC) program savings from fiscal year 2007 ($135 million) and Aged, Blind and Disabled (ABD) program savings from fiscal year 2008 ($400 million). [g]Expected.

Summary



Benefits to all stakeholders

- Predictability of revenue stream / cash flow from capitation attracts private investment and better budget planning
- State Medicaid can demand a higher level of performance and outcomes that it currently does
- Enables transition to integrated care and sustainability
- Outcomes determine payment so incentives are aligned