AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: June 14, 2012
Time: 10:00 AM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-May 24, 2012

CHIEF MEDICAL OFFICER REPORT — **DR. WILSON**

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

ACTION ITEMS:

1. Resolution authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an Affiliations Agreement with the State University of New York/Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at Kings County Hospital Center ("KCHC") for a period of one year, commencing July 1, 2012 and terminating on June 30, 2013, consistent with the general terms and conditions and for the amounts as indicated in Attachment A to provide the parties adequate time to conclude negotiations for a new agreement;
   And
   Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A. — **MR. PROCTOR**

2. Resolution a authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an extension to the Affiliation Agreements with the Physician Affiliate Group of New York, P.C. ("PAGNY) for the provision of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center ("Lincoln"), Morrisania Diagnostic and Treatment Center ("Morrisania"), Segundo Ruiz Belvis Diagnostic and Treatment Center ("Belvis"), Jacobi Medical Center ("JMC"), North Central Bronx Hospital ("NCB"), Harlem Hospital Center ("Harlem"), Renaissance Health Care Network Diagnostic and Treatment Center ("Renaissance") and Coney Island Hospital ("CIH") for a period of three months, commencing July 1, 2012 and terminating on September 30, 2012 with a funded option for another three months commencing October 1, 2012 and terminating on December 31, 2012, to provide the parties adequate time to conclude negotiations for a new agreement;
   And
   Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A. — **MR. MARTIN/ MS. ZURACK**

INFORMATIONAL ITEMS:

1. Business Continuity Program Update — **MR. KEIL**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: May 24, 2012

ATTENDEES

COMMITTEE MEMBERS:

Michael A. Stocker, MD, Chairman
Alan D. Aviles
Josephine Bolus, RN
Vincent Calamia, MD
Christina L. Jenkins, MD
Amanda Parsons, MD (representing Thomas A. Farley, MD)

HHC CENTRAL OFFICE STAFF:

Gary Belkin, Senior Director, Office of Behavioral Health
Deborah Cates, Chief of Staff, Board Affairs
Louis Capponi, MD, Chief Medical Informatics Officer
Nelson Conde, Senior Director, Professional Services & Affiliations
Paul Contino, Chief Technology Officer, Information Services
Diane Conyers, Corporate Risk Manager
Juliet Gaengan, Senior Director, Clinical Affairs
Marisa Salamone-Greason, Assistant Vice President, Corporation Information Technology Services
Evelyn Hernandez, Director, Media Relations
Erin Hughes, Director, Media Relations
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Irene Kaufmann, Senior Assistant Vice President, Office of Ambulatory Care Redesign
Mei Kong, Assistant Vice President, Patient Safety
Robert Kurtz, MD, Senior Clinical Advisor to Chief Medical Officer
Patricia Lockhart, Secretary to the Corporation
Ronal Low, MD, Senior Director, Office of Data Analysis
Tamiru Mammo, Chief of Staff, Office of the President
Irina Manarova, Assistant Director, Corporate Planning
Susan Meehan, Assistant Vice President, Medical & Professional Affairs
John Morley, MD, Deputy Chief Medical Officer
Bert Robles, Senior Vice President, Information Technology/Corporate Chief Information Officer
Salvatore Russo, General Counsel, Legal Affairs
David Stevens, MD, Senior Director, Health Care Improvement
Steven Van Schultz, Director, Office of Internal Affairs
Joyce Wale, Senior Assistant Vice President, Behavioral Health
Katie Walker, Assistant Vice President, Institute for Medical Simulation & Advanced Learning
Manasses Williams, Assistant Vice President, Affirmative Action/EEO
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer, Medical & Professional Affairs

FACILITY STAFF:

Machelle Allen, MD, Interim Medical Director, Bellevue Hospital Center
Chris Constantino, Executive Director, Elmhurst Hospital Center
Lynda D. Curtis, Senior Vice President, South Manhattan Network
Van H. Dunn, MD, MPH, Chief Medical Officer, MetroPlus Health Plan, Inc.
Iris Jimenez-Hernandez, Senior Vice President, Generations +/Northern Manhattan Network
Robert Hughes, Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility
George Proctor, Senior Vice President, Central & North Brooklyn Network
Gloria Ranghelli, Chief Financial Officer, Coler-Goldwater Specialty Hospital and Nursing Facility
Denise Soares, Executive Director, Harlem Hospital Center
Arthur Wagner, Senior Vice President, Southern Brooklyn/SI Network
William Walsh, Senior Vice President, North Bronx Healthcare Network
Meryl Weinberg, Executive Director, Metropolitan Hospital Center
Roslyn Weinstein, Acting Executive Director, Kings County Hospital Center

OTHERS PRESENT:

Melissa Dubowski, Analyst, Office of Management and Budget
Scott Hill, Account Executive, QuadraMed Corp.
Howard Krain, FACHE, Senior Sales Executive, Microsoft Corporation
Megan Meagher, Analyst, Office of Management & Budget
Richard McIntyre, Key Account Executive, Siemens
Tamara Robinson, Contract Administrator, CIR/SEIU

**MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, May 24, 2012**

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 2:03 P.M. The minutes of the April 19, 2012 Medical & Professional Affairs/IT Committee meeting were adopted. Dr. Stocker noted that it is suggested to hold future meetings of the Medical and Professional Affairs/Information Technology Committee at a minimum of one week prior to the full Board meetings to support the movement and approval of various action items.

CHIEF MEDICAL OFFICER REPORT:

Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer reported on the following initiatives:

1. Institute for Medical Simulation and Advanced Learning (IMSAL)

IMSAL hosted another very successful facilitator training program with the CMS group from the Harvard system. HHC was able to support this advanced training for another six members of our staff, to continue the expansion of expertise across more of our sites and hasten the facility based work of the IMSAL.

In addition, the first meeting of the re-vamped IMSAL Advisory Committee was convened this month, with the responsibility to advise on overall strategic direction for simulation training across our whole system, as well as new curriculum priorities.

2. Research

As part of the HHC-NYU partnership in the Clinical & Translational Science Institute (CTSI), we were pleased to announce the successful recipients of funding for HHC research projects after a competitive process. The recipients are:

- *L. Paladino MD (Kings County Hospital Center): The Rapidly Improving Stroke Symptoms (RISS) Study: A Pilot Observational study.*
- *H. Valsamis MD (Kings County Hospital Center): The Brooklyn Health and Hospitals Corporation TraumaticBrain Injury Network (BHHC TBraIN).*

3. Third Annual John Corser Symposium

The third Annual John Corser Bioethics Symposium *"An Ethics Journey from Global to Specific: Health Care Reform and Mediation at HHC"* was held on May 9, 2012 at Harlem Hospital Center with over 200 HHC leaders including physicians, nurses, chaplains and senior managers in attendance. Keynote speaker Bruce Vladeck, PhD, led the day with "The Ethics of the Affordable Care Act."

The symposium provided participants with an understanding of the new legislation dealing with health care reform affecting important end-of-life decision making, and ethical issues surrounding withdrawal of life sustaining treatments. Formal policy changes relating to the application of the Family Health Care Decisions Act, and the determination of brain death are being released following these discussions Corporate-wide for implementation, to align with the recent change in NYS policy from two assessments to one assessment to determine brain death.

4. HHC Walks to Raise Funds For The National Alliance For the Mentally Ill

On Saturday, May 12, 2012 HHC's Departments of Psychiatry and Central Office of Behavioral Health participated in a City-wide walk to raise funds for the National Alliance For the Mentally Ill, (NAMI) NYC Metro Chapter. NAMI is a national advocacy organization began by family members to create a voice for improved research and care for those suffering from mental illness. HHC had six facilities and central office participate (Metropolitan Hospital Center, Harlem Hospital Center, Bellevue Hospital Center, Coney Island Hospital, Kings County Hospital Center, and Lincoln Medical and Mental Health Center). There were a total of 97 walkers raising over $15,000.

5. 2012 Annual Behavioral Health Planning Session – June 7 at Draper Hall

The 2012 Annual Behavioral Health Planning Session will be held on June 7th at Draper Hall. This important meeting is the forum for the HHC discussion on the journey towards Behavioral Health managed care, with our experience to date with the BHO (Behavioral Health Organization), as well as our preparation for the next steps. Dr David Cutler, Otto Eckstein Professor of Applied Economics, Harvard University Department of Economics will be one of the keynote speakers.

6. HHC's Center for Teen Health Improvement

HHC has received grant funding from the Mayor's Young Men's Initiative (YMI) to improve services for teens and young adults, with an emphasis on improving sexual and reproductive health service quality and access for young men. This funding, which extends through fiscal year 2014, has enabled HHC to launch a system-wide improvement initiative focused on the health and development of young people in the populations that we serve. This work will be coordinated by the newly formed *Center for Teen Health Improvement* within the Office of Healthcare Improvement.

The goal of this Center is to improve the physical, psychological, and social well-being of young people. The aims are: 1) quality healthcare services for young people within HHC: a) "Teen Friendly" customer service practices to encourage young patients to openly communicate their needs, return for follow up care, and refer their peers; b) excellence in clinical service provision, in accordance with best practices in adolescent health care; 2) support for HHC's young patients in learning to make choices that promote long-term health; and 3) seamless partnerships with City-wide agencies that complement HHC in promoting youth development. Strategies include: 1) *Staff Training* – all clinical staff will be trained on clinical guidelines and skills, customer service, and issues in adolescent care; 2) *Systems Improvement* – a needs assessment will guide improvements to make HHC's services more appealing and accessible to young people. This may include updating clinic spaces, hours, equipment, and operating procedures; and 3) *Youth Engagement* – young people will be recruited and trained to help improve HHC's services for their peers. They will participate in provider training as model patients, educate their peers and communities about healthy behaviors and care-seeking, and promote HHC's services via outreach and technology. This work will improve participants' life and job skills, and build their self-esteem as they serve as important partners in healthcare improvement.

