

HEALTH AND HUMAN SERVICES COMMITTEE
OF THE
SUFFOLK COUNTY LEGISLATURE

Verbatim Transcript

A regular meeting of the Health and Human Services Committee of the Suffolk County Legislature was held in the Rose Y. Caracappa Legislative Auditorium of the William H. Rogers Legislature Building, Veterans Memorial Highway, Smithtown, New York, on Thursday, November 12, 2009 at 2:00 p.m.

MEMBERS PRESENT:

Legislator Kate Browning, Chairperson
Legislator Tom Barraga
Legislator Jack Eddington
Legislator DuWayne Gregory

MEMBERS NOT PRESENT:

Legislator John Kennedy

ALSO IN ATTENDANCE:

Sarah Simpson, Assistant Counsel to the Legislature
Barbara LoMoriello, Deputy Clerk of the Legislature
Craig Freas, Budget Review Office
Paul Perilli, Aide to Majority Caucus
Linda Bay, Aide to Minority Caucus
Marge Acevedo, Aide to Presiding Officer Lindsay
Mike Pitcher, Aide to Presiding Officer Lindsay
Jack Caffee, Aide to Presiding Officer Lindsay
Skip Heaney, Commissioner of Economic Development
Steve Tricarico, County Executive Assistant
Lynne Bizzaro, County Attorney's Office
Greg Blass, Chief Deputy, SC Department of Social Services
Dr. Linda Mermelstein, Acting Commissioner, SC Department of Health Svcs. Matt Miner, Deputy Commissioner, SC Department of Health Services
Len Marchese, SC Department of Health Services
Debra Alloncius, AME Legislative Director
Dot Kerrigan, AME
Other Interested Parties

VERBATIM TRANSCRIPT TAKEN BY:

Lucia Braaten, Court Stenographer

[THE MEETING WAS CALLED TO ORDER AT 2:06 P.M.]

CHAIRPERSON BROWNING:

Good afternoon. We'll start the Health and Human Services Committee meeting with the Pledge of Allegiance, led by Legislator Barraga.

(*Salutation*)

CHAIRPERSON BROWNING:

No cards I see. I guess we'll start with the agenda. I think we -- only two things on the agenda, and I know, Matt, you have a presentation for us.

MR. MINER:

Yes.

TABLED RESOLUTIONS

CHAIRPERSON BROWNING:

So, okay. We will start with Tabled Resolutions. ***1714 - A Local Law to prohibit the use of tanning facilities by minors (Viloria-Fisher)***. I'll make a motion to table.

LEG. BARRAGA:

Second.

CHAIRPERSON BROWNING:

Second, Legislator Barraga. All in favor? Opposed? Abstentions? Motion's tabled. ***(Vote: Tabled 4-0-0-1 Not Present: Leg. Kennedy)***.

1757 - Authorizing that Resolution No. 348 (2009) be rescinded which appropriated 100% State aid from the New York State Office of Mental Health to Brookhaven Memorial Hospital (Co. Exec.). Matt, go ahead.

MR. MINER:

We would respectfully ask that that be tabled again. Brookhaven Hospital and the State are still trying to finalize everything, and once we have that approval from Brookhaven, then we'll go forward with the resolution.

CHAIRPERSON BROWNING:

Okay. Thank you. I'll make a motion to table.

LEG. EDDINGTON:

Second that.

CHAIRPERSON BROWNING:

Okay. Second, Legislator Eddington. All in favor? Opposed? Abstentions? Motion's tabled. ***(Vote: Tabled 4-0-0-1 Not Present: Leg. Kennedy)***

CHAIRPERSON BROWNING:

Sorry, Jack. I didn't see you sitting there. Oh, and I did make a mistake. Legislator Kennedy does have an excused absence.

INTRODUCTORY RESOLUTIONS

Introductory Resolution 1919 - Accepting and appropriating 100% additional Federal Aid from New York State Department of Health and Department of Health Services, Division of

Patient Care Services for the Family Planning Program (Co. Exec.). Motion to approve, Legislator -- Legislator Gregory, second, Legislator Barraga, and place on the Consent Calendar. All in favor? Opposed? Abstentions? Okay. Motion is approved. **(Vote: Approved 4-0-0-1 Not Present: Leg. Kennedy)**

With that, Matt, if you'd like to come up to talk about the health centers.

MR. MINER:

Before I speak on the health centers, Dr. Mermelstein, our Acting Commissioner, just wanted to give the group an update on H1N1.

