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HEALTH PLANNING COMMITTEE
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ESP, CONCOURSE LEVEL, MEETING ROOM 6 ALBANY
TRANSCRIPT

Dr. Rugge This meeting, like all the others, has to start with the standard Miranda warning. We are being webcast. Important for people to identify themselves before speaking and not to rustle the papers too loudly and to be aware that we are being captured and recorded. You have to start in the only possible way with the big picture saying that we have a health care system under very severe stress, perhaps at the brink of a true crisis. As part of that or evidence of that some months ago, the State Emergency Services Council and the person of Marc brought to Steve an issue perceived delays in offloading ambulances and the emergency department setting with waits, sometimes extending for hours in the parking lot. In response for the first time in eight years, the Department of Health brought these issues to PHHPC and its Planning Committee for consideration and address. All this in the face of severe EMT workforce issues, loss of ambulance companies and all the other post-COVID problems. Even a quick look at the unloading, offloading problems led to consideration of overloading and boarding in the emergency departments, overloading of inpatient services with difficulties in obtaining admission, and also difficulties with getting discharges because of stresses on the long-term care system, with nursing home beds being closed for staffing and financial reasons. All this would suggest a need for system reform, a level of activity clearly broader, bigger and more intimidating than we as a council can possibly manage. System reform has to start someplace. It seems the ambulance unloading ramp, offloading ramp is on most poetically some poetically appropriate for a starting point talk about how to help our health care system function more appropriately. All of these observations were made at a previous committee meeting in February, and since then, DOH staff, certainly especially in the persons of Dr. Morley and Dr. Heslin, have been very supportive and very active and trying to look for ways in which we can address ED delays. Through their efforts, came to appreciate that there are two apparently special opportunities to start with. One is the presentation of patients with mental health problems in the ED setting. High volumes with low ability of the ED staff, the usual ED staff to really address those problems and those patients effectively. Also, non traumatic dental visits where the only possible treatments would be antibiotics and pain relief. Yet 17% of avoidable hospital stays or E.R. visits are ascribed to dental causes. With much help of our staff and lots of legal advice, we were able to convene two workshops, unofficial committee meetings, which really served as educational sessions so we could be well-informed or at least better informed in terms of how best to proceed. On the mental health side, we were privileged with a presentation by Dr. Anne Sullivan as Commissioner of the Office of Mental Health and the dental side a national authority from the University of California. I should say also, Jackie Sheltry was indispensable to us in pulling all this together. She has now moved over to the Division for Long Term Care. Is available and working hard to make all this possible. Just a few quick words about the structure of today's meeting. We'll start with a quick overview of the presentation. We've heard about mental health and dental care and the ED setting. Questions being very welcome, but we're trying to save suggestions for a little later in the agenda. Then Dr. Heslin will present on the likely time frame and category for levers of change over time so that we know how to compartmentalize and structure the work in front of us. Then back to the Committee for Policy Proposals that we should ask for consideration and possible enactment. We also will be considering what topics to address in future meetings and then proceed to a brief overview of MCP, Managing Care Primary,

again by Dr. Heslin as a federal pilot program for which New York has become eligible and may have a bearing and at least part of a solution in terms of the problems we've been considering. If there are members of the public interested in making a comment, we're glad to entertain those.

Dr. Rugge Having said all this, is on screen?

Ann Monroe Excuse me.

Dr. Rugge Yes.

Ann Monroe There are three of us here in Rochester. You probably want to know who they are.

Dr. Rugge Yes.

Ann Monroe We would all like to know who's there.

Dr. Rugge Yes.

Dr. Rugge Welcome and introduction was the first part, and I forgot the introductions.

Dr. Rugge Why don't you introduce the people in Rochester.

Chris Smith I'm Chris Smith. I'm the Associate Commissioner for Adult Community Care for the Office of Mental Health.

Mark Filippi Mark Filippi from the council.

Ann Monroe Who's there?

Dr. Rugge Thank you.

Dr. Rugge Shall we go down the table here.

Dr. Rugge Dr. Boufford.

Dr. Boufford Jo Boufford.

Denise Soffel Denise Soffel.

Dr. Rugge Both distinguished members of our Planning Committee for the council.

Dr. Rugge Thank you.

Dr. Boufford Distinguished members of the Planning Committee.

Dr. Rugge Absolutely. Absolutely.

Dr. Heslin Eugene Heslin, DOH.

Dr. Rugge Karen.

Karen Madden Karen Madden, DOH.

Dr. Rugge Across the room.

Steve Steve, Department of Health.

Mark Hennessey Mark Hennessey with the Department of Health.

Dr. Rugge And on screen, as we've already mentioned, Dr. Morley.

Dr. Morley Dr. Morley, Department of Health.

Dr. Rugge Who else?

Jennifer Tracy This is Jennifer Tracy.

Dr. Rugge Welcome, Jennifer.

Marci McCall Good afternoon, everybody. This is Marci McCall, Department of Health.

Shaymaa Mousa Can you hear me?

Dr. Rugge Yes, we can.

Shaymaa Mousa Perfect.

Shaymaa Mousa I'm going to share my screen.

Shaymaa Mousa Can everyone see the Power Point?

Dr. Rugge Yes, indeed.

Dr. Rugge You're up.

Shaymaa Mousa Okay.

Shaymaa Mousa As Dr. Rugge stated, the issue of hospital crowding, which is manifested most in the E.R. with long wait times in boarding of patients, has existed for decades now. So far, we've had the two educational meetings, specifically looking at behavioral health and dental patients in the E.D. I'm just going to be giving a brief overview of the information presented at those meetings. On May 4th, Commissioner Dr. Sullivan presented to the committee the current landscape for behavioral health patients. Dr. Sullivan identified three key issues for behavioral health patients in the E.D. The first is getting the right assessment and the right person to perform that assessment. Obviously, workforce shortages impact this as well, because getting an appropriate assessment would ideally be for a psychiatric staff to make a good assessment. In this area, she indicated telehealth could help. The second problem Dr. Sullivan identified is some patients with behavioral health diagnoses can be complex. So, for example, they can have a dual diagnosis or have other social determinants such as housing difficulties. Dr. Sullivan highlighted OMH and OPWDD residential treatment facilities, as well as home-based crisis intervention services as examples of models that can help with complex patients. Finally,

access to psych beds was the third key issue due to increased demand and closure of beds. Psychiatric bed occupancy has gone from like 70 to 80% pre-pandemic to high 80 low 90% occupancy. The state's been working really hard on getting those beds back. So far, two-hundred beds have been back online and there were one hundred and fifty new beds created as well as twelve added across the state. Other central issues identified by Dr. Sullivan to behavioral health patients boarding in the ED or disproportionately seeking ED level care is workforce training on either side, whether behavioral health or health care workforce. They aren't really trained to manage complex cases that have dual diagnosis. When patients are discharged, connecting patients to behavioral health services that will stay connected to the patient for a period after discharge can help with the revolving door of cases. Finally, payment from Medicaid is actually better than commercial insurance. This is the one area where that's the case. We received a number of questions from the committee. DOH and OMH are working hard on getting the answers to you for those to help inform the recommendations. Some of the key takeaways from the conversation pertained to the need to enhance workforce, both by attracting new and retaining existing providers, increasing capacity for patients in need of behavioral health services, and exploring the role of other providers such as FQHCs, urgent care and primary care in decreasing the burden on hospitals. On June 8th, the second topic we heard about was dental health in the emergency department. Approximately 70% of the patients who go to the ED have non-emergent issues.

Dr. Rugge Just before you proceed, I just wonder if there are any comments or suggestions regarding mental health presentation by Dr. Sullivan.

Dr. Heslin Before we go there, I'd invite our colleague from Office of Mental Health if he wanted to add anything to the presentation. Also, if when we did look at the questions and we were working on them, many of the questions were germane to OMH. I believe they have some answers and some directional inputs. I'd like to welcome Mr. Smith, Dr. Smith. I'm not sure. If you could go through that for us, please.