An announcement will go out the HHC facilities informing them of this new initiative and state how HHC staff can support and benefit from the Center for Teen Health Improvement such as: by joining our HHC professionals interested in care for young people – send us your contact information and tell us where you work and what you do; we will inform you about relevant news, events, resources, opportunities; tell us what needs to be done – respond to our surveys, talk to us… we need your insights and ideas!; and take action –

start or join workgroups to address specific improvement needs. Make a difference, be a leader, connect with your colleagues from around HHC!

Staff contacts are: Shoshanna Handel, MPH, *Director, Center for Teen Health Improvement* – Shoshanna.Handel@nychhc.org (212) 788-3606. Elet Howe, *Assistant Director, Center for Teen Health Improvement* – Elet.Howe@nychhc.org (212) 676-0205 . David Stevens MD, *Senior Director of Healthcare Improvement* – David.Stevens@nychhc.org (212) 442-4067 .

METROPLUS HEALTH PLAN, INC.

Dr. Van H. Dunn, Chief Medical Officer, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Dunn informed the Committee that the total plan enrollment as of April 24, 2012 was 427,245. The breakdown of plan enrollment by line of business is as follows:

Medicaid	359,414
Child Health Plus	17,131
Family Health Plus	36,295
MetroPlus Gold	3,084
Partnership in Care (HIV/SNP)	5,733
Medicare	5,588

For the first time in many months, MetroPlus had a decline in enrollment. From March to April MetroPlus dropped 675 members overall, 230 in Medicaid, 391 in Child Health Plus and 117 in Medicare. The reduction in Medicaid was due to a lower rate of applications, while the reduction in Child Health Plus was due to loss of eligibility. For Medicare, MetroPlus had 250 members disenrolled for failing to pay their premiums since January after a 90 day grace period. Dr. Dunn provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

Each month, data is shared with the Committee that reflects members that have disenrolled from MetroPlus and have transferred to Health First. In collaboration with HHC Finance, these transfers were studied, and 80% of those who transferred were no longer receiving care at HHC. A sample survey was done on those individuals who transferred. Eight hundred and fifty one members with valid phone numbers received outreach. Two hundred and forty two or 28% of those were reached. The two main reasons for members leaving MetroPlus and HHC were desire to receive care from providers not in our plan, and problems with accessing care. 76.6% reported leaving to go to a non network provider. 17.9% left due to difficulties accessing care.

MetroPlus also conducted a survey of Medicare members that voluntarily disenrolled in January and February 2012. Of the members disenrolled, approximately 12% were reached and a disenrollment survey was completed. The main reason given for disenrolling was dissatisfaction with benefits offered by the Plan. MetroPlus is currently finalizing a renegotiation of provider contracts that should allow them some flexibility in offering enhanced value added benefits. Preliminary results for May show that MetroPlus will gain between 1,500 to 2,000 members.

On the other hand, MetroPlus will continue to face challenges in their ability to offer additional services to their Medicare population. Based on current federal legislation there will be a projected 19.28% base premium reduction in MetroPlus' Medicare Advantage rates over the next five years. The Affordable Care Act requires that counties such as those within New York City that are above the national fee-for-service

(FFS) average reduces costs to 95% of FFS. Re-evaluated annually, county rates will be reduced over a maximum of six years to achieve these rate reductions.

The New York State Department of Health (SDOH) will be providing 2012-2013 rates in two phases. In Phase I (early May), plans can expect the April 1st base Medicaid and FHP medical rates. Regional trends are about 5% vs. 7% last year. This is before SDOH applies the legislative cuts from last year (it was a 2 year deal for managed care plans). These include a 1.7% trend reduction and a 2% overall reduction, leaving an approximately 1.3% trend. Separately, pharmacy rates are being reduced from the October carve-in to reflect an increase in the expected generic dispensing rate (from 72% to 77%) and an elimination of the funded carve-in transition period. An analysis of these new pharmacy rates reveal that MetroPlus will receive approximately 36 million dollars less in pharmacy revenue over the next year. In Phase II, MRT adjustments will be funded and include the carve-in of new populations and expenses, including low weight and disabled (SSI) babies, homeless recipients, and dental. All of these will come with incremental revenue and cost. SDOH is still developing those rates and those will probably not be available until mid-year. Chronic mediations that someone has been on for three months, look at prescriptions per member per month for those with chronic disease and monitor whether there has been a decrease in those being filled. Filled rates are monitored since formulary change to ensure all patients are receiving their appropriate medications – one of the major issues is that providers are not filling the 'prior authorization' required for non-formulary medications which we are addressing by outreach to both patients and providers.

On April 12, 2012, Governor Cuomo issued an Executive Order to establish a State-wide Health Exchange, an online marketplace where individuals and small businesses can choose among competing health insurance plans. The Governor stated that this will reduce cost of coverage for individuals, small businesses and local governments.

CHIEF INFORMATION OFFICER REPORT

Bert Robles, Chief Information Officer provided the Committee with updates on the following initiatives:

1. Meaningful Use (MU) Stage II

On February 23rd, the Centers for Medicare and Medicaid Services (CMS) released a Notice of Proposed Rule Making for Eligible Hospitals and Eligible Providers to meet Meaningful Use (MU) in the program's second stage. As presented to the Board previously, the Corporation has made steady progress towards Stage I MU for the HHC hospitals and HHC is currently meeting thresholds for all Stage I measures.

Stage II introduces the following significant changes to the program:

- Hospitals will have 16 core items and can pick two of four menu items were previously they had 14 and could choose five out of ten. Eligible providers will have 17 core and can pick three of five menu items.
- Most thresholds for MU will be increased. For example, patient demographics must be recorded for 80% of patients, where previously it was for 50%. The threshold for assessing smoking status is also up to 80% from 50% and the requirements for decision support rules are increased to five from one.
- Almost all Stage I menu requirements will be core including the requirement for *Summary of care at transitions,* syndromic surveillance, R\reportable lab results for public health, medication reconciliation, and providing educational resources to patients.
- The Summary of Care Document must be provided for at least 65% percent of transitions and referrals **and** would have to be electronically exchanged between the hospital and a provider that is **not** affiliated with the hospital and is using a **different** EHR vendor product. This proposed

requirement may present particular difficulties for integrated delivery systems, where a large majority of referrals are within the system and using the same EHR. Professional Organizations such as the Greater New York Hospital Association (GNYHA), National Association of Public Hospitals (NAPH), the American Hospital Association (AHA) and the Hospital Association of New York State (HANYS) have identified this as an unreasonable request for their constituents. HHC concurs with their position.

- CMS proposes that at least ten percent of a hospital's patients would need to view or download information about their hospital stay, or electronically transmit their information to a third party. This requirement would make providers accountable for patients using computer technology. While GNYHA, NAPH, AHA and HANYS encourage electronic interaction with patients through the use of computer technology, they have found this requirement to be untenable. HHC concurs with their opinion.
- A new menu objective for Hospitals is to generate and transmit permissible discharge prescriptions electronically (eRx) for more than 10% of patients. This requirement could cost HHC an additional two million dollars annually for fees related to eRx and accelerate the planned implementation of eRx in the inpatient setting.
- A new objective for eligible providers would mandate that secure electronic messaging be used to communicate with more than 10 % of unique patients seen during the EHR reporting period. Although the requirement does not require the patient to respond, a requirement to electronically communicate with one out of ten patients may not be appropriate in many cases.

In addition to the new measures and thresholds, all hospitals will be required to submit quality metrics electronically in 2014.

The Notice of Proposed Rule Making also articulates the timetable where penalties will begin to be levied on providers who are not meaningful users. A one percent reduction in Medicare rates will commence in 2015 for Hospitals who have not attested to meaningful use by July 1 of 2014. Unexpectedly, eligible providers who elect to attest under the Medicaid Program will nevertheless be subject to Medicare Part B penalties if they have not attested by October 1, 2014. This is despite the fact that the Medicaid Program allows eligible providers to begin meaningful use as late as 2016, without reduction in incentive funding. Thus the program, on one hand recognizes that Medicaid eligible professionals may need more time to reach meaningful use and gives them until 2016 to start, but on the other hand penalizes what limited Medicare revenue they receive if they don't start by 2014.

2. Enterprise Business Intelligence (BI) Initiative

EITS is embarking on one of the most critical initiatives for HHC- establishing an Enterprise Business Intelligence (BI) strategy. BI is widely viewed as a key strategic imperative for the success of information driven organizations. With the explosion of information technology in healthcare and the accelerated pace of health care reform, we are grappling with enormous amounts of data and an incredible pace of change that requires new and sophisticated ways to allow us to timely and effectively analyze and model.

At its core, BI is about decision making. BI converts enormous volumes of data into meaningful analytics and metrics about HHC's current business and clinical operations. It identifies evolving patterns that allow us to be more responsive to changing conditions and therefore, make more informed decisions. Some of the key objectives of the BI initiative will be to:

- Strengthen data and information governance
- Integrate data from diverse systems to enable advanced, comprehensive analytics to drive clinical, financial and operational improvement

- Streamline the data reporting process flow and improve efficiency and service levels
- Deploy meaningful reporting, dashboards and alerts for various user levels that track and monitor key performance indicators
- Provide both retrospective and predictive forecasting capabilities to answer not only what happened but why did it happen.
- Enable self-service reporting analytics and the ability to drill down into key performance indicators for better evidence-based decision-making.

Our goal in deploying this Business Intelligence and Analytics strategy is to greatly enhance our ability to execute on our Corporate objectives and mission.

3. Patient Centered Medical Home (PCMH)

EITS is working in partnership with Medical and Professional Affairs on another of HHC's most critical strategic initiatives- the implementation of Patient Centered Medical Home (PCMH). Presently, HHC has a primary care population of more than 477,000 adult and pediatric patients.

The primary goal of the PCMH initiative is to improve patient outcomes through improved care management and care coordination. All of our acute care facilities and diagnostic and treatment centers, 17 separate sites in all, have received designation as Patient-Centered Medical Homes (PCMH) by the National Committee for Quality Assurance (NCQA) and awarded each the highest, Level 3, PCMH Recognition. HHC is in the process of PCMH designation for 22 community health centers and extension clinics. If all of our primary care sites ultimately receive Level 3 NCQA Recognition status, HHC will ultimately qualify for at least $15 million annually in enhanced Medicaid reimbursement rate increases.