DR. MERMELSTEIN:

Thank you, very much. I just wanted to let everyone know that the Department has received a fairly significant size shipment this week of H1N1 influenza vaccine and we are using that in our points of distribution clinics, which we have pretty much scheduled almost daily. We've been doing these clinics on an invitation-only basis so that we can reach the high priority groups for the vaccine. However, today we do have an open clinic for pregnant women, which will be starting at 3 o'clock in the afternoon and going from 3 to 5. We are recommending that people who are in the high priority groups get the vaccine. And we are also, in addition to having our own clinics to provide the vaccine directly, we're going to be transferring some of the vaccine that we receive from the State to local providers so that they can give it to their patients in the area.

If anyone has questions about the vaccine, they can call our H1N1 hotline, which is staffed from 8:30 to 4:30 every day on weekdays, and the hotline number is Area Code 631-787-2200. Thank you very much.

CHAIRPERSON BROWNING:

Thank you. Does anyone have any questions? No?

LEG. BARRAGA:

I have a question.

CHAIRPERSON BROWNING:

Yeah, I do want to ask you, because I just -- I received a message from a lady I know. She has a son with autism and she's been paying attention very closely to a lot of this H1N1 immunizations because there is Thimerosal in the vaccinations. Am I -- is that correct? And also, she just found out that there was a child who almost died from the vaccination. Do you know anything about that?

DR. MERMELSTEIN:

I'm not aware of any children that have died because of the vaccination. Children are much more at risk of dying because of the disease itself, so the risk benefit ratio of the vaccine to getting the disease is well in favor of getting the vaccine to protect yourself from influenza.

As far as the Thimerosal content of the vaccine, the Department has received a variety of different types, including the flu mist vaccine, which is appropriate for children and does not contain Thimerosal. We also have some of the pediatric doses which have either none or trace vaccine -- trace Thimerosal, if people are concerned. If patients, or parents of children, or pregnant women have questions about it, they can ask their health providers for guidance. But Thimerosal has really not been shown to have any link to causing any kind of harm or illness. So we have -- the New York State Health Commissioner has waived the law in New York State to allow Thimerosal vaccines to be given to people who previously wouldn't have been allowed based on the law because there is such a shortage of the vaccine.

CHAIRPERSON BROWNING:

Okay. I know the child didn't die, but got very ill, close to death, and that's the scary part, is, you know, I know while you're saying that so many more people may be saved, that's not how the

parent would feel. And me, as a parent, I would be I think very hurt and very upset to think that getting the shot could potentially kill my child, so --

DR. MERMELSTEIN:

As far as I know, there's not really a risk based on the current vaccine. The vaccine's very safe. Hundreds of millions of doses of influenza vaccine are given every year safely to people, and the H1N1 vaccine has been prepared in exactly the same way as all of the seasonal influenza vaccines have been created. The CDC is monitoring for side effects, as they do every year, and with all vaccines, through their vaccine -- it's a monitoring system for reporting of vaccine side effects. And so they're keeping a close watch on it to see if there's any side effects. But, as far as we have been told from the CDC, it's a safe vaccine and there's -- really shouldn't be fears about the safety.

CHAIRPERSON BROWNING:

We'll see. Legislator Barraga.

LEG. BARRAGA:

I don't know if you can answer this question, but maybe just your opinion. There has been a tremendous amount of publicity associated with H1N1 in all the media, yet I recently saw a letter from the Presiding Officer questioning whether or not we should spend an additional \$250,000 in making people even more aware. I could see he had some, which I thought were legitimate reasons maybe not to do that. Then I did see a response from the County Executive's Office indicating that we should pursue this. Is it necessary for the County, even if there's money coming from some other level of government, to spend another \$250,000 making people aware of H1N1 when all of this publicity -- every day we pick up the paper, we see major articles dealing with this. Is it necessary to do this?

DR. MERMELSTEIN:

I believe that it's necessary to have some funds available to be able to get the message that we want to get out at a right -- at the right time. I'll give you -- I'll give you an example. A couple of days ago we put out a press release about our POD clinic for the pregnant patients. Before that, we put out notice to the press about the availability of our PODS and that people needed to call our hotline. And a report was done in Newsday about Nassau County's pregnancy clinic, there was not any mention about Suffolk's program. So -- or there was a mention that the vaccine was available, but the specifics that someone would need to be able to follow up on that information was not there.

So we don't always have control specifically of what the press reports when we put out a press release, so to be able to get that message out and the message that we want to get out requires that we have access to resources for -- you know, for publicity or public education. So there is a need for that and the message changes. There is a possibility that the virus will change, there's a possibility that we'll have different instructions to give people about how to get the vaccine and to protect themselves. And so, as a department, it's our responsibility to get that information out, that's part of public health, so we would need that capacity.

The \$250,000 that was requested has been reduced now to \$100,000, so that we could get more vaccinators to come and help us to give vaccine in the clinics. So, yes, there is a need for it, and I think that we got the message from the Legislator. We have worked to try and come up with the reduced amount.

CHAIRPERSON BROWNING:

Go ahead.