Dr. Heslin Thank you.

Dr. Rugge Perhaps as a preface to that, I should say, I thought Dr. Sullivan's presentation was very eloquent in looking to identify someone to call with a new 988 number, someone to come in the person of the mobile crisis team and home-based crisis intervention programs and somewhere to go by way of crisis stabilization centers in lieu of the emergency departments. Chris Smith, If you have anything to add, you're very welcome to take that microphone and put it to use.

Dr. Rugge Is Chris trying to speak to us or are we all set to go?

Chris Smith Can you hear me?

Dr. Rugge Yes, now we can.

Chris Smith Great.

Chris Smith Thank you.

Chris Smith Again, Chris Smith. I'm a psychologist, so the doctor is accurate. I'm the Associate Commissioner for Adult Community Care. First, I wanted to give my regrets for Dr. Solomon and Dr. Tom Smith. As some of you probably know, we're having a meeting

this afternoon with hospitals to discuss some of these issues and the implications of our budget on working with hospitals and community providers across the state. They weren't able to make it. We have answers to a lot of the questions. I can start sort of walking through some of these. If there were any that are priorities, please let me know. We have draft answers for some and we're working on answers for all, and we'll get those out to the group as soon as we can. I'll start with, you know, we have a really extensive budget this year, which is really primarily focused on addressing this issue. It's timely to be talking about this with this group. Under that budget we're in just a large initiative. As you mentioned, we're bringing back 850 beds. We're adding 150 new state psychiatric beds, but we're also adding a whole host of new services and expanding existing services to help with transitions from inpatient and emergency to the community. We're developing more assertive community treatment teams, which are community-based teams that work with people with high need and expanding those across the lifespan. We're adding new transitional teams that are called critical time intervention-based teams. They're focused on supporting people for up to nine months and moving at critical times in people's lives, moving from homelessness into housing. Somebody who's been hospitalized numerous times and as moving needs support and being more stable in the community. We're developing those. We're really developing a whole host of services. The question here was, are we looking to have immediate or long-term impact? Really both. A lot of the things that we're doing in the budget will be more of a medium term. We're in the process of releasing numerous RFPs. We'll be posting the schedule for that on our procurement page so you can sort of see the timeframe. The vast majority of these are going to be released during this calendar year with a view hanging over into the first quarter of next year. We want to have everything at least out on the street from this year budget by the end of the fiscal year. Where we think we can make some impact immediately is really working, doubling down on working with the enormous amounts of resources that are in the community that are really intended to be helping with these kinds of problems with transitions in care. One being like Health Home Plus. Health Home Plus is a modified version of Health Home Care management that OMH manages and sort of programs its work for people with high needs, with high behavioral health needs, people who have repeat admissions, repeat hospitalization use. We've been working with those teams to enroll more members over the last several years to really make the quality targets consistent across the state. We're working on now under this budget with hopefully being able to work with them and hospitals to be able to provide more linkages directly to hospitals, have people embedded in hospitals. Our immediate work with Health Home Plus, with at teams, with the mobile crisis teams that are in fifty-one of the sixty-two counties right now. Those are opportunities where hospitals can immediately develop better relationships with and develop better communication with and protocols around communication and collaboration that we think can have pretty rapid response. We're also access to outpatient services is a huge barrier right now. It has been a challenge for a long time. As we all know, COVID made it a lot worse. We're going to be releasing RFPs to expand and augment existing clinic programs to hopefully increase access for outpatient level of care. We think those will have a pretty rapid turnaround. That's about the timeframes.

Chris Smith Any questions about that?

Chris Smith I'll keep moving and feel free to interrupt me because there's a lot of questions here. If I run out of time, feel free. We could talk about it later, too. There's a question about payment for behavioral health services that contribute to the ED problems. Are they age related? Commercial versus public programs? As mentioned in her summary, historically, there is a interesting pattern for behavioral health versus other

areas of medicine where Medicaid pays more in many cases, and often commercial doesn't pay at all. For hospital-based services and ED services they do pay, but across the system for ambulatory services they often pay less. For more of our specialized programs, they don't pay at all. Those programs are much less accessible for people with insurance. We did get budget authorization this year to improve this situation. Following up on budget approval we got two years ago when we sponsored the crisis stabilization centers. Commercial insurances will be reimbursing those programs. We are working in that direction to make sure that insurance companies are paying for the types of services that are really helpful in these areas; mobile crisis services, critical time intervention teams to really be able to assist with those junctures where people need additional supports to move into the community and be able to stay there and stay out of the hospital. We have an enhanced rate for school-based clinics this year, which will help with the problems with youth. Hopefully they can access services more readily in schools. They may be able to be stabilized in the community and not need to go to emergency rooms.

Dr. Heslin Dr. Smith, I have a question for you. Sorry to interrupt.

Dr. Heslin Two of our members here are going to have to leave to catch trains probably before 4:00. We're probably going to have to be focused a little bit. The question is, did I hear you right, that the emergency department and the hospitals are actually paid better than outpatient?

Chris Smith The outpatient system is dramatically underpaid by Medicaid. Dramatically underpaid by commercial as opposed to Medicaid. Any of our clinics, community services get much lower reimbursement from commercial. Hospital and E.R. services, I think, are more the standard sort of discrepancy where they're paid less.

Dr. Heslin Commercial pays E.R.'s and hospitals better. Is that what I'm hearing? Because that could be a perverse incentive, actually, in a weird way that people divert to those services because, frankly, they get paid better no matter how bad the payment is.

Chris Smith We'll look at that.

Ann Monroe Maybe we could share those questions, the remaining questions in writing to not make people lose their train. Is there anything of critical importance that you wanted to add?

Chris Smith There were like twenty questions. We can share some things. There was a question about mobile crisis services and how effective they may be at diverting individuals away from emergency rooms. I have limited data, but it's from the mobile crisis system in New York City where only about 5% of the calls that mobile crisis in New York City end up being transports to emergency rooms. About 95% of the mobile crisis calls are handled on the spot. Now, I don't think we can have assurance that all 95% of those would have gone to the emergency room. We do know that a lot of them are serious calls that if there weren’t mobile crisis teams in place, a number of those would also end up going to emergency rooms. In talking about mobile crisis teams there's a couple of things. One, most of our wherever we have CPEPs, which is mostly in New York City, where there's 23 CPEPs, and in the rest of the state where there's six, which are mostly in the cities, but one rural in Ontario County and one in Binghamton. They all have mobile crisis teams associated with them. Those mobile crisis teams are intended to both divert admissions to the emergency rooms, but also follow up with people upon departure from the emergency rooms and be able to support them in the community until they are connected to the next

level of care. We're working with all of the mobile crisis teams across the state to not only work on preventing emergency visits, but also following up if they are not currently connected with emergency departments to make connections with their emergency departments and be a resource for them to support people in those transitions and leaving the hospitals as well. There was a question about children and youth from emergency rooms and the scope and numbers of those. We don't actually have that data specifically from schools, but we are going to follow up with just general data we have about kids. We'll talk to our colleagues at the State Education Department to see what they have that can be helpful there. There was a question about health homes and how effective they are in identifying people with SMI and providing them support and services to help keep them stable. Again, we worked closely with the DOH on health home programming in general, but our focus is on the Health Home Plus population. Where we struggle to get people enrolled, I believe only about 25% of eligible people are enrolled. These are people with any...It's not limited to like heart members. It's people with high service utilization. We work with the hospitals to use data using QE data to identify people who are eligible and work on enrolling them. As I said before, one of our current plans to get a jump on the problem is supporting a collaboration between Health Home Plus and hospitals, potentially impairing health home plus people, case managers in hospitals to be able to outreach and enroll people. There are questions about CPEPs. I can give you an overview of CPEPs. Again, twenty-two in New York City. Twenty-three. One program has two sides. A CPEP is a like an enhanced psychiatric emergency room with dedicated staffing as to have a full array of behavioral health staff, but also has other components. They have extended observation beds where people can be admitted for up to 72 hours for a short-term stabilization stay, or that they may go on and be admitted to an inpatient service. They also have a mobile crisis associated with them as well. It's a really robust model that typically does a good job of supporting people and doing good evaluations and having that unique staffing. There were questions. Are there restrictions on CPEPs that aren't in other hospitals resulting in severe cases going to CPEPs? We don't see it as there being any restrictions. We see it as often. It's less so in New York City, where there are so many CPEPs. In most of the other, no other city in New York is there two CPEPs. If there's one CPEP, they're literally the only game in town as they are in Buffalo. There's not even any other 939 admitting facilities in Buffalo. In other cities, Rochester, Syracuse, Binghamton, they're the only CPEP. If there are other hospitals, which I know is the case here in Rochester and to some extent in Syracuse, it seems like often they get preferentially a more serious behavioral health cases might be taken to the CPEP more often, but then it also can be more difficult to discharge people to other hospitals, like if their beds are full, then being able to transfer people to other hospitals becomes a real challenge. It seems to us that it's more of these sort of system challenges rather than any regulatory abuses or restrictions on CPEP, since it's more relationships and flow through the system and access to beds across the entire system.