4. IT Asset Management

EITS' Service Management Office is in the process of developing and implementing IT Asset Management for the division.

IT Asset Management is a set of business practices that leverage financial, contractual and inventory functions to support life cycle management and decision making for the IT environment. This is especially critical for EITS as budget dollars shrink and demand for IT services increases. There are multiple benefits of implementing this type of program for EITS. They include but are not limited to: accurate budgeting, cost and risk reduction and increased asset utilization. Presently, the Service Management Office team is implementing Asset Management at the Jacobi Data Center with implementation at both Queens and South Manhattan Networks targeted for the end of this Fiscal Year. The remaining networks (North Bronx, Generations+, North &Central Brooklyn and South Brooklyn Networks) will be completed by the end of this calendar year. Successfully implemented, IT Asset Management will enable EITS to support user demands quickly while rationalizing the cost of services.

ACTION ITEMS:

1. Resolution authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an amendment to the Affiliation Agreement with New York University School of Medicine ("NYUSOM") for the provision of Health Services at Woodhull Medical and Mental Health Center and Cumberland Diagnostic and Treatment Center which terminates on June 30, 2014, to include the provision of General Care Health Services at Coler-

Goldwater Specialty Hospital and Nursing Facility ("Coler-Goldwater"), consistent with the general terms and conditions and for the amounts indicated in Attachment A;
AND
Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

Presenting to the Committee was Robert Hughes, Executive Director, and Gloria Ranghelli, Chief Financial Officer, Coler-Goldwater Specialty Hospital and Nursing Facility.

The current Affiliation contract Roosevelt Island Medical Associates, P.C. (RIMA) served as the affiliate for the consolidated Coler-Goldwater Specialty Hospital and Nursing Facility (Coler-Goldwater) has been in existence since July 1997 and will terminate effective June 30, 2012. Effective July 1, 2012 the New York University School of Medicine (NYUSOM) will serve as the Affiliate for Coler-Goldwater. To ensure a smooth transition and continuity of care for our patients, residents, and staff. The RIMA staff on payroll, as of June 30, 2012, will become NYUSOM employees. Doctors Council will continue to represent the non-managerial physicians. NYUSOM to continue the sub-contracts for services established by RIMA and the assignment of those contracts are currently in process.

The services currently being provided include: Long Term Care Hospital Medicine- virology, wound care, ventilator care and general medicine; Nursing Facility Medicine; Rehabilitation Medicine - cardiac rehabilitation, pulmonary rehabilitation and general rehabilitation; Dentistry; Consultative and Liaison Specialties; Rehabilitative Therapy Services (occupation therapy, physical therapy, speech pathology & audiology); and Occupational Health Services.

The profile of the current affiliate workforce that will transition to NYUSOM is: 67% minorities; 52% women; 95% Board Certified physicians of which 30% of Boarded physicians have multiple Board Certifications in various areas.

The existing Post-Graduate Training Programs will continue with NYUSOM such as the Coler-Goldwater/Bellevue Hospital Center Dental Residency Program (currently 10 residents in program) and the Kingsbrook Jewish Medical Center Resident Pulmonary Rehabilitation Rotation site as well as the Interfaith Medical Center Pulmonary Fellowship Rotation site.

The projected goals and expectations of this new Affiliation relationship include: successful regulatory surveys which will reflect high quality of patient care and patient safety; in light of modernization plan and plans for Goldwater North a strong emphasis will be placed on working with the Affiliate and engaging their participation in strategic planning and program development and participation in the relocation of Coler-Goldwater operations to Goldwater North; participation in breakthrough initiatives which began this past march; development of performance improvement activities; the Medical Director will continue to lead the Patient Safety Program; and participation in the State of the art technology advances (including electronic medical record migration. We are also looking to put into place a pay-for-performance program that aligns incentives with quality outcomes and other business objectives

The proposed contract amendment terms are that services will be provided from July 1, 2012 through June 30, 2014. Compensation will be based on costs. The costs reported assume no material change in patient volume or services provided and no additional impact from managed care programs or other third-party

payer developments. Any change to the affiliate budget must be approved by the Joint Oversight Committee and the Corporation as per policy.

Other contract terms include: the Corporation retains the right to bill all patients and third-party payers for services rendered; and payments are subject to adjustment due to new initiatives for expanded programs or services, elimination or downsizing of programs, services or other reductions, market recruitment, retention-based salary adjustments, service grants or other designated programs consistent with the terms of the agreement.

The proposed contract costs for each Fiscal Year 2013 and 2014 is $27,500,000 for a total two year contract cost of $55,000,000. NYU will be paid $535,800 less (2%) in FY 2013 than the FY 2012 payments to RIMA after taking into consideration adjustments made due to differences in contract services. A pay-for-performance program will be implemented that address patient safety and effective management. An incentive up to $498,000 in incremental compensation to the Affiliate will be provided annually if all goals are achieved.

The pay-for-performance indicators eligible for incentives under the pay-for-performance program include: informed consent; consultation/specialty referral request and response; influenza vaccine and pneumococcal vaccine administration for both patients/residents and staff.

In the area of transfers and referrals: patients will be transferred and referred to other facilities when the required services are not available, if a third-party payer does not authorize reimbursement or at the patient's request; if a service is not available, such transfers and referrals will be made to other HHC facilities; transfers and referral to non-HHC facilities will only be made with the approval of the Executive Director or his/her designee and if an agreement with the receiving facility is in place; and transfer and referral activity will be monitored on a monthly basis.

Dr. Calamia inquired as to the pay-per-performance incentives was part of the RIMA agreement or new to the NYU agreement. Mr. Hughes responded that in the RIMA agreement there were 'withholds' that was in place based on performance indicators and thresholds and the current agreement will be additional. Dr. Parsons inquired as to whether consideration was given to readmission rate as a performance indicator and holding the providers accountable for the reduction. Mr. Hughes responded that New York State is currently evaluating readmission rates for nursing facilities and are in the process of putting together data collection in the next 12 months to see how that falls out and from that will ultimately develop indicators related to pay-for-performance, one of which will be readmissions, however, this plan is in the very early stages with New York State.

The resolution was moved for the full Board of Directors approval.

2. Resolution authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Microsoft Corporation to provide a care plan information system. The contract shall be for a period of five years with two, consecutive, one-year options to renew exercisable solely by the Corporation, in an amount not to exceed $11.43 million for the five year term, and an amount not to exceed $2.3 million annually for the two, consecutive, one-year options to renew, for a total of up to $16.1 million for seven years.
   AND
   Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy.

Presenting to the Committee were Irene Kaufmann, Senior Assistant Vice President, Office of Ambulatory Care Redesign and Paul Contino, Chief Technology Officer, Information Services.

Ms. Kaufmann informed the Committee that the care plan information system is a regulatory requirement and clinical need. It is a person-centered web-based inter-operable care plan that supports care coordination services for HHC's Patient Centered Medical Home (PCMH) and Health Home (HH) patient populations. The system supports care providers whether within the HHC system or community provider arena to function as an integrated care delivery team by providing access to information and capturing documentation about patient needs, goals, and integrates, and tracks progress of patients' clinical and non-clinical health-care related needs, and services (ranging from current medications and appointments to housing or entitlement needs). The system has an electronic notification component to assigned care teams that allows providers to render *timely and effective* care, through alerts and other communication tools; data reporting capability to ensure end-to-end tracking and billing for outreach and HH services; and can work effectively with a Personal Health Record and existing EHRs.

To obtain this care plan information system a Request for Proposals (RFP) and an RFP Selection Committee was established which scored the proposals on care plan system functionality, architecture and cost proposal. Ten proposals were received and 50% of them did not meet minimum qualifications, of the 50% that did meet the minimum qualifications they were invited to demonstrate their system for Care Coordination services for a diabetic patient with behavioral health conditions. Two of the five vendors scored significantly higher. A five year cost analysis for scaling up to 500,000 patients for both of the two finalists was conducted which would cover HHC's entire primary care population across the system. The two finalists cost proposals for the five year term of the contract (exclusive of the two, one year optional renewals) was GSI: $11.7 million and Microsoft Corporation ("Microsoft") : $11.4 million. The final selection of Microsoft was based their system's functionality, implementation plan, embedded PHR solution, cost, and fit with HHC's future EMR system and was rated the highest by the RFP Selection Committee.

Mr. Contino presented the time line and costs to the Committee as follows: a) estimated time to commence implementation = planning and initial design of two months; care plan implementation of three to nine months with multiple phases in between; estimated time to scale up to the full PCMH population of 500,000 was scaled over a five years period which will vary based on our business and clinical needs; b) total contract expenditure over 5 years: $11.4 M; and c) expenditure in the first year would be: $3.6 M to Microsoft and $300,000 costs for the two HHC additional FTEs to support the technical implementation of the system; and two, one-year extensions would be available at the conclusion of 5 years at an additional $2.3 M for year six and seven of the contract – thus totaling $16.1 M for a seven year contract.

Dr. Stocker inquired as to whether there was a representative present at the meeting from Microsoft and inquired as to whether this system was a new endeavor for Microsoft. Mr. Howard Krain, FACHE, Senior Sales Executive, Microsoft responded that Microsoft began involvement in health care technology seven to eight years ago in the non-traditional way by developing a specific business unit aside from operating systems to address health care specific needs and applications which are used nation-wide in various large integrated health care systems.

In response to inquires of the Committee, Mr. Contino explained that the initial set-up of the care plan is to serve the regulatory requirements of the Health Home and PCMH program which will eventually be integrate bi-directionally with our EMR and billing system. As we move forward there will be an aggressive level of integration including RHIOs – information out and in.