LEG. GREGORY:

I know there's been -- I was watching a show the other day or on the news and they were talking about the concerns that people have because of the mercury that's in them, and some vaccines have it and some don't, and, you know, the link to -- possible link to autism and other things. Have we gotten a lot of calls on that, or what's your opinion about that, and what are we doing to educate

people about the safety or -- of the vaccines?

DR. MERMELSTEIN:

Okay. My opinion about that is based on information that is available on the websites at the CDC and through the State. So I would encourage people who have curiosity or questions about that to review the information that's available. It specifically addresses mercury. The Thimerosal, which is a preservative that's used in some of the vaccines, does contain ethylmercury. It is a type of mercury that is available in -- it's in various amounts, depending on the type of vaccine. So, when there's a multi-dose vial where you're taking multiple doses out of a single bottle of a vaccine, you need a preservative and that's what it's used for. The amount that is in a single dose is about 25 micrograms. To put that in perspective, if you eat a tuna -- six ounces of tuna fish, of albacore, you're getting about 30 micrograms. So it's about the same as having a tuna sandwich, essentially. And tuna is methylmercury, which is a different type, and there's different types of metabolism in the body.

The vaccine that has trace amounts of Thimerosal has less than one microgram. So, for example, for our clinic today where we're treating pregnant women, we are using the vaccine that has the least amount that's available that's appropriate for adults.

How we're educating people, we have the hotlines, so people are able to call, ask questions. Again, we've been encouraging people to speak to their own healthcare providers who they trust to get appropriate information. People should make themselves educated by reading the websites for the CDC where it goes into great detail to explain these. And people should really take with a grain of salt where they get their information from and make sure it's a reliable source. Did I answer all your questions?

LEG. GREGORY:

Yes. Thank you. And I just have something separate from the H1N1. Just I was talking to someone last week and there were some concerns, and maybe you could just look into this, not to catch you off -- on the spot. There were some concerns about the Riverhead Center, and that we are servicing patients in the hallways with masks, and there's some -- you know, some concerns there that have been relayed to me. And I'm not sure if you're aware of it, if there's anything going on because of that condition. I just heard of this probably just last week, so I assume it's a recent situation. I'm not sure if anything particular is going on there.

DR. MERMELSTEIN:

I have not heard those concerns, although we have put notices out, I think, in the health centers and we're trying to educate our patients that if you come in with an influenza-like illness and you think you have symptoms where you might spread to people in the waiting areas, to let someone know that they can put on a mask. So that would be the only thing that I could think of, but I have not heard any of those complaints, but we can certainly look into that.

LEG. GREGORY:

Okay. I would appreciate that. Thank you.

CHAIRPERSON BROWNING:

Legislator Eddington.

LEG. EDDINGTON:

Yeah. I wanted to ask you a question, that I was in my doctor's office yesterday and she said, "Well, you're a Suffolk County Legislator. Let me ask you a question about the vaccine." She said, "I can't get any. I have a thousand clients." And she said something to do with it's available in CVS and they're not -- they didn't order as much, or what she's finding is people are -- doctors are afraid they'll be stuck with it, or something, and I didn't know what to really recommend to her. I said, you know, "Stay tuned, I'll get back to you." Where can they go, what can they do, and is this a problem?

DR. MERMELSTEIN:

There's two things we're talking about. One is the seasonal influenza vaccine, which is probably what your provider was referring to. Because I think all of what's going on with H1N1, a lot more people are taking the seasonal vaccine this year, so there's a relative shortage of it. Keep in mind that right now there is no seasonal influenza out there. The primary influenza that is being tested and found is H1N1. So for the seasonal flu vaccine, there relevant really is somewhat of a shortage. In our department, we ordered about double the amount we usually do. We only received about half of it, and we have given out a significant portion of that. We've seen at least double the amount of people coming into our clinics for H1 -- for seasonal influenza vaccine all total. We still have a couple more clinics, so we have a little bit of vaccine left that we're using. And providers in the community also have felt that shortage, and because the vaccine is available throughout some of the commercial pharmacies, a lot of them had it when a lot of providers were not able. It's partly related to how they order, what the availability is. And it's sort of a federal issue in terms of how that distribution happens, it's not something that we control locally.

With regard to the H1N1, there really -- the vaccine has just been trickling in very little to the counties. The State is trying to control the distribution and make it equitable according to, you know, the per capita in each county, and they have been sending it primarily to hospitals. They're doing it on an equal basis by county, or trying to, but they are giving, you know, more of it to providers who treat patients in the priority groups. So they're giving it to health departments and they're giving it to hospitals who have health care workers and they're giving it to pediatricians' offices and obstetricians' offices so that it can get to the patients who need it the most.