Dr. Heslin I mean, that's great.

Dr. Heslin As Ann suggested, is it possible to get some of those in writing? Because honestly, you're talking so quickly. The speaker system here is just so bad that we're hearing mainly when you enunciate every fifth to tenth word. We're missing a lot of it ufortunately. We should all be in Rochester.

Dr. Rugge You could take care to submit written responses to these questions, which are all very important. We will be guided by those answers.

Dr. Rugge Thank you.

Chris Smith I would be happy to come back and discuss them further in a subsequent meeting.

Dr. Rugge Thank you very much.

Ann Monroe The questions we had for DLA that we'll get the answers in writing, or are they going to be presented here today as well?

Chris Smith I'm having trouble hearing you, Ann.

Dr. Heslin I think, Ann, if I heard you, what the answer is, is that DLA's questions are still being worked on at this point in time. We don't have them for today. They're going to be provided in writing back.

Chris Smith We should have comprehensive answers to those very comprehensive questions.

Chris Smith We will turn it over to Shaymaa again for a dental overview.

Chris Smith Thank you.

Chris Smith Shaymaa.

Shaymaa Mousa The second topic we heard about was about non traumatic dental patients in the ED. As Dr. Rugge mentioned, approximately 17% of patients that are going into the ED that have non-emergent issues are going in for dental causes.

Shaymaa Mousa Sorry. It went back to the beginning.

Shaymaa Mousa We heard from a number of experts. We heard about the demographics which showed that generally ED utilization for non-traumatic dental conditions is more prevalent in young adults versus children in rural counties versus urban counties. Economic influences played a large factor with 60% of these ED visits covered by Medicaid and the majority of the rest uninsured. Patients who use the ER are often repeat users and receive antibiotics or opioids, but they don't get the care they need and that's why they end up going to the ER over and over again. Talked about her work with the Dental Quality Alliance, which looked at Oregon Medicaid data, focusing on assessing the number of ED visits and what happens after those visits. they found that they had 209 non traumatic dental ED visits per 100,000 member months, which translates to about 2.5% of Medicaid enrollees. Looking at those patients who presented to the ED they found that thirty days after that visit, only 30% had followed up with a dentist, which means 70% did not receive any definitive dental care. Those individuals are likely to return to the ED. We also heard from the speakers about the importance of prevention, maintaining good oral hygiene, having regular checkups and eating healthy. Dr. Richardson outlined some of the department's initiatives to promote oral health, including water fluoridation, school-based prevention programs and oral health education, among others. Having insurance and dental home are also factors that make regular dental care more likely. What happens if we're past the point of prevention? We heard about a number of ED diversion programs that can be used. The first was tele dentistry. One way it has been used is essentially as a platform where they're able to screen patients when they call 911. They could transfer them to speak to a nurse who decides the urgency. The nurse decides whether they need

to actually go to the ED or whether they can notify an on-call dentist. Mobile dental plans are another way to divert patients from the ED. They can increase access to care because you can take them anywhere. They can be at schools or homeless shelters, or you can even park them in a parking lot. There are a number of different models of co-located dental offices, for example, with the pediatrician or in the ED partnered with the residency program to offer dental treatment. FQHCs may also play a role here as they may be well-suited for integration. Has actually supported the expansion of dental services for FQHCs. Finally, connecting patients with a dental home is where referral and care coordination become important. If they do visit the ED, there's a mechanism to connect them with a dental home so they receive the care they need. During the meeting, we heard about how workforce is a barrier to expanding dental services. Ms. Morne presented the variation in scope of practice of dental hygienist by state. Where here in New York, hygienists are able to provide prophylactic care and sealants, while other states have also allowed hygienist to create treatment plans, receive direct Medicaid reimbursement, supervise dental assistants, have prescriptive authority, and two states have even allowed for hygienist to diagnose. We also heard about dental therapists, which have been authorized to practice in a number of states. This chart shows the status of dental therapists by state. Legislation for potential therapists has actually been proposed in New York for a few years now. There's actually currently an active bill for licensing of both dental therapists and advanced dental therapists. Some of the common themes across the presentations we heard regarding ED diversion for non-traumatic dental patients was utilizing tele dentistry, mobile dental units and equipment, scope of practice from mid-level providers, including licensure of dental therapists and care coordination and utilizing models such as co-location in dental homes. As far as next steps for these topics, as well as future topics, Dr. Heslin will be discussing today how to best organize and prioritize recommendations, keeping in mind the timeline and impact as well as feasibility of implementation given the department's authority and areas, we're able to influence.

Shaymaa Mousa I'm actually going to turn it over to Dr. Michele Griguts, who is a Dental Director in the Office of Health Insurance Programs to give us Medicaid's perspective.

Dr. Michele Griguts Good afternoon, everyone. Again, I'm Michele Griguts with the Dental Medicare program. I just wanted to add a few thoughts today as the council thinks about this issue from a Medicaid perspective. New York is very fortunate to have a really extensive dental benefit package compared to many other states. Right now, the program does reimburse for services in school-based health centers, also for mobile vans that are operated by Article 28 facilities. The program also reimburses dental services at the six academic dental centers, as well as various dental residency programs throughout the state. I also wanted to add that the program also reimburses for tele dentistry, and that started even before the pandemic. I think there's a lot of untapped potential in this area for the use of tele dentistry. That's all I had to add.

Dr. Michele Griguts Thank you.

Dr. Michele Griguts I will pass it back to Dr. Rugge.

Dr. Rugge Thank you.

Dr. Rugge Any questions from members of the committee?

Dr. Rugge Yes, I see a waving hand.

Dr. Rugge Ann.

Ann Monroe Thank you for that.

Ann Monroe I have a question for you. We know that Medicare plans cover dental. What I'm trying to understand is who pays, who determines how much a dentist is paid through a Medicaid managed care plan? Is that up to the plan? Does the state send a rate that the plans then follow? I'm trying to find where the points of leverage are.

Dr. Michele Griguts The managed care plans negotiate contract fees with their providers. It's individual based on each provider. And then, of course, Medicaid fee for service has a set fee schedule.

Ann Monroe She's not happy with a panel, the dental panel that the Medicaid Medicare care plans have. I'm wondering what kind of oversight you have for Medicaid, Medicare plans and their dental. Do you review them? Do you approve them? What role do you have with those?

Dr. Michele Griguts There's a whole separate division of the Division of Health Plan Contracting and Oversight. I have some interaction with them, but generally, they are the ones that handle those contracts with the managed care plans.

Ann Monroe You just don't know the answer to that, right?

Dr. Michele Griguts I wouldn't be directly involved with any of the contract negotiations. That's another division.

Dr. Rugge Dr. Soffel.