Dr. Wilson stated that the real challenge here is to make sure that we do not end up creating something bigger than it needs to be. We have a new electronic health record coming up which we do not want to

duplicate, the idea of this care plan system is that there is a core data set that we are required to share under regulatory requirements. Going forward we will ensure that this system aligns up with all other initiatives but we need to be careful that we do not make this system requirement more complicated than it needs to be. Responding to a prior inquiry of the Committee, Dr. Wilson responded that this care plan system does require a steward: one is the care manager who ensures coordination of care amongst all providers on behalf of the patient to ensure continuity of care and the other is the patient which is opening up the whole dialogue with patients and how they control their conditions and how they use their care plan to drive change.

The resolution was moved for the full Board of Directors approval.

INFORMATION ITEMS:

1. Readmissions

Presenting to the Committee was Dr. Ross Wilson, Senior Vice President, Corporate Chief Medical Officer. Readmissions are an easy target as a reflection of waste in health care systems in that percentages of readmissions are regarded as preventable. Certain payer groups such as Centers for Medicare and Medicaid Services (CMS) and others have latched on to this as readmission is a reflection of poor care. Dr. Wilson put on the table that no real readmissions are preventable, some of them actually reflect the deterioration the chronic status of a patient or that they have other socio or other needs that need to be met. Dr. Wilson further added that of the preventable readmissions we need to do better.

CMS has introduced the readmissions reduction program which is basically a financial penalty starting in 2013 for patients who are readmitted within 30 days of discharge with heart failure (HF), pneumonia and acute myocardial infarction (AMI) – any site of readmission, any cause for readmission. CMS has been reporting this data for sometime but now the penalty has started to be introduced which amounts to around 3% of our Medicare revenue in a financial year associated with these readmission cases. The 30 day readmission maker is not a very good marker it just happens to be the one we have. Early readmissions in the first seven days often reflect the fact that what was cared for in the hospital could have been improved, either the medication stabilization or the discharge plan etc. Readmissions after 14 days up to 30 days can be due to any number of reasons that may or may not be preventable. CMS will base the financial penalty on a three year rolling average of performance of July 1, 2008 to June 30, 2011 and compare this rolling average against our 2012 performance.

Dr. Wilson provided the Committee with a slide that drives CMS and all payers. The horizontal axis displays the readmission rates by State for Medicare patients and the vertical axis is the Medicare reimbursement per enrollee. The slide demonstrates that the readmission rates and cost per enrollee increases (linear relationship) with some outliers. CMS's view is if you can drive down the readmission rate you can predominately project a reduction in the payment per enrollee which is how they financially determine the penalty.

Dr. Wilson then provided the Committee with HHC specific data for Calendar Year 2011. The total percentage of readmissions across the entire HHC system has fallen with some variations for which there are conjecture seasonal components operating in February as noted by the high increase but the overall direction is declining. In order to try to understand our problem better we are focusing on different groups of readmissions: psych readmissions slightly declines towards the end of CY 2011. Dr. Wilson noted that each month, HHC facilities receive a readmission report for HF, AMI, and pneumonia. In addition we report on total readmissions and readmissions in psychiatry. Behind the reports the medical record number for each one of the readmissions is provided so that each clinical department can actually review the records and see what the learning points are behind the readmission.

In response to Dr. Stocker's question regarding benchmarks, Dr. Wilson noted that the only real case-mix or risk adjusted benchmark is the one provided by CMS. They correct for age, some social-demographics and the corrected diagnoses within the Medicare population of our facilities. So it is not Medicare diagnosis or the co-morbidities per patient it is actually more about the complexity of the whole Medicare population that each facility treats. There is a lot of argument about whether this is in fact a valid risk adjustment or not, however, it is the one we have to use. So when Medicare readjusts these raw figures we have to wait 24 to 30 months to get the Medicare figures as they use the rolling three year data. Separately we are going to start to look at what the risk adjustment algorithm looks like for our populations because when we risk adjust Coney Island Hospital it looks different when we risk adjust Lincoln Medical and Mental Health Center – the impact on raw figures changes quite a bit between the two sites.

The next slide that Dr. Wilson presented to the Committee demonstrated heart failure (HF) readmissions in CY 2011 for Jacobi Medical Center and Coney Island Hospital and looks at two subsets of patients. The slide illustrates that in CY 2011 Jacobi managed to continue a significant reduction in HF readmissions, while it bounces around but the overall projectory is significant over the 12 month period. At Coney Island there is a mirror image of deterioration of HF readmissions, due to the fact that the Coney Island population is bigger, older and has different co-morbidities and when we risk adjust the Coney Island figure it may not look as quite bad as this. However, it is important to note that many of HHC sites have made substantial improvements in HF and pneumonia readmissions.

Dr. Wilson then provided the Committee with several slides in his presentation that demonstrates how CMS sees readmissions (which are public domain information) based on Medicare data from July 1, 2007 and June 30, 2010. In comparing the rate of readmission for HF between Bellevue Hospital Center, Woodhull Medical and Mental Health Center and New York University on the basis that they share some the same medical staff, the first thing one sees on this slide is that the National benchmark or National average is 24.8% which is the risk adjustment figure. Figures of 20% is good performance. The number of Medicare patients tracked for Bellevue was 171 patients, Woodhull 150 patient versus 973 patients at NYU which shows that in terms of the Medicare population we treat relatively few compared to the Medicaid population particularly related to the voluntary sector. There is a big consequence of this because if you look at Bellevue's rate of 29.8% and Woodhull's rate of 32.1%, both are worse than the US National rate versus NYU at 22.9% which is no different than the US National rate – the fewer patients you have the broader the 'bar' will be as illustrated on the chart and yield a higher rate than the US National rate. A larger number of patients reduces the scale of the rates. Statistically there is a better performance at NYU than Bellevue for Medicare patients with heart failure readmission. Current preliminary figures show that there is significant improvement at Bellevue. Since readmissions rates are both a financial and clinical problem, it is an indicator in the Affiliation agreements so there is a bonus for reducing to a level that gets us into the black.

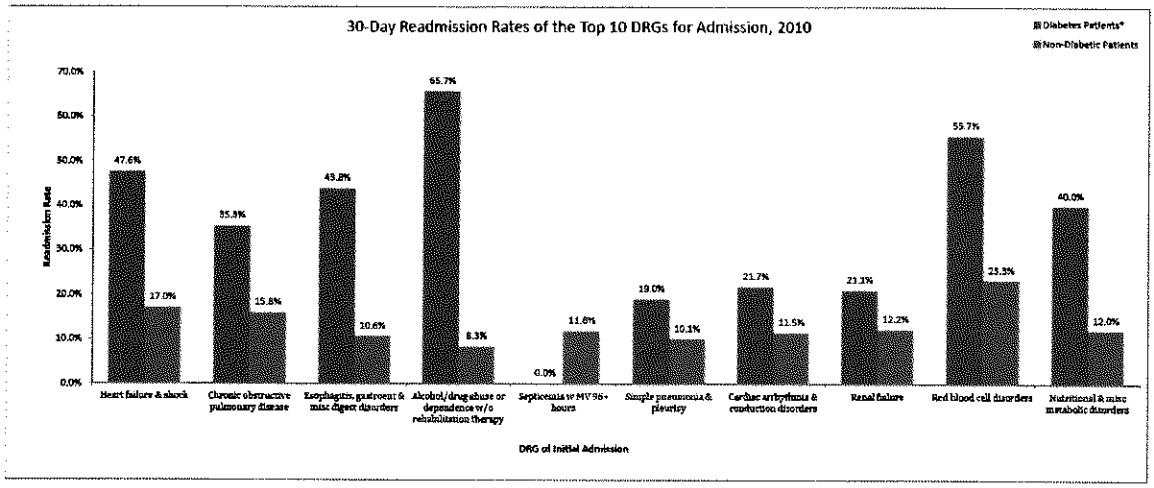
Data on the death rate for heart failure patients are for the same time period and same population of patients. The US National 30-day death rate for heart failure patients is 11.3%. Both Bellevue (10.5%) and Woodhull (9.8%) are no different than the US National average, while NYU at 6.9% is better than the National rate. While we have a higher readmission rate, based on mortality data we are no different from the National average. One can speculate as to why that is the case – is it that our care of these patients are fine but they have more social needs and are harder to discharge, or NYU patients are less sick than ours, or treat them better – but we don't know the answer to these speculations. What we do know is that in terms of mortality rate for heart failure our performance is consistent with the National rate.

Dr. Wilson then provided the Committee with the other HHC hospital's data on readmissions rates as follows: Jacobi at 28.1%, Metropolitan at 27.9% - both no different than National rate; Lincoln at 30.3%, Coney Island at 31.0%, Elmhurst at 29.5% and Kings County at 30.8% - all slightly worse than the National rate. The last slide in Dr. Wilson's presentation illustrates the causes of readmissions using Harlem's data as an example, for all payers, all causes and unadjusted. The blue bars on the graph are for diabetic patients and

the red bar's non-diabetic patients. For heart rate failure the diabetic population has two and one half times the readmission rate than the non-diabetic population. For chronic obstructive pulmonary disease (COPD) the diabetic population's readmission rate is double that of the non-diabetic population. The table below provides the rates for other top diagnoses. Dr. Wilson notes that this level of granular data illustrates that we need to evaluate the diabetic population and see what we might have to do differently or separately.