LEG. EDDINGTON:

If I can follow up, then, so that what I'm hearing is that there is a shortage of both types of flu vaccines, and so it doesn't sound like it would be appropriate to advertise for something that we are not sure we're going to be able to get a handle on. I mean, that was one of the proposals, to advertise the flu vaccine and we're having trouble getting it.

DR. MERMELSTEIN:

Our public information campaign is not limited to advertising about the vaccine, it's to give information on -- really on the public health on what needs to be done to protect against influenza. To the extent that we have vaccine, we do need to advertise to get people to come and get it where they can, and to give them the right information so they know what they can do to get it. It's estimated that in the next few weeks we will get more and more vaccine, or it's hoped, in which case we'll have plenty, and then there will not be such concerns. It's just I think because, you know, we're in -- in a very short time frame of about six months, the CDC has produced this vaccine and made it available. It's taking time for it to get out. And six months is a lot shorter than the normal time that's available for production of the seasonal flu vaccine. Most of our emergency plans have been assuming that there would be no vaccine for a pandemic. So in some ways we're lucky that we have something that's out there to help protect us, but understanding that it was a very short turnaround time. It's a big process and project for the CDC to get all that vaccine into providers' hands throughout the country.

LEG. EDDINGTON:

Thank you.

CHAIRPERSON BROWNING:

Any more questions? Okay. Well, thank you. And I guess, Matt, you're on.

MR. MINER:

Thank you. And just to the right of me, right of Dr. Mermelstein, I'd just like to introduce Len Marchese. He's also in the Commissioner's Office. I'm here today just to talk a little bit about our current status in the Health Department, in particular, our health centers, and potential future options. I've had an opportunity to speak to some of you individually about some of the concerns we have within our health centers' network, and also share with you what I was able to learn at a

recent conference I attended in Chicago regarding federally qualified health centers.

Just taking one step back, the County Health Department and the administration both in patient care and in the Commissioner's Office, has been working over the last two-and-a-half years to improve the efficiency and effectiveness of our health center network. One of the first things that we do, when I came on board, was to establish working group meetings with all of our health centers and our hospital partners. In the past, the hospitals, although they contract and they staff many of our health centers, they weren't a partner or, from a management level, they did not participate in the operations of the health centers. We have changed that and we have working group meetings every six weeks with all the health centers. We share best practices, and we really make everybody a stakeholder, from the nurse manager or the medical director and administrator at the health center to the hospital CEO or CFO, as well as the administration and patient care in the health centers or in the administration office.

We've implemented over the last two, two-and-a-half years a number of best practice methods, including establishing provider productivity goals. When we get into federally qualified health centers, they have a goal of forty-two hundred visits per provider. A couple of years ago, we were around 2,000 per provider, so we were not very efficient. Over the last two years we've been able to change that and we've gotten it up to close to about 3,000 visits per provider, and we are working with all the administrators and medical directors to advance that even further.

We've also taken a look at how we allocate staff and had an opportunity to redeploy staff. So, for instance, in our Family Planning Network we found that the productivity was even less there and we actually had too many nurse practitioners. So we've redeployed those nurse practitioners into other critical areas, mainly prenatal PCAP Assistance Program, again, to try to hit where the staff is most needed and realign staff appropriately. We're developing staffing ratios to provider with industry standards, and we're taking a look at making sure we have the right mix of staff. We had a very intensive RN and provider mix. There are other health centers throughout the country that use -- rely on more nurse practitioners and physician assistants instead of an M.D., and they also rely on medical assistants and LPNs rather than all RNs.

The other thing we're doing is about 50% of our population is Spanish-speaking. We've created and the Legislature approved a medical assistant, Spanish-speaking. We also have clerk typist, Spanish-speaking. So, as people attrit out, we've been back-filling those slots with the appropriate titles. We issued an RFP for an efficiency consultant to come in and assist us in implementing best practices and they have been on board now for a few months. We were awarded five-and-a-half million dollars in HEAL money, 5 million for the Regional Center in Brentwood, and 250,000, approximately, for Shirley, and 250,000 for Riverhead. And we are also moving forward with an electronic medical records system that is part of the capital plan for next year, and hopefully around Spring of next year we'll start developing that EMR and having it implemented in about a year.

Despite all the best efforts of the Department, patient care, and our hospital partners and the staff at the health centers, the County is subsidizing the health center network and that subsidy is increasing. If you look at the bottom line here, the net cost to the County Health -- to the County for the operation of the health centers, in 2005 was about 22 1/2 million dollars. This year it's going to about 36 million, and going into next year, over 37 million dollars. At the same time, the primary care visits, at least for the first three years, '05, '06, and '07, remain relatively constant. You will see an uptick in primary care visits in '08 and '09, and that's primarily due to the productivity enhancements that we've put in place. With the same staff at the health centers we are able to see more patients because of some of the best practice measures we've put in. So you'll see, you know, 30,000 additional visits as compared to '07. And again, without adding staff, what we've done is change the doctors' schedules around, provided them with medical assistance, where possible, have implemented the POD either fully, like in Shirley, or partial PODs in many of the other health centers. And again, this is an effort to become as efficient both in terms of patient care and financially as possible.