Denise Soffel I have a follow up to Ann's question. Do you look at any of the quality data that the managed care plans are supposed to be submitting to review those? Is that also done completely in the office of contracts? Are there dental indicators in the Medicaid caps data?

Dr. Heslin That I do not know.

Denise Soffel That's interesting.

Dr. Michele Griguts I mean, there's dental measures. The plans have to report on a couple of dental measures and that's handled by the Office of Quality and Patient Safety. They oversee that data.

Denise Soffel It could be part of the challenge is that we have the Office of Patient Safety doing one piece of it. The Office of Managed Care Contracts doing another piece of it. Your office... I don't even. Where do you sit in the world? I mean, it seems to me that we have a coordination challenge in that we have completely disparate parts of the Department of Health overseeing different slices of dental care, at least for the Medicaid population, which certainly makes coordination more of a challenge.

Dr. Rugge Just as another kind of global comment. Fifty years ago, there were two places to obtain care; a doctor's office and the ED. Fifty years ago there were two kinds of providers. There were doctors and there were nurses. I think as we've seen from these

proposed solutions on the mental health side and the dental there are all kinds of teams approach, new kinds of providers, new locations of care, and also need to mention telehealth and remote care. What I think we've seen through these presentations is a whole series of initiatives are being proposed, not yet capable of being implemented for the failure of regulatory guidance and the catch up we need to do. The next item on the agenda is to talk about levers of change. The process that needs to be undertaken to bring this care up to date with all the kinds of advanced solutions we're hearing about from our departments and our reformers.

Dr. Rugge We'll turn to Dr. Heslin for that.

Dr. Heslin One moment.

Dr. Heslin Let me get my slide up and see if I can do this.

Dr. Heslin Can you guys see the screen?

Dr. Rugge Yes.

Dr. Heslin Not exactly sure how to move it forward now that it takes up my entire screen. We're talking about the levers of change. Basically, what we're trying to figure out is how to build a rubric to prioritize planning options. Because when we start to think about these educational sessions, which so far there's really been three, the first one about community power medicine and emergency department overcrowding and EMS, the second one about Office of Mental Health and mental health care and then the third one about dentistry. Those were picked specifically to highlight different types of use cases to think about how and what are the levers that we can use to be able to effectuate the changes. These educational sessions really are advocates that are giving us best- and worst-case scenarios under how and what they see helping to guide the deliberations. One of the tasks we started to think about was what are the actionable deliverables? What is the time frame under which those deliverables can be established in the likeliness of success of trying to accomplish a deliverable? As we all know, sometimes these things can take a decade to move through the various legislative and regulatory bodies to be able to accomplish something. Some can be done literally immediately. Part of this was to figure out how to help guide that process and figure out what could be the recommendations to the full council that people might want to support. We have basically four levers really that we functioned under within the department. The first one is the superstructure of statutory change, which drives regulatory change and the authorities we have to be able to actually tell people what to do. And then that comes with the regulatory teeth and whatever we put into the structure to support that. The third one is financial. We control some of the finances through Medicaid, DFS control, small group and individual market. Doesn't have to follow pretty much a lot of what we say unless it's statutory because they get to make their own decisions. For example, the all-payer database is optional for plans to be able to participate in them. That means that a large group of people doesn't have to submit their information for us to understand what is actually happening in the market space. And then of course, we have Medicare, the eight Medicare plans that are managed care and the sixteen Medicaid managed care plans just to make it complicated. The next one we really have is workforce. Workforce falls into entry into the market scope of practice, career ladders and then also what happens when we don't have enough workforce to be able to meet the needs of the community. We control portions of that in terms of how we think about things. Our partner, State Education Department really is the group that controls a lot of that because they determine licensure, and they also determine what the scope of

practice will be for different various clinicians to practice. While the Department of Health has the regulatory ability to control the system and some of the financial levers, our partner really has the moral obligation to be able to help make sure there's enough workforce for us to be able to work within New York State and the bounds of what we try to accomplish. What we're going to try to do is to use a couple of use cases here in terms of timeline to look at short-, medium- and long-term possibilities and maybe likelihood of success as we start to think about them. Put together a little paradigm matrix so that as we come up with different issues, we don't forget about those issues and we don't leave dangling participles in place because as part of planning, we're not necessarily doing operations, but we need to make sure that we have a comprehensive list of what we would like to accomplish and then also make sure that we've accomplished it or taken it off our list for whatever reason. The first one, as an example I put on the list is a program that has recent statutory language, is a demonstration project for two years, needs further development. We've got now community permits. There's I don't know how many of them in the state, Steve, about fifty-two of them in New York State at this point in time. That's an immediate time frame because pending signature, we'll have a statute. We don't have any regulations yet. They need to be developed. There are multiple different financial models, none of which have been stood up yet in terms of being viable on a long term or a sustained basis. The workforce is EMS and others, particularly as you start to think about when people are being diverted from emergency rooms. We have a workflow of an immediate need and what needs to now be developed. What I didn't put down on this was how long do we think it's going to take for regulation to be developed, which would then come to the council for evaluation, modification and approval. How we're going to look at this through a financial lens for Medicaid, DFS and the plan to move that forward and then ultimately the workforce. The second example is an example of a program that exists with opportunities in a couple of different domains. I put up dentistry because there's mid-term and long-term time frames that we have statute in place. We have regulation in place. We have financial with an opportunity for network expansion that needs to be thought about in terms of the networks. To Denise's point, we need to have the data from the different portions of the department which actually function together. We did not bring it together here. That was my failure. I will take responsibility for that. That won't happen again. There is the scope of practice issues like dental therapists or others that could potentially expand and work as force multipliers and team-based care. The third example that I'm going to put up on the screen, a third example is tele dentistry. While we do have a program, I don't think we have a 911 program where people can actually be diverted from the 911 system at this point in time to a dentist's office or to a tele dentist visit, because pretty much everybody that goes to 911 goes to the emergency room at this point in time. That is the current existing statute and ruleset that exists that we don't have the ability to yet modify. We need to develop statutory language if we wanted to accomplish that. That involves a time frame of starting this year pretty soon actually, if we wanted to pursue that. We need to have regulations. In terms of financial, clearly, we already have a tele program. There's not much that needs to be developed, but we need to have an on-call system. That's going to take finances. Finally, workforce. If you're going to have a 911 system that moves from basically someone calls up and the message is sent for someone to be picked up to a smart EMS system where you actually have to have somebody be able to make a medical decision or in this case, a dental decision. You're going to need to have a different type of workforce available to be able to make those needs appropriately worked on. Those are kind of three use cases just to have on the list here. In this model design for the committee members, does this make sense? That is one question. The second question, what another lever should be included or should we be taking something off the list?

Dr. Heslin I'll stop there and entertain both thoughts and questions.

Dr. Rugge Dr. Boufford.

Dr. Boufford Thank you.

Dr. Boufford It makes sense. I like the way you're thinking about it like the sequencing. I think one of the dilemmas for me is that the PHHPC has had a, you know, there's this sort of ideation that comes before the statute, if you will. I mean, I was thinking back and I think that Scott raised this during the conversation on behavioral health was recently as the Article 28, Article 33 distinctions, which were laid out pretty clearly by people who have to manage both systems and the solution space was also pretty clear. It may have been at the time. I think one of the questions that our colleague was asked is, are some of the financial gaps fixed or obviously there were federal constraints and other. It's sort of as the problem gets more complicated, it seems to be maybe its politics is the missing cross-cutting link. I don't really know. It just strikes me that that there's something missing in the sort of solution space can be pretty clear, but then the problem is, you know, how do you get the statute or the regulation?