Harlem Hospital Center

30-Day Any Hospital, All Payer, All Cause, Unadjusted Readmissions



State Rank based on Volume of Initial Admissions	DRG Name	Diabetes Patients* Hospital Readmission Rate	Diabetes Patients* NYS Readmission Rate	Non-Diabetic Patients Hospital Readmission Rate	Non-Diabetic Patients NYS Readmission Rate
1	Heart failure & shock	47.6%	25.2%	17.0%	17.5%
2	Chronic obstructive pulmonary disease	35.3%	26.0%	15.8%	15.5%
3	Esophagitis, gastroent & misc digest disorders	43.8%	14.3%	10.6%	9.2%
4	Alcohol/drug abuse or dependence w/o rehabilitation therapy	65.7%	21.0%	8.3%	14.3%
5	Septicemia w MV 96+ hours	0.0%	18.8%	11.8%	14.0%
6	Simple pneumonia & pleurisy	19.0%	16.0%	10.1%	10.5%
7	Cardiac arrhythmia & conduction disorders	21.7%	15.5%	11.5%	10.9%
8	Renal failure	21.1%	22.5%	12.2%	15.4%
9	Red blood cell disorders	55.7%	30.2%	23.3%	17.2%
10	Nutritional & misc metabolic disorders	40.0%	16.6%	12.0%	11.8%
	Overall Readmission Rate	**27.0%**	**25.5%**	**9.9%**	**10.5%**

Source: December 1, 2009 - December 31, 2010 SPARCS Data (excludes obstetrics, neonatal, rehabilitation and transfers)
*Includes all diabetic patients (patients with a primary or secondary diagnosis of diabetes mellitus (ICD-9 250.X or 648.0))

Mr. Aviles inquired as to how transparent is CMS about the algorithm they use for risk adjustment. Dr. Wilson responded that no, CMS doesn't share their algorithm, only the information on the principles they have taken into account and the statistical reference of the external agency that is doing this for them to give us the confidence that it is a credible process. We cannot replicate the data so I cannot tell you how is diabetes weighted, but I can tell you that homelessness is not weighted, nor ethnicity. Dr. Wilson believes that the algorithm that CMS uses is not particularly sensitive to the population we serve, but generalizations that have to pertain to the whole country.

2. ED Dash Board

Presenting to the Committee was Dr. Ross Wilson, Senior Vice President, Corporate Chief Medical Officer.

The Clinical Information Systems division led the design, build and implementation of documentation screens and whiteboard functionality in the Emergency Departments (EDs) of ten acute care hospitals across HHC as part of pre-ICIS work and to help resolve disparate use of data in the EDs. The Clinical Information Systems team engaged numerous stakeholders within central office and within each acute care hospital across HHC in 2011 to complete the ICIS: ED project.

The project transformed hospitals that relied on a patient flow driven by paper charts to one where patients can be electronically tracked via real-time updates triggered by electronic clinical documentation. There are currently three ED Dashboards that are live in 10 acute care hospitals and one dashboard that is not yet live with all users. The Dashboard includes the following components.

- Volume and Throughput Metrics Dashboard: displays monthly volume & throughput performance
- Operational Dashboard: displays overall status of the ED in near-real time
- ED Trends Dashboard: displays historical trending information on the volume and throughput metrics
- Corporate Overview Dashboard: displays a snapshot of all HHC hospitals specific to wait times

The benefits of the Dashboard include:

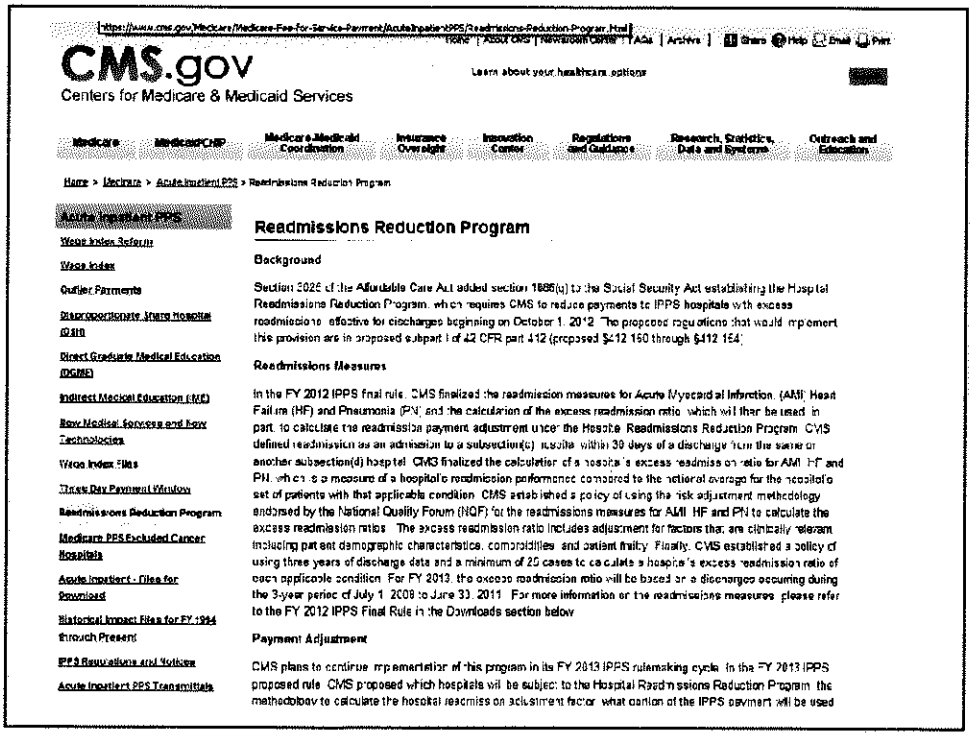
- Value to Patients: Patients can be tracked electronically via real-time updates to electronic clinical documentation to ensure the appropriate level of care is provided at the appropriate time.
- Value to Clinicians: Clinicians can assess the patient care demands placed on care teams in near-real time and assign new patients to the most available team.
- Value to Administration: Hospital administrators are able to use concrete data to identify bottlenecks in patient flow and base decisions such as modifying staffing levels to reduce long wait-times.

Due to time constraints the entire presentation is attached hereto.

There being no further business the meeting adjourned at 3:29 P.M.

Readmissions

MPA/IT Committee
May 24, 2012



https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

CMS.gov
Centers for Medicare & Medicaid Services

Learn about your healthcare options

Medicare | MedicareCHIP | Medicare-Medicaid Coordination | Insurance Oversight | Innovation Center | Regulations and Guidance | Research, Statistics, Data and Systems | Outreach and Education

Home > Medicare > Acute Inpatient PPS > Readmissions Reduction Program

Acute Inpatient PPS

- Wage Index Reform
- Wage Index
- Outlier Payments
- Disproportionate Share Hospital (DSH)
- Direct Graduate Medical Education (DGME)
- Indirect Medical Education (IME)
- New Medical Services and New Technologies
- Wage Index Files
- Three Day Payment Window
- Readmissions Reduction Program
- Medicare PPS Excluded Cancer Hospitals
- Acute Inpatient - Files for Download
- Historical Impact Files for FY 1994 through Present
- IPPS Regulations and Notices
- Acute Inpatient PPS Transmittals

Readmissions Reduction Program

Background

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The proposed regulations that would implement this provision are in proposed subpart I of 42 CFR part 412 (proposed §§412.150 through §412.154).

Readmissions Measures

In the FY 2012 IPPS final rule, CMS finalized the readmission measures for Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN), and the calculation of the excess readmission ratio, which will then be used, in part, to calculate the readmission payment adjustment under the Hospital Readmissions Reduction Program. CMS defined readmission as an admission to a subsection(c) hospital within 30 days of a discharge from the same or another subsection(d) hospital. CMS finalized the calculation of a hospital's excess readmission ratio for AMI, HF and PN, which is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition. CMS established a policy of using the risk adjustment methodology endorsed by the National Quality Forum (NQF) for the readmissions measures for AMI, HF and PN to calculate the excess readmission ratios. The excess readmission ratio includes adjustment for factors that are clinically relevant, including patient demographic characteristics, comorbidities, and patient frailty. Finally, CMS established a policy of using three years of discharge data and a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition. For FY 2013, the excess readmission ratio will be based on discharges occurring during the 3-year period of July 1, 2008 to June 30, 2011. For more information on the readmissions measures, please refer to the FY 2012 IPPS Final Rule in the Downloads section below.

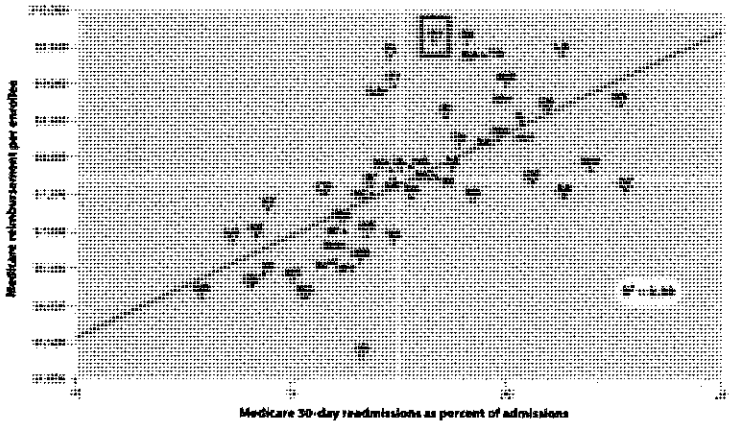
Payment Adjustment

CMS plans to continue implementation of this program in its FY 2013 IPPS rulemaking cycle. In the FY 2013 IPPS proposed rule, CMS proposed which hospitals will be subject to the Hospital Readmissions Reduction Program, the methodology to calculate the hospital readmission adjustment factor, what portion of the IPPS payment will be used