Graphically displayed, again, this is the net cost to the County. You could see, it's rising considerably, 66% increase between '05 and 2010. One of the biggest driving factors in this is the loss of State Aid and the loss of State Aid comes in two areas. One, which is about 6 million dollars, is a reduction in bad debt and charity aid. Back in the early 2000's, we were receiving almost 10 million dollars a year in bad debt and charity. That has been reduced to about 4 million a year. Now this year it may be retroactive to '08. We are appealing that and fighting that, but the State is now revising its Article 6 formula. Article 6 is reimbursement that the Suffolk County receives, basically between 30 and 36%, for services. The State has issued guidance documentation, contrary, in our opinion, to the law, that they will no longer fund adult diagnostic and treatment. They will still reimburse us 30 to 36% on children, but anybody over the age of 19 that we treat, they have made a decision not to fund that. That will be another 4 million dollar hit. So, in a relatively short period of time, the State Aid assistance will be reduced by -- or has been reduced by 10 million dollars.

At the same time, this is just another slide showing -- it should be per patient visit. In '05 it cost the County about \$87 net cost to see a patient when they walk through the doors at the health center. Today it's over \$125 per visit. Again, this is despite our best efforts in implementing best practices. The loss of State Aid has really impacted our ability to -- you know, the financial hit on the County. Trying to transition now into federally qualified health centers, but this one slide is -- just shows you, our gross cost to treat a patient when they walk through the door is \$229. A federally qualified health center, it only costs to treat about \$123. There's two primary driving forces in that; one, is the staffing compliment and their expenditure side, and the other is their revenue side. So, with that as a backdrop, that's one of the reasons we wanted to at least start a dialogue with considering other options more cost effective to the County, especially in the lapse of State Aid.

So again, we're looking from the patient care administration and the health center or health administration, looking to ensure the long-term sustainability of the health center network. It is vital to the community. We see about 70,000 patients and between 270 to 300,000 patient visits. So, in order to do that, we need to look at other delivery models, including the federally qualified health center model.

And also one note. It's important that consumers that have the ability to pay something, that they do pay their fair share. We did start earlier this Spring an initiative to enroll all of the children in Child Health Plus. That has been met, unfortunately, with some resistance with the parents at our health centers. But every child that uses our health centers is eligible for Child Health Plus, and we are working with our medical directors and providers to educate the parents of these children on the importance of getting insurance, not only for the utilization of the health center, but should that child need specialty services or visit the emergency room, having that insurance, obviously, is a benefit to them. So we are pushing hard on the health center administrators and health directors to encourage enrollment into Medicaid managed care where applicable.

So what is a federally qualified health center, an FQHC? It's a federal program and it's administered by HRSA, and it provides primary care services, that's their mission. It's funded under Section 330 of the Public Service Act. FQHC's are located in all 58 -- 50 states, they're also in the U.S. territories and Washington D.C. There's over 6,600 delivery sites, 440 alone in New York, and this is just FQHC. There are additional sites for look-alikes. And over 16 million patients representing 63 million annual visits receive primary care via FQHC's.

When we established our health centers network 40 years ago, FQHC's weren't around. As they developed we didn't convert over. In hindsight, we probably should have taken advantage of Federal money all these years and we haven't done that. So it's something that we suggest that the Legislature and the Executive start to consider, especially as the State funds continue to dry up.

The mission and purpose of an FQHC is to provide comprehensive primary care services. This message, without the -- regardless of the ability to pay, this is essentially identical to the patient care mission statement. They have the same mission as our patient care, as our health centers, and that's why we think that this is a model that merits some consideration by the Legislature and

Executive going forward.

There are certain advantages to becoming an FQHC, and there's two types of FQHC's. There's a -- the grantee, and there's also a look-alike. If you become a grantee, you have access to certain Federal funds, including \$650,000 in startup money for each center, annual recurring, 650,000. Also, you have access to the ERRA funds, the American Reinvestment Recovery Act. There was 2 billion dollars that was set aside for federally qualified health centers. Unfortunately, Suffolk County, because it's not an FQHC, was not able to apply and capture any of that money, which was a significant loss. It would have went towards infrastructure and operations, and it really could have boosted our health center network.

Also, as a grantee, you are eligible for Federal Tort claim coverage, which would protect against liabilities. From time to time, we do have lawsuits within our health centers that our County Attorney defends us on, and many times these are very costly. Under the grantee, FQHC, you would have the protection of the Federal Government. They would defend you, and if -- they would also pay any liability, so there certainly is a tremendous benefit to that.