Dr. Heslin No, no, that's clearly the case. This was just really an attempt to start the function of organization. Each one of those is going to need to have a like sub matrix underneath it that has the different levers within it because statute will have a timeline involved with it. Is it going to be a state of the state issue? Is it going to be a department? Is this something that's going to be in the executive budget? All those play a role. Then it becomes, how does that become socialized? Is it going to be something that committees, the health committee is going to take up, etc., etc.? That's going to be there. Regulatory is the easiest one for this group because essentially, we bring all regulations to you. They get developed. They get read. You guys make comments on them and changes, etc. Financial is largely based off of the scorecard, right? We have a scorecard that everybody follows. It has to be what's the level of prioritization on that scorecard in order to make sure that this need is met? Because as we've been clearly indicated, there's only so many dollars that are going to come into the system. It's going to happen in an incremental way. While we may have great ideas, we have to figure out how to appropriately operationalize them within that infrastructure.

Dr. Boufford I was just thinking also, as you presented it relative to the committees, thinking about priority setting, I mean, you gave some use cases here where there already is a statute. I'm just thinking of how to... If this is a checklist in a way, which is all of their complications under each one, but let's say if there is a statute, is that a place to start, arguably, or if there's a statute? I don't know.

Dr. Heslin It may be, or it may be something that public health counsel feels is that important that doesn't exist right now, that they want to advocate for this as something they believe should be something we are doing. For example, right now, telehealth in a 911 system doesn't exist. If we think it's that important, or if you think it's not important, you don't get to write law or statute, but you can certainly have input into the thought that this makes a difference. As a council, we think this is directionally what you should support.

Dr. Heslin Denise, you look like you have a question.

Denise Soffel No, I don't at the moment.

Dr. Rugge Just as a comment, Dr. Heslin. Just seems to me your presentation, the graphs elegantly indicate the kind of approach needs to be taken, and that is one that is very comprehensive. The idea that right now if someone calls 911, automatically the ambulance comes to the home, automatically that patient, that person is brought to an emergency department with all the charges and all the many times inappropriate location and behavior. It seems to me a 911 diversion strategy is the beginning point for how to improve ED utilization. What that will require is all four. It takes statutory change, it takes regulatory change, takes financial adjustment and certainly workforce recognition. Perhaps, the role for this council is to highlight those top priorities that we need calling attention to everyone concerned, including the Governor. Here are the priorities that need to be addressed. Here are the implications by way of all four levers of change.

Dr. Heslin I think you may be right on that. I also think that when you take a system like that you have to also look at the safety net component of it and do no harm. It becomes a chicken egg problem, making sure there is appropriate services available. You build these things out incrementally. I think that there's room for all this.

Dr. Heslin Steve, you look like you wanted to say something.

Steve Yes.

Steve Specifically, on the topic of 911 triaging of patients. This is actually a practice in place that a lot of 911 centers already just not specific to dental care. In a majority of 911 systems across the state they perform at the time of a 911 call for medical call. They perform what's called emergency medical dispatch. It's a telephone triage procedure to identify what type of emergency is occurring and what type of resources need to be sent. In addition, we're starting to see programs pop up across the state for what's called nurse navigation tied into a 911 system. If during the emergency medical dispatch triage process, a 911 dispatcher identifies that it's a low priority, low acuity emergency that may be able to be handled outside of an emergency response by an ambulance or EMS crew or taking the patient to a hospital, they will transfer that call to a nurse navigation line that's hooked up with their 911 center. The nurse does a triage of the patient's condition, identifies community resources available in that area, makes referrals, sets up medications, those types of things. If at any point that patient is not eligible or the nurse identifies that it's a little higher acuity than originally thought, they push the call back to the 911 system for dispatch of emergency medical resources.

Dr. Heslin Two things. First is how many of them in the state exist right now?

Steve There's I want to say there's less than six at this point, but they're growing in popularity as counties start to realize there's limited resources.

Dr. Rugge Are those 911 recipients of calls, especially trained, qualified, credentialed to make those diversionary calls?

Steve I don't know. That's something we'd have to look into. In fact, I believe Mark has some experience with nurse navigation. He may be able to speak a little more on that.

Mark Hennessey Steve, you teed me up perfectly.

Mark Hennessey Thank you very much.

Mark Hennessey Thank you, Dr. Rugge.

Mark Hennessey The nurse navigation program in New York happens to be a subset of a couple of different organizations. Speaking to right now, there's four counties that I'm aware of that are running nurse navigation through their 911 system. Right now, Erie, Monroe, Onondaga, and I believe Albany is about ready to start up. I think Oneida is also on the cusp of starting up so that would be five. They run fairly consistently through their 911 systems medical direction and then the nurse program is overseen by physicians, both from the company that oversees the providers, meaning the nurses themselves, but also internally by the medical director to the 911 system. There's handshake between the 911 medical director and the provider service. They use a system that is very similar to the International Emergency Medical dispatch mentioned. They are using consistent terminology and consistent methods for triage. I can speak specifically to Rochester, where we do actually use the Eastman Dental Center, which is a dental clinic associated with the University of Rochester, and our nurse navigators will actually divert patients to the Eastern Dental Center. That is as a success story, that is a use instance that is going on currently. The only drawback to that right now, the largest problem is hours of service. If someone has a dental issue 1:00 in the morning they're clearly going to the emergency department. The nurse navigation program, the single largest contributor to our continued use of 911 system to transport people to the hospital is the lack of available services after hours. Between 9:00 at night and 9:00 in the morning there are no services available outside the emergency department, many of these areas. They're forced to default back to 911 to emergency transport. One of the things that using telehealth is helpful with is potentially setting these folks up for a near term appointment with either clinic or a FQHC at which they can see that person the next day. That still, unfortunately, is going through a culture that we face in New York State, which is if I call 911, I'm going to get help right now and folks want help right now. I think another piece of this looking down the line is how do we educate our consumers? How do we educate the public to understand that there are other alternatives? Obviously, looking at the methods to get 24/7 service from those alternative destinations.

Dr. Heslin Two questions that I have and I'm going to direct them towards Steve. The first is who pays for this? The second is, who regulates this and who is managing the quality?

Steve To respond in order, who pays for it? Most of these services are initiated by the county public safety answering centers, 911 centers who have identified that this is critical to preserving the emergency resources within their municipal boundaries to emergencies and not those non-emergency calls. As far as who regulates up until recently, I would have said it's a locally driven effort. However, we did have some statutory change that was brought about as part of the Executive Budget proposal that included the ability of the State Emergency Medical Services Council to establish system and agency performance standards, including emergency medical services and any facility or agency that dispatches or accepts emergency medical services resources. That gives us the opportunity to possibly, for the first time, establish these emergency medical dispatch systems and nurse navigation systems and so on and so forth into public health regulation through Article 30. As far as quality goes, I think that's part of the standards process, right? As of right now, it was best practice and locally driven quality assurance practices that they utilized when they implemented these systems. I do think there's an ability to go a little beyond that in our regulation and establish at least a minimum standard set of quality metrics, as well as some reporting requirements so that we can understand at a state level if these programs are actually beneficial.

Denise Soffel I want to go back to my sort of recurring theme in this conversation, which has to do with accountability, because part of the challenges, if we don't measure it, they won't do it, right? I mean, we know this is human nature, that we only sort of pay attention to the things that we're being evaluated on and paid on. I think it's really interesting that neither Dr. Heslin nor I knows whether we collect core data on planned performance on dental care. How many of your adults saw dentists in the last twelve months. Seems to me that should be a question that we ask every Medicaid managed care plan in the State of New York every year and hold them accountable to some standards. Because shouldn't it be at least 90% of all adults see a dentist every year? I mean, some number. There's some standard out there. I don't know what it would be, but it seems to me we don't. I don't know that we measure it. I don't think that we do. We also don't then sort of ask those plans. I'm sorry. I've lost my train of thought here. It seems to me that we could do some thinking about what is it that we are asking of our Medicaid managed care plans on the dental front? How many of your people showed up at an emergency department in the course of a year and say, you know what, If half of your people are showing up in the ED with a dental crisis, that's not an acceptable number. I think that it's an area where we could think about creating standards and evaluation and try to build some accountability into the managed care system.