Known

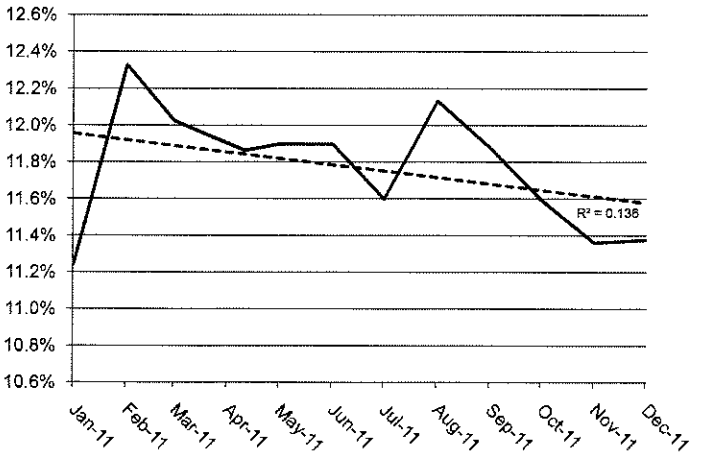
Price and Reimbursement

Medicare Cost Per Beneficiary and 30-Day Readmissions by State



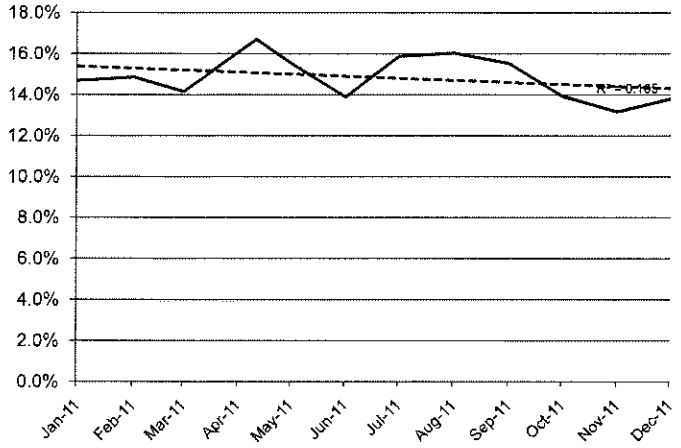
DATA: Medicare readmissions — 2008–09 Medicare 5% SAF Data; Medicare reimbursement — 2008 Dartmouth Atlas of Health Care
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Total Percentage Readmissions HHC cy 2011



~ 2000 readmissions/month

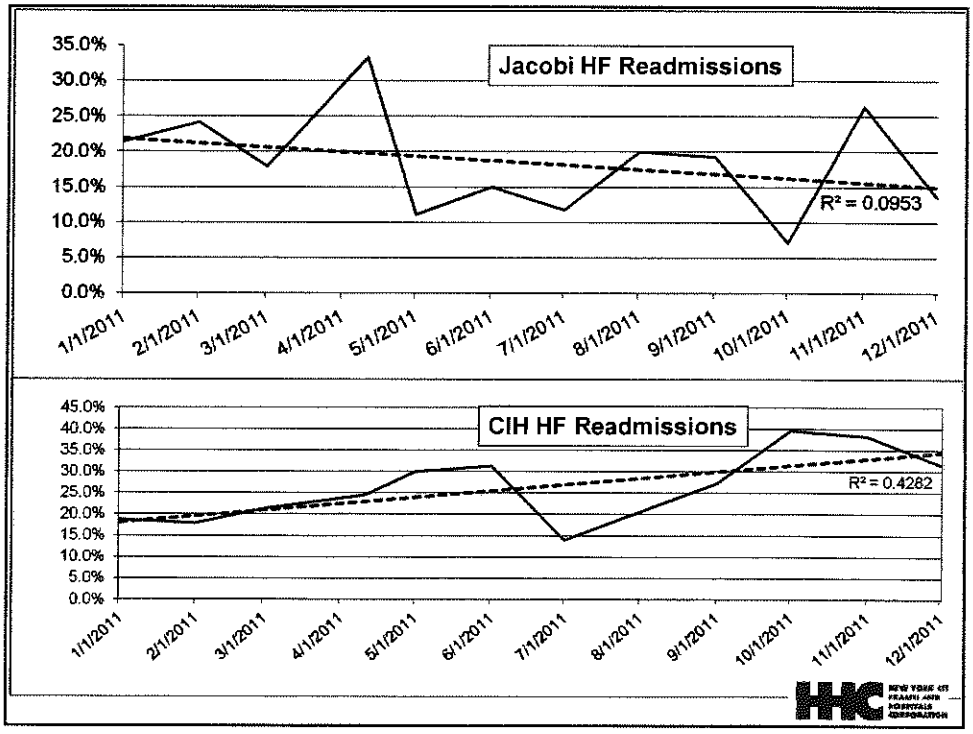
Total HHC Psych Readmissions 2011



~ 1400 readmissions/month

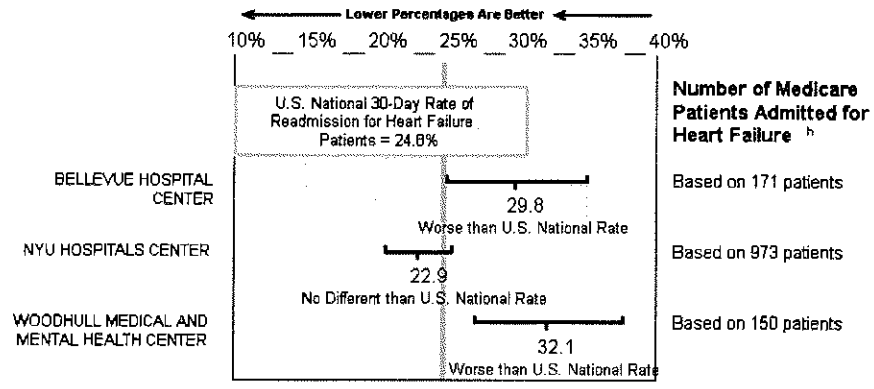
Heart Failure	Facility Discharges, Re-admits, Re-admission Rate															
	BELLEVUE		CONEY ISLAND		ELMHURST		HARLEM		JACOBI		KINGS COUNTY					
Discharge Month	Discharges	Re-admits	%	Discharges	Re-admits	%	Discharges	Re-admits	%	Discharges	Re-admits	%	Discharges	Re-admits	%	
Jan-11	61	10	16.4%	69	13	18.8%	36	5	13.9%	24	8	33.3%	28	6	21.4%	42	14	33.3%
Feb-11	28	10	34.5%	56	10	17.9%	33	5	15.2%	17	6	35.3%	29	7	24.1%	47	12	25.5%
Mar-11	56	10	17.9%	47	10	21.3%	25	7	28.0%	16	1	6.3%	28	5	17.9%	43	13	30.2%
Apr-11	42	6	14.3%	45	11	24.4%	32	7	21.9%	23	6	26.1%	24	0	32.3%	50	9	18.0%
May-11	76	18	23.7%	50	15	30.0%	26	8	30.8%	19	8	42.1%	27	3	11.1%	52	10	19.2%
Jun-11	44	15	34.1%	48	15	31.3%	23	5	21.7%	15	5	33.3%	20	3	15.0%	46	12	26.1%
Jul-11	38	12	31.6%	43	6	14.0%	35	7	20.0%	11	3	27.3%	17	2	11.8%	42	10	23.8%
Aug-11	35	4	11.1%	39	8	20.5%	26	4	15.4%	19	6	31.6%	25	5	20.0%	39	11	28.2%
Sep-11	42	9	20.9%	33	9	27.3%	34	10	29.4%	25	8	27.6%	26	5	19.2%	36	6	20.0%
Oct-11	46	7	17.6%	56	23	39.7%	35	10	28.6%	22	8	36.4%	14	1	7.1%	45	6	13.3%
Nov-11	34	4	11.8%	47	18	38.3%	16	4	25.0%	18	4	22.2%	19	5	26.3%	57	15	26.3%
Dec-11	52	10	19.2%	60	19	31.7%	28	6	21.4%	9	2	33.3%	37	5	13.5%	54	12	22.2%
Total	561	119	28.9%	593	167	28.4%	349	78	22.3%	219	65	29.7%	294	55	18.7%	547	130	23.8%

Heart Failure	Facility Discharges, Re-admits, Re-admission Rate															
	LINCOLN		METROPOLITAN		NCB		QUEENS		WOODHULL		Total					
Discharge Month	Discharges	Re-admits	%	Discharges	Re-admits	%	Discharges	Re-admits	%	Discharges	Re-admits	%	Discharges	Re-admits	%	
Jan-11	29	10	35.7%	14	4	28.6%	12	1	8.3%	30	4	13.3%	24	4	16.7%	368	79	21.5%
Feb-11	21	5	23.8%	12	2	16.7%	8	3	37.5%	35	16	25.6%	33	12	36.4%	324	82	25.5%
Mar-11	25	10	34.5%	7	2	28.6%	17	4	23.5%	33	6	18.2%	30	7	23.3%	359	74	22.4%
Apr-11	32	6	18.8%	10	2	20.0%	16	4	25.7%	41	10	24.4%	36	11	30.6%	350	80	22.9%
May-11	25	12	41.4%	14	3	21.4%	11	3	27.3%	33	8	24.2%	34	10	29.4%	373	95	25.4%
Jun-11	35	11	31.4%	11	4	36.4%	11	1	9.1%	27	6	18.5%	25	5	20.0%	305	81	26.6%
Jul-11	16	5	31.3%	14	5	35.7%	7	2	28.6%	31	7	22.6%	16	3	18.8%	270	62	23.0%
Aug-11	27	10	37.0%	11	2	18.2%	11	2	18.2%	23	5	23.8%	19	6	31.6%	273	63	23.1%
Sep-11	26	8	30.8%	9	2	22.2%	10	1	10.0%	28	8	28.6%	20	3	15.0%	289	65	24.0%
Oct-11	21	8	38.1%	24	12	50.0%	8	3	37.5%	27	4	14.8%	27	4	14.8%	321	85	26.8%
Nov-11	30	5	16.7%	20	3	30.0%	14	2	14.3%	24	4	16.7%	22	6	27.3%	281	70	24.1%
Dec-11	39	12	30.8%	10	2	20.0%	11	0	0.0%	24	0	0.0%	20	5	25.0%	341	73	21.4%
Total	333	102	30.6%	146	43	29.5%	135	26	19.3%	358	78	19.6%	306	76	24.8%	3833	917	23.9%



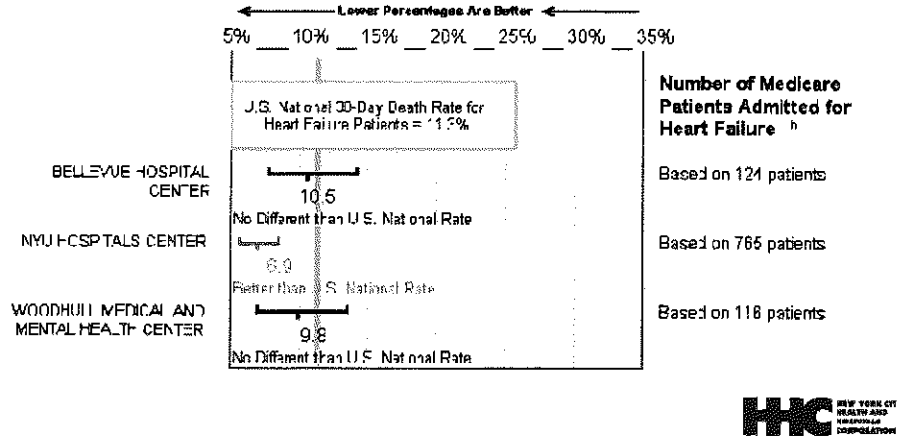
hese percentages were calculated from Medicare data on patients discharged between July 01,2007 and June 30, 2010. They don't include people in edicare Advantage Plans (like an HMO or PPO) or people who don't have Medicare.