Look-alikes, as well as grantees, also receive enhanced reimbursement. And essentially what that is is wraparound money. You may have heard that term. We receive approximately \$129 per visit through Medicaid. Wraparound money would increase that somewhere between 180 to \$200, we believe, based on our preliminary estimates. And our consultant estimates that incremental revenue alone would generate an additional 7 million dollars a year to health center network. Again, just going backwards, the State has hit us by 10 million, so this would go a long way to offset some of the State cuts in recent years.

Also, patients would have access to 340B drug pricing, which is much favorable. We really don't have a drug program in our health centers right now, but under the FQHC program or look-alike, patients would have access to much more favorable drug pricing.

There are a variety of models of FQHC's. One of them is a public entity model where, if the County looked to go in that direction, it would be basically a co-applicant with a governing Board of Directors. The Board of Directors consist of basically consumers. Fifty-one percent of the Board must be a consumer, so it's the patient -- it's a patient-driven health center model, they decide the programs. And Len uses the example that under the public entity model, it's somewhat like the Community College, where they have their own Board of Trustees. The County would have a budget and the Board would work underneath that. The board has an obligation to meet monthly, and it has certain requirements, including determining services, policies and procedures and hours. So the patients, again, would run the center, and it's highly regulated by HRSA and the Bureau of Primary Care and the Federal Government.

So, to try to wrap this up, we've implemented a series of best practices. We're working with our consultant to continue to do that, but despite that, the County health center network has seen a 66% reduction in State Aid. So, in order to ensure long-term stability, we need to look at, as a County, other models. The Health Department believes that the federally qualified health center and the look alike model is a good one. And what we are proposing is a resolution, which I believe will be considered in December by this committee, to create a bipartisan Working Group consisting of the Legislature, Executive's Office, and the Health Department to examine other options, FQHC and other options that may be available to you, again, ensure the long-term stability of our health center network. Any questions?

CHAIRPERSON BROWNING:

I'm sure there is.

P.O. LINDSAY:

A lot.

CHAIRPERSON BROWNING:

Where do we want to start? Who's got questions? I guess I'll give the Presiding Officer first dibs.

P.O. LINDSAY:

Thank you, Madam Chair, for the honor. Matt, if we went to this Federal model, so we wouldn't be dependent on the State anymore for subsidies, lack of subsidies? Because, you know, even now in the latest dilemma to cut another 3 billion from the State, first thing they talk about is Medicaid. How many more cuts can they make of Medicaid without the system totally collapsing?

MR. MINER:

This is only for our health centers, so Medicaid would hit in other areas, nursing home and other areas, but --

P.O. LINDSAY:

I realize that, but --

MR. MINER:

With respect to the health centers, it would decrease our reliance on the State dramatically. There are some State grants that we would receive, and I would assume that any FQHC would also apply for them. But, no, the Medicaid one, the money would come through the Feds, and the wraparound money is really -- is key.

P.O. LINDSAY:

So we wouldn't get -- we wouldn't bill Medicaid for every patient we would see, we would bill the Feds? It.

MR. MARCHESE:

No, that's not -- actually, what happens is it's a joint application, and the State has to approve it as well. The way Medicaid works is the Federal Government kicks in 50% of that to the State as well, so the State is getting money from the Federal government. So what happens is not only does HRSA approve our application, but the State also has to approve it as well. And the funding mechanism is basically the same way we do it now, where we bill for every Medicaid patient. However, the Medicaid rate, what we get now, which is a hundred -- roughly \$130 a visit, would go up to 180 to \$200 a visit, because we would qualify for this wraparound funding. So, in fact, we would continue to get Medicaid dollars, it just would be -- it just would be at a higher rate because of this special election.

P.O. LINDSAY:

Okay. But would State in their budget deliberations be able to effect the amount that we get?

MR. MARCHESE:

To the extent that they reduce Medicaid to the whole -- if they were doing a blanket reduction in the State's portion of Medicaid, which meant that if they wanted to reduce a benefit package, or something like that, and the State did it on a system-wide basis, yeah, we would get reductions as well. It's just a -- it's a funding through the Medicaid Program, but it's more Federal dollars coming through the State.

P.O. LINDSAY:

Would the patient see any difference in services?

MR. MARCHESE:

No, no.

MR. MINER:

No.

MR. MARCHESE:

No. In fact, part of what we provide at the Health Department are services, regardless of whether or not you're Medicaid, private insurance, whatever you might have. So we're pretty much blind -- our physicians are blind to that, so our services --

P.O. LINDSAY:

It's just a funding issue.

MR. MARCHESE:

It's a backroom funding issue, correct.