Dr. Rugge I think this raises an interesting question about where does the responsibility lie? Shall we go to the managed care plans to say, what's the utilization? Do we go to the primary care provider and say, these patients your responsibility? What kind of caregiving are you assuring they obtain? I think that speaks to the model of health care services being cross walked in so many different directions.

Denise Soffel I think, though, Dr. Rugge, the challenges. We know that the managed care plans have responsibility for both dental and behavioral health care for their members. I don't think it's as clear that the primary care provider has that same sort of breadth of responsibility. I mean, I may be wrong, but I'm not sure that we can expect the same sort of breadth of integrating all aspects of an individual patient's well-being on the primary care provider. I mean, you're a primary care provider, so you tell me.

Dr. Rugge That's a public policy question. I think it probably varies by plan and varies by provider. An open question is, should there be standardized expectations in some way delivered or imposed and the caregivers or on the insurers and the payers?

Ann Monroe Oh, all right. I'll follow you, Jo.

Ann Monroe Go ahead.

Dr. Boufford I keep screaming from thirty, forty years of doing the same thing over and over. Instead of like, if you're crazy, you keep applying the same solution to the same solution to the same problem, and it doesn't solve the problem. It seems to me the roads lead back to the question, the issues that are raised by other colleagues. I mean, the reason, do we want to keep people out of the emergency room, if we can? If the answer to that is yes, then that's where we ought to be focusing the resource investment, right? I mean, people aren't open in the evenings. Back in the old days, people used to pool and have somebody covering even a set of clinics or a set of practices or there was a shared nurse navigator who was on the call, and they could triage and people knew who to send them to. I mean, all those systems, I guess by the boards. I'm not sure. I mean, like most hospitals who have crowded ER's have nurse navigators or a call system to try to triage people to keep them from coming in. It's sort of like we're still going at the here's the

problem, let's treat it as it manifests itself rather than dealing with more for better strategy, especially if there is something in the wings that's supposed to be dealing with primary care practice. Believe me, I don't you know, having just had a primary care visit, which lasted about twelve and a half minutes and the physical exam was listening to my chest and my heart through my clothes. I appreciate the time frame, and the level of responsibility is de minimis, but we're talking about systems now. We're not talking about individual doctors. The issue is if the incentives are promoting the things that we know, keep people out of the E.R., then, you know, let's look there as well at least. I appreciate there may be a momentary crisis, but it's not going to be a sustainable solution because we've done this before and then it stops happening and it starts happening again. In this process of thinking, it's sort of in the sorry, but in the earlier discussion on the prevention agenda, we're talking about the issue of maternal mortality and women's health in general. If the bundle for primary care doesn't include reproductive health, you know, there's a missing connector there that we ought to deal with. If one of the issues is a bundle of primary care or to a clinic system or to others, does it include investment in a triage kind of system or extra hours or whatever? We have to explore that at the same time we're exploring these other solutions.

Dr. Rugge This discussion goes way beyond what I would expect by way of new policies specifically for the emergency departments, but it suggests as we develop pilot programs for paying and new ways for care, defining their care, which is to be given, will be essential. It's a monstrous, huge project.

Dr. Rugge Dr. Heslin.

Dr. Heslin No, I was going to say, Ms. Monroe was next.

Ann Monroe First of all, John, can you speak into your mic when they talk. It's very hard to hear you here. I don't know if you hear me either. I want to go back to what was your name?

Mark Hennessey Mark.

Ann Monroe Mark said, you know, I think we're. I don't know when the emergent when these folks, behavioral health and dental when they're showing up in the emergency room. If it's after 5:00, I don't know that there's much that we can do short of looking at different ways to assemble community-based care so that it's in the evenings, even perhaps overnight, because a lot of these pilot programs that we just started again for. They're going to be available during the day. I don't know if that's the problem we're trying to alleviate or if we're really trying to alleviate after hours. That's one comment. The other is that while I appreciate the rubric, looking at all four of those things, it strikes me that it is the priority of all of these ideas that we've come up with over the last six months that is critical. I don't know what our priorities are or should be. Should it be affecting both patients? Should it be affecting the most expensive procedures? Should it be affecting only certain communities? I think we have to talk at some point about how we separate priorities. We're evaluating all of these good ideas. I don't know what that is yet. I think we need to spend some time on that at another meeting.

Dr. Rugge Certainly, in terms of afterhours care, that suggests that that new payment policies, new pilot programs, specifically reward after hours care if we think that's important, and I think we do. As we do the checklist of what we're accomplishing today

there's another policy proposal coming from Ann Monroe that should be listed, addressed at our future meetings.

Ann Monroe Well, hopefully, if others agree.

Dr. Rugge Well, exactly. This is only laying it on the table for the first time to see what kind of a consensus and what kind of a need there is. Just as another technical issue going back to one of Steve remarks, I take it.

Ann Monroe If I could just add to that. I don't know what restrictions there are on transportation. Let's assume we have six FQHCs who get together and staff 24-hour operation. Can ambulances deliver people to that operation, or is that something else we would have to figure out? Just a comment.

Dr. Rugge Another policy consideration, policy proposal to be addressed clarified with the help of expert staff.

Dr. Heslin I don't know what the side conversation in Rochester is right now. As a primary care doc, Dr. Boufford, every single contract. Every single contract that I've signed ever since I started for every single insurance plan, bar none. I always have a clause in that contract that requires that I provide 24-hour care to my patients. Theoretically, if people are actually following in their contracts, they have nights, weekends and otherwise provision of coverage. Now, that has slipped, and many people send people to urgent care and to ERs and otherwise. At the end of the day, that is still a contractual obligation for every single primary care provider that has a contract with anybody, including Medicare.

Dr. Heslin I don't know the dentist world well enough to answer your question.

Dr. Rugge But also, what we know is once the ambulance is called, that ambulance is going to go to the nearest hospital. It's not a matter of delivering a patient to some more appropriate setting. That's another level of discussion in terms of how we do that at diversion. Just again, back to a technical question for Steve. I take it that the 911 services are county based, but is it possible to have a diversion from that 911 core to some more regional enterprise for mental health evaluation or dental evaluation?

Steve Medicaid, just a phone a friend. Someone phoned me while we were here and gave me an answer. There is actually a managed Medicaid plan measure for annual dental visits for adults as well as for children. There is already a measure in place for both of those.

Dr. Boufford I was going to say, is there anything in Medicaid managed care back in a 24-hour availability of something?

Steve Phone a friend didn't send me that answer. Thank you to the phone a friend out there who is paying attention to this meeting.

Steve To answer the other two questions, you had, Dr. Rugge. First of all, I would say, generally speaking, and I can't say all the time, but generally speaking, most 911 centers are county run. There are pockets of the state where there's exceptions, where they're run by towns or villages or more local system. In most cases, we see an overarching even in those an overarching 911 county level system as well. To the question of ambulances have to transport to a hospital. We made some modifications. The State Emergency

Medical Services Council clarified, I believe it was two, maybe three years ago now. I apologize for losing track. Clarified transport destinations. We allow transport to alternative destinations that are regionally approved. One of the issues we've seen with that taking off is that there is a little bit of lack of consistency among services offered at different places. I'll use the most common one that we hear about is urgent care. It would make sense to take a patient at times to an urgent care versus an emergency department. The problem is no two urgent cares operate in the same way. The ambulance crew would have to have intimate knowledge of does that urgent care offer X-rays. Do they have ultrasound? What types of services and specialties are available at that urgent care center versus another one across the street? We haven't seen a very good adoption of alternative destinations as of yet because there's not standards in place. I imagine the same would come up if we were to talk about dental clinics. Who can do what at what clinic? Do we take the patient there? I live in an area with urgent cares. I've gone to one where I thought they should be able to take care of my emergency, but they ended up recommending I go to the hospital and suggested we call an ambulance. We don't want to end up with two transports here because that actually hurts the system even more. We want to identify right off the bat getting the right patient to the right place in the right amount of time. That's our goal.

Denise Soffel Can you explain how the mobile crisis teams fit into that? Who calls them? Does the 911 system call them?