Rate of Readmission for Heart Failure Patients



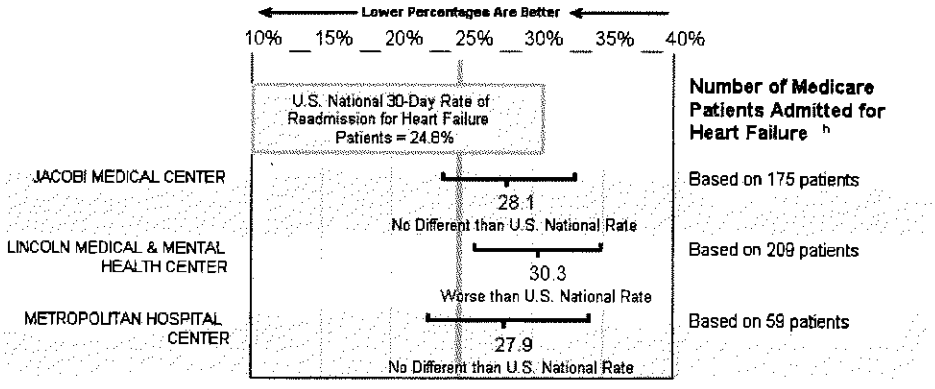
These percentages were calculated from Medicare data on patients discharged between July 01,2007 and June 30, 2010. They don't include people in Medicare Advantage Plans (like an HMO or PPO) or people who don't have Medicare.

Death Rate for Heart Failure Patients



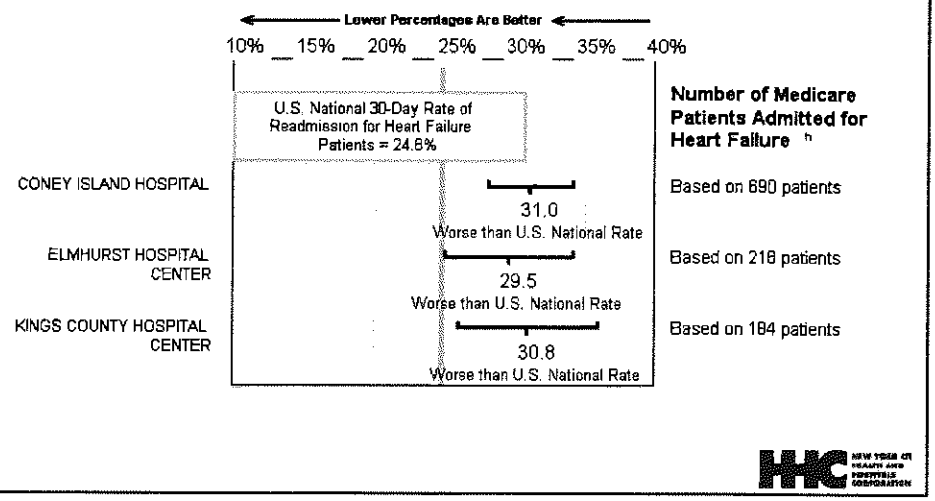
These percentages were calculated from Medicare data on patients discharged between July 01,2007 and June 30, 2010. They don't include people in Medicare Advantage Plans (like an HMO or PPO) or people who don't have Medicare.

Rate of Readmission for Heart Failure Patients



hese percentages were calculated from Medicare data on patients discharged between July 01,2007 and June 30, 2010. They don't include people in edicare Advantage Plans (like an HMO or PPO) or people who don't have Medicare.

Rate of Readmission for Heart Failure Patients



MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
June 14th, 2012

Total plan enrollment as of May 25th, 2012 was 433,003. Breakdown of plan enrollment by line of business is as follows:

Medicaid	364,979
Child Health Plus	16,704
Family Health Plus	36,792
MetroPlus Gold	3,096
Partnership in Care (HIV/SNP)	5,778
Medicare	5,654

This month, we added 5,788 members to the plan. This gain represents our largest addition of members for a one month period in 2012. Our largest growth was in Medicaid.

Attached are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

This month, we added 224 new enrollees in Medicare, with the largest growth in our Advantage (Dual- Eligible) product.

The New York State Department of Health released utilization data for the Managed Care Pharmacy Carve-In that became effective on October 1st, 2011. The data, a comparison of the three months before the carve-in and the most current three months post implementation, reveal that statewide, utilization is up and costs are down. MetroPlus' cost in the three months prior to the implementation was $76.80 per member per month (PMPM). MetroPlus' costs for the first three months of 2012 were $59.75 PMPM. Due to these declines in cost, seen also by other plans, the state's actuary, Mercer, has recommended significant decreases to the Pharmacy capitation. Essentially, the MRT cost savings has been realized for this benefit.

The New York State Department of Health (SDOH) has provided a draft of the Phase 1 pharmacy rate change analysis. The total rate change for Medicaid in NYC was -7.1%. The total rate change for FHP in NYC was -11.5%. The release of this data solidifies our initial analysis which found that MetroPlus will receive approximately 3 million dollars less in pharmacy revenue per month, retroactive to April 1st, 2012.

The 2013 Medicare Bids were due to CMS on June 4th, 2012. Cost savings allowed us to add benefits in our Medicare Advantage (Dual), Select (Dual) and Platinum (Straight Medicare) lines of business. We were able to reduce co-payments and deductibles and include some value added benefits such as an over-the-counter non-prescription benefit card and a gym membership at NYC Parks & Recreation sites.

Unfortunately, MetroPlus' historical utilization especially in pharmaceuticals was very high in our Medicare HIV/PIC Special Needs Plan (SNP). In addition, CMS reduced our risk intensity and our rates were dramatically reduced. Changes to the HIV SNP product were made to account for this reduction and include an increase in co-payments and reduction in some benefits. These changes affect the 300 members in our HIV/PIC SNP and may make this product more difficult to market and add membership in 2013.

As I reported earlier this year, as of July 2nd, 2012, all Medicaid managed care plans will be required to cover dental services for their enrollees. The MetroPlus dental implementation is going well. We have contracted with Healthplex to administer dental benefits for all our MetroPlus Medicaid and Medicaid SNP members. Also as of July 2nd, 2012, MetroPlus Family Health Plus, Child Health Plus, and Medicare Advantage members will have management of their dental benefits transition from DentaQuest to Healthplex.

Also part of my report earlier this year, mandatory enrollment for Managed Long Term Care begins on July 2nd, 2012. The MetroPlus application is complete and we are eagerly awaiting the SDOH's response. We have learned that the SDOH is moving slowly in awarding these new licenses but we are prepared to offer services as soon as our license is effective.

MetroPlus is also in the process of meeting all network and facility leadership in regards to our strategic initiatives to grow the Medicare product. I will continue to keep the committee updated on our progress.

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 05/14/2012

Other Plan Name	Category	2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	INVOLUNTARY	0	3	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	6
	VOLUNTARY	11	143	18	97	10	125	13	99	10	137	21	124	19	98	10	108	15	90	6	71	7	130	13	128	1,503
	TOTAL	11	146	19	99	10	125	13	99	10	137	21	124	19	98	10	108	15	90	6	71	7	130	13	128	1,509
CarePlus Health Plan	INVOLUNTARY	1	5	2	5	0	0	0	0	0	0	2	1	0	0	0	0	0	0	0	1	0	1	0	0	18
	VOLUNTARY	6	33	2	34	4	26	2	33	2	24	5	43	2	42	1	27	3	25	3	19	1	28	33	186	584
	TOTAL	7	38	4	39	4	26	2	33	2	24	7	44	2	42	1	27	3	25	3	20	1	29	33	186	602
Fidelis Care	INVOLUNTARY	1	3	0	3	0	0	0	0	1	1	0	1	0	0	0	1	0	2	0	0	0	1	0	0	14
	VOLUNTARY	32	280	27	211	41	252	20	176	22	202	26	258	27	233	27	223	33	267	17	146	22	265	28	274	3,109
	TOTAL	33	283	27	214	41	252	20	176	23	203	26	259	27	233	27	224	33	269	17	146	22	266	28	274	3,123
Health First	INVOLUNTARY	2	2	0	1	0	0	0	0	0	1	0	2	0	0	1	5	0	1	1	0	1	3	0	0	20
	VOLUNTARY	45	538	35	419	44	502	35	411	39	407	41	489	40	462	27	516	42	549	29	300	53	478	62	637	6,200
	TOTAL	47	540	35	420	44	502	35	411	39	408	41	491	40	462	28	521	42	550	30	300	54	481	62	637	6,220
Health Plus	INVOLUNTARY	2	4	2	5	0	0	0	0	0	0	0	8	0	1	0	2	0	0	0	0	0	2	0	0	26
	VOLUNTARY	13	208	13	160	22	208	18	185	21	145	22	216	25	188	10	176	15	241	11	109	19	170	0	0	2,195
	TOTAL	15	212	15	165	22	208	18	185	21	145	22	224	25	189	10	178	15	241	11	109	19	172	0	0	2,221
HIP/NYC	INVOLUNTARY	0	1	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	5
	VOLUNTARY	3	102	10	72	8	83	6	90	11	55	12	77	12	87	11	92	8	90	9	54	17	112	13	98	1,132
	TOTAL	3	103	10	75	8	83	6	90	11	55	12	77	12	87	11	92	8	91	9	54	17	112	13	98	1,137
Neighborhood Health	INVOLUNTARY	0	0	2	2	0	0	0	0	0	0	0	2	0	1	0	2	0	1	0	0	0	1	0	0	11
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 05/14/2012