P.O. LINDSAY:

There won't -- there won't be any difference to our patients? How about to our employees?

MR. MINER:

Just on the patients for a second. Some of the services actually may be enhanced in terms of there's a requirement to have mental health, dental services that we don't have for all of our patients right now. So there would actually -- and then 340B pricing as well. So actually it would be an enhancement of some of the services.

MR. FREAS:

There are also opportunities under the FQHC program for us to receive additional revenue for services that not only -- not only we would be required to provide, but, for example, social work services are billable as FQHC's. Currently, we -- you know, provide substantial social work services, but we don't get any reimbursement at all from them. If we were an FQHC, we'd get reimbursement at the Medicaid threshold rate for our social worker services.

MR. MINER:

In terms of the employees, the FQHC, again, would be a not-for-profit 501c3. I think this is one of the things that we have to explore with our consultant with the Working Group Committee exactly how things would be structured. My understanding is that the FQHC, the not-for-profit new entity could contract with the existing hospitals that we have, or contract perhaps with the Health Department for like Riverhead and Tri-Community where we have County staff. Again, that has to be looked at a little bit more, and that's one of the reasons we're suggesting that we take the next step, not immediately apply, but have a working group where we can flush some of this out and model it appropriately for the full Leg. and Executive.

P.O. LINDSAY:

So, in effect, we'd be privatizing the health centers.

MR. MINER:

It's a not-for-profit board. It's not complete -- it's a public entity FQHC. Fifty-one percent is board of -- is non-County, but there is a County, significant County program, and there would be a County subsidy required under this model.

P.O. LINDSAY:

Is there any way of qualifying for this without privatizing?

MR. MINER:

It's a co-applicant application. It's the County and the Board of Governors applying jointly as a public entity model. The alternative to that would be to have a third party, a preexisting FQHC that operates, you know, somewhere else in the State or country that could come in and operate all of our health centers for us.

P.O. LINDSAY:

How -- and it really doesn't relate to this alone, but in the debate that's going on in Washington

about healthcare reform, how is -- how, if that's passed in like the House version that passed, how is that going to affect our health centers, or is it going to affect our health centers?

MR. MARCHESE:

Well, more people would have insurance under that model, so the current patients that we're seeing now that don't have insurance, theoretically, would have insurance and can choose their own providers, and they may choose to continue to come to the health centers or they may choose another provider. So, theoretically, depending on where that person chose to go, that would affect our volume or not.

P.O. LINDSAY:

So it could affect our volume. Would it affect our -- well, if more people are insured and they choose to stay with the health centers, it could add a new revenue stream as well.

MR. MARCHESE:

Yeah. Yeah, that's correct, so we would have the revenue stream from that, sure.

P.O. LINDSAY:

And how quick can we convert to this Federal --

MR. MINER:

There's, again, two FQHC models, there's the grantee model and there's the look-alike. What would probably be the County -- if they were going to go that way, we'd probably apply for a look-alike first, because that's a rolling application, it's much less competitive, and it would put us in position to convert over, and again, capture of the wraparound money, the 7 million dollars or thereabouts. The full grantee status is a very competitive process and depends on the Federal allocation each year. That we would also apply for, but that may take a little bit more time to actually acquire, and that is not a rolling application, there's one cycle per year. The 2010 cycle, the date for the application has not been announced yet. What we were hoping is if we could get this resolution moved forward, there would be a 60-day window where the Legislature, this bipartisan committee would meet, formulate some type of recommendation, and presumably at that point direct the Health Department to apply for either look-alike or full or both, and that we can apply for both, which would probably be the avenue that we would go. But I think what has to be explored is exactly how we structure the FQHC application and what model we would like to look at.

P.O. LINDSAY:

Thank you, Madam Chair. I'm sorry, so many questions.

CHAIRPERSON BROWNING:

Okay.

MR. MARCHESE:

If I could just add one thing on -- you mentioned something about privatizing. The fact is that a large -- a large percentage of the work that we do at the health centers has to do with our public health mission with the Health Department. In that case, we would never get out of that business, because we still need to provide those services under the law. So, in any model, whatever we chose, we would have to -- it would be a mandatory thing that we would contract with whoever was going to run it or whatever entity would be to provide all of those public health services. So those are -- and that is basically why we would have to continue to have a financial relationship with that entity, because we would have to pay for those services. So there would always be a County interaction with whatever this FQHC model was to provide those health services.

P.O. LINDSAY:

Well, just the thing that's worrisome is if we created this community board, that 51% of the -- you know, the board controls or has 51% of the health center. They make the decisions, but we're paying for it, and that's --

MR. MINER:

Much like the College, the Legislature and the Executive would agree on the budget, the FQHC would have to operate within that budget, or find an alternate. They can do fund-raising as 5031c -- 5031c.