Steve I cannot explain that. I don't have enough knowledge of it yet. It doesn't operate in the emergency medical services.

Denise Soffel It does not.

Steve No.

Denise Soffel Does anybody else know the answer to that?

Ann Monroe Go ahead.

Unknown Chris is going to say what you were going to say, I think.

Chris Smith There are a handful of pilots going on right now for interaction between 911 and 988 call centers to deploy mobile crisis teams either directly by 911 or through an interaction with 988. That's where we think the future system should go. For behavioral health crises is 988. It can be handled going back and forth between 988 and 911 to settle on the appropriate destination. I think that'll be helpful going forward. I mean, we worked on this in New York City several years ago with the fire department and wanted to start transitioning like the lowest tier of emergency calls of the seven, I believe it is in the New York City system are low level behavioral health crises that don't have a medical complication associated with it. They were going to start deploying those to the then, say, 988 equivalent in New York City. It ended up not working more for political reasons than practical reasons. There's work going on in that direction there again. We think that's a promising approach. That approach is going on in Rochester right now. The City of Rochester has a mobile crisis team stood up through the city government itself. They are utilizing that through 911 for those very low acuity calls that you mentioned them.

Dr. Rugge Just a quick statement. One is standardizing regularizing urgent care expectations; I think is another agenda item that we should consider. We've tried before

and it failed. Could try again. A quick question for Steve. Goes to an alternative destination, it is still reimbursed.

Steve Very good question.

Steve It depends. If the services participating in Medicare's ET3 pilot demonstration program alternative destinations are included in their payment model. ET3 is emergency triage treatment and transport. Let's triage on scene, treat them on seen if we can and release them or refer them or transport to an alternative destination. Under those payment models, they allow payment for transport to destination. For those not participating they would not be reimbursed. The ambulance service reimbursement model is based on moving a patient to an approved facility as defined by Medicare, which in our case most of the time is a hospital.

Dr. Rugge Those three locations are very limited within New York State. Is that correct?

Steve Again, it goes back to the number of people participating in those. There's, I believe twenty-five in total across the state. Again, they're struggling to get those off the ground. It goes back to the discussion about standardization. Getting a patient to a psychiatric center that's an alternative destination or a dental clinic or an urgent care, all those they sound like great ideas, but when you really get into the weeds of it and try and figure out, can this patient go to this facility? You realize there's no standardization of those systems.

Dr. Heslin What I was going to end this section with was that it would be great to have a smart 911 system, but all the infrastructure that is underpinning it still has to be built, standardized, regulated and financed. That's a challenge that needs to be there.

Dr. Rugge An observation I would make. I can only commiserate trying to figure out from all these discussions what represent future topics for discussion, what represents preliminary proposals for further consideration and then how to organize our work going forward. Are you saying we should move already to MCP?

Dr. Rugge With that, again, very substantive discussion. Is very hard to organize with some clear, clear outline, but we'll do that in the minutes.

Dr. Rugge The next topic is MCP, making primary care primary as a demonstration program by CMMI that initially included seven states, but now includes state number eight, New York. Asking Dr. Heslin to give a brief overview of what that program is because it has distinct implications for how to avoid inappropriate cost ineffective ED utilization.

Dr. Rugge With that, Dr. Heslin.

Dr. Heslin Thank you.

Dr. Heslin I'm going to go really quickly. If I can figure out how to shut off, the thumbnails would be even better.

Dr. Heslin Great.

Dr. Heslin Making care primary as a CCMI project, as Dr. Rugge outlined, which is a new primary care model that is built upon the previous comprehensive primary care initiative, one and two primary cares first and the Maryland model of medicine.

Dr. Heslin Why is my screen not moving?

Dr. Heslin There we go.

Dr. Heslin Essentially, the problem statement is, as we have stated throughout this entire day, is we have a fragmented system that's increasingly fragmented, expensive, and that primary care faces existential challenges to its core mission and function. As Dr. Boufford smirks, this has been a thirty-four-year problem that's only worsening at this point in time. What they did was they actually came up with a model to try and work to be able to enable primary care to coordinate services. Wouldn't it be wonderful if all these services actually coordinated with the use of community health workers, office staff, care managers, pharmacy, home care, social work, behavioral health and the EMS system specialists and otherwise? New York is one of eight states that's part of this model. We signed a non-binding letter of agreement similar to all the other seven states, and we're in the process of negotiating with CMS, CMMI, as to the terms of the agreement. I would like to point out that Medicaid did sign that non-binding letter of agreement, and this closely aligned with the Medicaid 1115 waiver and the goals of that waiver to structurally support primary care and to grow that base in order to be able to accomplish many of the goals that we want to do. We need to have structural investment in a way that actually can move the ball forward. Medicare and Medicaid are participating in this model that would be managed Medicaid plus fee for service Medicaid. It would be Medicare fee for service at this point in time. They're still looking at the managed Medicare. It's expected that it will be a multi payer model and that other payers will probably join this as well. It's a 10.5-year model, which is twice as long or more than any of the models they've done previously. The goal is to try to actually take practices from any place where they are along the value-based continuum and be able to put them within the model to grow the model. It has three tracks in it. I'll go through them in a moment. Its basic goal is to advance primary care services. Its belief is, is that it's foundational to any high performing system. If you start looking around at some of the high performing systems around the country like at Geisinger, these all have massive primary care bases which actually support their models, and that's Pennsylvania model. Moving along because I want to make sure we get through this. The first track is a two-and-a-half-year track, acknowledging the fact that we're starting big year with this program. It's anticipated that they're going to be enrolling people starting in the Fall of this year to have this start in 2024, probably first quarter. The first track is an infrastructure building track. The second track is trying to improve how you function within the model, recognizing that everybody's at a different place and improving efficiency. The last track is where you are functioning and are truly in the accountable care model. Practices don't have to start in track one, for example. They could start in track two. They could start in track three and spend ten years in the track three component of the model. You can't spend more than the maximum amount of time in any one of the three tracks. Care management part of the model is to develop coordinated care and care management. You must have educational tools. You must use those tools. You have to be able to have people function care integration. Something new that they're doing. They're going to have e consults where both the primary care physician and the specialists that you're consulting on the phone are getting paid. That's different from what it had been previously. They're also talking. About specialty consult integrations, which is where if you have a care compact with a specialist you could in fact, have that specialist have an increased reimbursement. This is not just getting at reimbursement to primary care. This is actually incentivizing specialists to work with primary care to help to decrease E.R. utilization, hospitalizations and total cost of care. Community connections. The new phraseology for the social determinants of health is this HRSN, which is the health-related