MR. MARCHESE:

501c3.

MR. MINER:

They can do not-for-profit fund-raising and other things like that.

CHAIRPERSON BROWNING:

DuWayne.

LEG. GREGORY:

My question is how would our -- Nassau has an FQHC, right?

MR. MARCHESE:

Yeah.

MR. MINER:

I believe they are now look-alike and applying for the full status now, yes.

LEG. GREGORY:

Okay. After everything's complete, we get the status, or whatever, the designation. How would our overall network of healthcare centers look? Would we just have one healthcare center, would we have 12, would we have 11, you know?

MR. MINER:

No. What --

LEG. GREGORY:

Because my concern is, similar to what Bill's eluded to, you know, would we go into privatizing? And from what I understand, with FQHC, it's only -- it's tied to census tracks, and it's only certain communities that the population and income is related to the designation, at least from my understanding of it.

MR. FREAS:

You're -- I'm sorry. You're required to have some sort of medically under-served population in the area you served. However, once you have that census tracked, or population, or designated area, you can then from there serve various other populations that don't necessarily exist in that area. So if it was in Wyandanch that we got the MUA, we could have Martin Luther King who might be the base, but the rest of them would then run under the same license, just the way the Article 28 isn't just for each health center, it's all the health centers right now.

MR. MINER:

If we were to pursue this, we would apply as a network. And we do have a medically underserved area designated by the Federal Government and that's the area of North Bellport that is designated as a medically underserved area. So HRSA and our consultant has confirmed that we can apply as a network, because residents from that census track do use one of three of our health centers; they use Shirley, Patchogue or Coram, so we can apply as a network. Our consultant has encouraged us and we're working with them to designate other areas or apply for designation of other areas throughout Suffolk County that may either be medically underserved population or medically underserved area, again, to strengthen our application. But as long as you have one site, you can apply as a network. And we would not look to change the model, you know, the nine health centers

that we have is what we would be applying for.

LEG. GREGORY:

Okay. So you'd be looking to service all of our health centers through this designation, not --

MR. MINER:

That would be what the --

LEG. GREGORY:

Okay.

MR. MINER:

Application would be for all of the health centers, yes.

LEG. GREGORY:

Okay. All right. Thank you.

CHAIRPERSON BROWNING:

Okay. I was going to ask a question and I'm drawing a blank now. I know that LION was here, had to be about a year ago, right, to talk about this, so I see that you are moving on trying to work on this. But get back to our health centers. If you -- we could choose to continue to have them as County-run health centers.

MR. MINER:

Again, the way we structure the FQHC, if we went that direction, would either be a public entity model where it would be a partnership between the County and this Board of Governors, or, as an alternative, the County could, if it chose to hire or contract with another FQHC, let's say Hudson River who operates out in Greenport and has several facilities out in Poughkeepsie and Westchester County, that's something that I think has to be modeled and discussed by the Working Group. There are pros and cons to both. But if we elected to go into the public entity model where it's basically a 50-50 partnership with the Board of Governors, my understanding is, and we are working with the Feds and our consultant to confirm, and again, part of the Committee -- these are discussion points for the Committee, that we could subcontract, that works. So the vendor that we have, whether it's a County basically in Amityville, Riverhead, East Hampton and Southampton, or whether it's like Brookhaven Hospital and Shirley and Patchogue, they could continue doing operation, they would just have a contract with the County, they would have the contract with the 501c3.

CHAIRPERSON BROWNING:

Okay. Any other questions? Craig, do you have any other comments?

MR. FREAS:

(Shook head no).

CHAIRPERSON BROWNING:

Okay. Well, we thank you for the presentation. And I did --

P.O. LINDSAY:

Can I ask a question, not on this?

CHAIRPERSON BROWNING:

Yeah. Let me finish. I did speak with Matt about if there was any interest of the Committee to look into any of the other health centers, the FQHC health centers that currently exist, if you want to visit them, whatever, I think we should be open to doing that to see how they operate. But with that, Bill?

P.O. LINDSAY:

I don't know whether you covered this before I came in the room, but H1N1?

LEG. GREGORY:

Yes.

P.O. LINDSAY:

We did, okay. I'm sorry.

CHAIRPERSON BROWNING:

That's okay.

DR. MERMELSTEIN:

I'll be happy to meet with you after.

P.O. LINDSAY:

Okay. Thank you.

CHAIRPERSON BROWNING:

Okay. I thank you.

MR. MINER:

Thank you very much you.

CHAIRPERSON BROWNING:

And do we have anyone in the room? I know we have a couple people who walked in later. No comments? Okay. With that, I guess I'll make a motion to adjourn; seconded, Legislator Gregory. So we're adjourned.

[THE MEETING WAS ADJOURNED AT 3:57 P.M.]