social needs. That's the new phraseology that CMS is using to determine the social determinants of health. That plays significantly in the model. As part of this model, you must hire community health workers into your practice to be part of connecting people back into the community. It's been recognized. The importance of community health workers in addition to the nurses, care managers and other people that work within your team-based care in your primary care office. Track one is creating the workflows, identifying the staff and special care partners. Track two is implementing it, growing it, formalizing it and hardening in place. Track three is optimizing it, expanding it, and enhance specialty services. In terms of metrics that are being followed, they slimmed down the list of things that people had to do and decided that it was more important to have process, patient experience, behavioral health, health equity and cost. Where you've been in previous models, for example, CBC or CBC Plus, you had twenty to forty measures that you had to complete in order to be able to achieve any of the goals. They have three measures in chronic disease and prevention. They have an experienced measure that's being built into this. They have behavioral health measures. Track one, you actually have to do those four measures in order to achieve bonus potential. When you get to track two and track three, they add in the health equity measures and under total cost of care for cost utilization. You'll note that the second one in that list is emergency department utilization. They are specifically focusing on the emergency department utilization because the belief is if you go to the E.R., you're more likely to be admitted. If you don't go to the E.R., that also changes your entire team-based care. The important thing about this model is it's also functionally different than any previous model. FQHCs will be allowed to participate in this model. Previously, FQHCs have been blocked from these models based upon the fact of how they work their risk associations. They've figured a way around that so the fellow qualified health centers will be able to participate. There's a series of programs that are excluded. MSSPs can't participate. Primary Care First can't participate. There's a couple of other. Royal Health Clinics, I think is the other one. Again, that's all part of discussion and negotiation. The payment model, the first two years in track one, you get to do fee for service with an enhanced investment. That is a significant enhanced investment. They're talking about adding hundreds of thousands of dollars to practices helping build out the infrastructure. They've recognized that areas of have high utilization of underserved patients and high need patients will probably get larger enhanced investments. That's a guaranteed payment. Different than any other model where you kind of got your fee for service and then you had to work for your bonus right away. You get an enhanced investment immediately. That does not go away. It does decrease over time. Track two is a prospective payment model for 50% of your payment, which means you have to learn how to do cash management. You have to figure out how to run a business not just based upon what you eat and kill, but what you actually are going to be seeing in terms of team-based care and optimizing your patients. 50% still is fee for service. Smaller enhanced investment, but much larger bonus in track three, which is where you're going to spend the bulk of your time. It is full perspective payment. Again, cash management, value-based care. Very small, enhanced investment and a very large bonus. We're going to speak to that in a moment. In track one, your bonus potential is 3% of your total fee for service for Medicare payments for your primary care payments. That's pretty small. Again, a guaranteed payment. Track two is 45% of the sum of the Medicare fee for service. That's a pretty impressive amount of money. Track three is 60%. If you think about a fee for service plus 60%, 160% of Medicare, that's actually a really good payer. What do you have to do for that? Because all these projects are cost neutral as far as Medicare is concerned. That's the authority that CMMI has in order to be able to put these types of projects together. That means that you actually have to figure out how in the aggregate you're going to save money. Where do you save your money? You save it in your quality measure. You save it in your prevention. You save it in your ED utilization.

You save it in your total cost of care. It's incentivizing people once you get beyond those initial payments of, you know, an enhanced infrastructure which is guaranteed to actually have to modify the system. It's incentivizing both specialists and primary care to participate in this model.

Dr. Heslin Dr. Boufford.

Dr. Boufford Just a quick question. It's not driving volume, because the bonuses are based on fee for service?

Dr. Heslin The bonus is based upon your total fee for service payments. Fee for service is still the underpinning thing. Whether you get it as a prospective payment or not, your net fee for service is what it is.

Dr. Boufford I'm just asking, wouldn't it drive volume in fee for service versus in the managed care model?

Dr. Heslin That increases your costs, decreases your bonus. We don't have the details on the exact payment yet. They're actually doing a presentation tomorrow as the first public presentation with a bunch of data. This is like peeling back the onion. We saw the model. We liked the model. We said we'd sign up for a non-binding level. We're now engaged. We're contemplating marriage. We still have to get more details to get married. Once you get married, there's still a time where you're actually learning how to live with each other, so to speak. Very important in terms of equity. What they have done is they're requiring people to actually do these health screens and to actually collect beneficiary information, which is extremely important in order to understand your population and where you can make these leverage changes. They're going to reward people for actually doing that screening. What they're also looking at is how to provide resources to practices that are serving more underserved people. I'll point out the final one on the list for the sake of time. They're going to waive co-insurance for high need beneficiaries. People that are high need, they're going to eliminate that 20% co-insurance to make sure that they have access to care. That's huge. That is because, you know, now people don't necessarily need to have their secondary insurance, at least in terms of their primary base. It is a huge change. The final slide that I'm going to end with is tomorrow they are having a webinar on the model overview. Largely, these slides are probably mostly correct because I got them this morning, but they're going through the approval process and so there might be some small tweaks to the system that are there. Medicaid is currently in the process of negotiating the 1115 waiver, and Medicaid is also in the process of doing the negotiation for this. Medicaid would be that second big partner participant. After that, we'd see about aligning the commercial insurances up to see if we can get this more towards a total cost involvement for regions that wanted to participate. This is based upon individual practices and their kins. For example, small practice in the middle of the state could decide that they want to participate in it. We still have to figure out is the entire state participating or portions of the state. That's all stuff that Medicaid is still working out and is still under discussion. I don't want to be premature, but as a primary care physician looking at this, where it gives me a ten-year runway in terms of some sort of stability and at least guideposts under which I can function in this very fragmented world is very exciting to me.

Dr. Heslin I'll stop and entertain questions.

Dr. Rugge At the risk of repeating what Dr. Heslin said, it seems to me that my life has been one pilot after another. What we've heard about is T3 is a small pilot. I heard about

para medicine. It's a small pilot. What I lived through was the Adirondack primary care pilot as a way of going. It seems like coming up next with MCP is possibly the aggregation and the expansion of this to include providers of both type and across the entire geography of New York. A huge step forward, which will then depend upon lots of good policy thinking in terms of how we want to drive state policy changes to make this integrated into make it work. As one additional, perhaps final comment. It's disappointing we had such few so many people in the committee unable to attend today but encouraging by the level of the discussion and the number of ideas and can only look forward to the presentation of minutes and summaries that will tell us all the work ahead.

Dr. Heslin One thing I will add is Med PAC recommended that primary care be reimbursed at 150% of where it is now. My expectation with this project is that starting with the eight states, because the likelihood is for these projects to succeed. They didn't pick states that they thought it wouldn't work. They want to make this expansion. They'd like to try to probably take it to a larger level across the country.

Dr. Heslin Ms. Monroe, you have your hand up.

Ann Monroe John beat me to it, but it feels a little bit like Deja vu all over again with the number of times that we started to get excited with whatever the next iteration was of ways to organize and reimburse care to get better outcomes. One of the questions that I would ask, has the department really looked at why some of those did not work? Sometimes it's the design of the pilot, which is outside the department's control, but sometimes it's the essence of the parties more involved with the pilot and either barriers they ran into or ways that they didn't want to make a change that the pilot would have required. I'm concerned about us moving into this without a really clear-eyed understanding of what really needs to happen to make this successful that has not happened before. You mentioned some of it is the way reimbursement and some of it is the way it's organized, but some of it has to be some fundamental change in how care is provided here in New York to make us able to be successful. I just want to be sure that we've done those retrospective assessments of why certain things didn't work and what would have to be different for practices and clinics and systems to be involved with this that would make it more likely to be successful for us. I don't need you to go into that today, except just to share whether or not you think that retrospective assessment of previous pilot was like this had been done.

Dr. Heslin Yes, there's been look at previous pilots. There are two fundamental differences. I can get into more in the future, but there are two fundamental differences. The first is all the projects fail because they were too short. They demonstrated tendency towards savings, but they couldn't hit the threshold necessary by the CMMI rules to be able to become generalized in Medicare. Each pilot has failed because they couldn't get to that full nugget of the threshold requirement. The second fundamental difference, this is the first time that Medicaid has ever been put on the table at all and brought to the table. That is a completely different approach. Medicaid was always by whatever managed care plan.

Dr. Rugge I would suggest, Ann, that the questions you've just raised become, again, potential topics for us to address over the initial period of this new pilot.

Dr. Rugge Other final comments.

Dr. Rugge We have some departing people, departing souls. Rather than looking at the time frame suggested some time ago, we will look at the room and suggest that we will be meeting again and have much rich thinking behind us and in front of us.

Dr. Rugge Dr. Morley, do you have any comments or observations?

Dr. Morley Observations. The interest in this issue is intense and there's going to be a great deal more work. We're going to be getting back to you with much more information than we have already. I want to thank everybody that's already been working on this, particularly chairman Dr. Shaymaa Mousa, who's put an intense amount of work into this over the last week.

Dr. Rugge Yes.

Dr. Morley We will be getting back to you with much more information because it's obvious the importance of the issue and the intense interest on the part of the council.

Dr. Rugge Thank you very much.

Dr. Rugge I'm not sure we have a quorum to adjourn, but we will simply call it adjournment.

Dr. Rugge Thank you very much.