		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Neighborhood Health Provider	VOLUNTARY	12	124	21	115	8	169	8	120	7	114	15	144	14	131	16	94	11	122	8	75	15	94	13	137	1,587
	TOTAL	12	124	23	117	8	169	8	120	7	114	15	146	14	132	16	96	11	123	8	76	15	95	13	137	1,599
United Healthcare of NY	INVOLUNTARY	1	0	0	1	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	1	0	1	0	0	6
	VOLUNTARY	11	107	11	69	14	68	10	72	7	48	18	111	16	75	14	70	8	82	7	49	8	68	12	103	1,058
	TOTAL	12	107	11	70	14	68	10	72	7	48	18	112	16	75	14	71	8	82	7	50	8	69	12	103	1,064
Wellcare of NY	INVOLUNTARY	0	3	0	5	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	11
	VOLUNTARY	4	26	2	33	2	27	3	22	8	18	0	9	2	29	0	20	2	24	1	13	1	17	3	27	293
	TOTAL	4	29	2	38	2	27	3	22	8	18	0	9	2	29	0	21	2	24	1	13	1	18	3	28	304
Disenrolled Plan Transfers	INVOLUNTARY	7	21	7	27	0	0	0	0	1	2	2	15	0	2	1	12	0	5	1	2	1	10	0	1	117
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
	VOLUNTARY	137	1,561	139	1,210	153	1,460	115	1,208	127	1,150	160	1,471	157	1,345	116	1,326	137	1,490	91	836	143	1,362	177	1,590	17,661
	TOTAL	144	1,582	146	1,237	153	1,460	115	1,208	128	1,152	162	1,486	157	1,347	117	1,338	137	1,495	92	839	144	1,372	177	1,591	17,779
Disenrolled Unknown Plan Transfers	INVOLUNTARY	4	51	6	46	5	47	3	35	7	53	5	36	3	27	3	43	2	31	5	22	5	78	5	22	544
	UNKNOWN	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2
	VOLUNTARY	0	24	3	40	6	48	6	63	4	53	25	94	16	115	4	53	8	79	18	69	25	77	6	37	873
	TOTAL	4	75	9	86	11	96	9	98	11	106	30	130	19	142	7	96	10	110	23	92	30	155	11	59	1,419
Non-Transfer Disenroll Total	INVOLUNTARY	1,176	8,727	1,359	10,100	1,033	9,713	1,112	10,295	1,011	9,917	1,023	9,743	1,155	10,165	1,159	10,297	1,019	10,206	1,250	10,150	1,021	9,597	1,153	9,843	132,224
	UNKNOWN	1	1	1	0	1	2	1	3	1	3	1	5	1	6	1	5	1	13	2	9	1	11	0	0	70
	VOLUNTARY	0	61	0	42	0	52	0	52	1	55	252	386	2	60	2	81	1	62	79	780	2	94	7	103	2,174
	TOTAL	1,177	8,789	1,360	10,142	1,034	9,767	1,113	10,350	1,013	9,975	1,276	10,134	1,158	10,231	1,162	10,383	1,021	10,281	1,331	10,939	1,024	9,702	1,160	9,946	134,468

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 05/14/2012

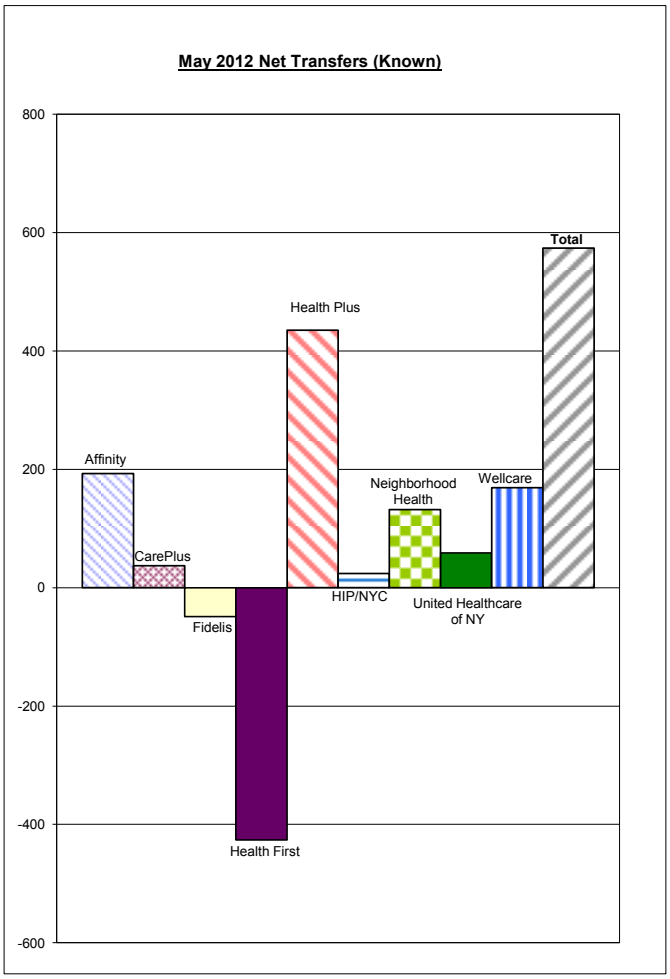
		2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Total MetroPlus Disenrollment	**INVOLUNTARY**	1,187	8,799	1,372	10,173	1,038	9,760	1,115	10,330	1,019	9,972	1,030	9,794	1,158	10,194	1,163	10,352	1,021	10,242	1,256	10,174	1,027	9,685	1,158	9,866	132,885
	UNKNOWN	1	1	1	0	1	3	1	3	1	3	1	5	1	6	1	5	1	13	2	11	1	11	0	0	73
	VOLUNTARY	137	1,646	142	1,292	159	1,560	121	1,323	132	1,258	437	1,951	175	1,520	122	1,460	146	1,631	188	1,685	170	1,533	190	1,730	20,708
	TOTAL	1,325	10,446	1,515	11,465	1,198	11,323	1,237	11,656	1,152	11,233	1,468	11,750	1,334	11,720	1,286	11,817	1,168	11,886	1,446	11,870	1,198	11,229	1,348	11,596	153,666

Disenrollments TO Other Plans		May-12			June-11 to May-12		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	0	0	1	5	6
	VOL.	13	128	141	153	1,350	1,503
Affinity Health Plan	TOTAL	13	128	141	154	1,355	1,509
	INVOL.	0	0	0	5	13	18
	VOL.	33	186	219	64	520	584
CarePlus Health Plan	TOTAL	33	186	219	69	533	602
	INVOL.	0	0	0	2	12	14
	VOL.	28	274	302	322	2,787	3,109
Fidelis Care	TOTAL	28	274	302	324	2,799	3,123
	INVOL.	0	0	0	5	15	20
	VOL.	62	637	699	492	5,708	6,200
Health First	TOTAL	62	637	699	497	5,723	6,220
	INVOL.	0	0	0	4	22	26
	VOL.	0	0	0	189	2,006	2,195
Health Plus	TOTAL	0	0	0	193	2,028	2,221
	INVOL.	0	0	0	0	5	5
	VOL.	13	98	111	120	1,012	1,132
HIP/NYC	TOTAL	13	98	111	120	1,017	1,137
	INVOL.	0	0	0	2	9	11
	VOL.	13	137	150	148	1,439	1,587
Neighborhood Health	TOTAL	13	137	150	150	1,449	1,599
	INVOL.	0	0	0	1	5	6
	VOL.	12	103	115	136	922	1,058
United Healthcare of NY	TOTAL	12	103	115	137	927	1,064
	INVOL.	0	1	1	0	11	11
	VOL.	3	27	30	28	265	293
Wellcare of NY	TOTAL	3	28	31	28	276	304
	INVOL.	0	1	1	20	97	117
	VOL.	177	1,590	1,767	1,652	16,009	17,661
Disenrolled Plan Transfers:	TOTAL	177	1,591	1,768	1,672	16,107	17,779
	INVOL.	5	22	27	53	491	544
	VOL.	6	37	43	121	752	873
Disenrolled Unknown Plan Transfers:	TOTAL	11	59	70	174	1,245	1,419
	INVOL.	1,153	9,843	10,996	13,471	118,753	132,224
	UNK.	0	0	0	12	58	70
	VOL.	7	103	110	346	1,828	2,174
Non-Transfer Disenroll Total:	TOTAL	1,160	9,946	11,106	13,829	120,639	134,468
	INVOL.	1,158	9,866	11,024	13,544	119,341	132,885
	UNK.	0	0	0	12	61	73
	VOL.	190	1,730	1,920	2,119	18,589	20,708
Total MetroPlus Disenrollment:	**TOTAL**	**1,348**	**11,596**	**12,944**	**15,675**	**137,991**	**153,666**

Disenrollments FROM Other Plans	May-12			June-11 to May-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	38	296	334	248	2,223	2,471
CarePlus Health Plan	28	228	256	239	1,777	2,016
Fidelis Care	27	226	253	194	2,139	2,333
Health First	19	254	273	190	2,062	2,252
Health Plus	49	386	435	322	2,950	3,272
HIP/NYC	5	130	135	84	1,096	1,180
Neighborhood Health	30	252	282	223	1,812	2,035
United Healthcare of NY	11	163	174	99	1,028	1,127
Wellcare of NY	15	185	200	197	1,388	1,585
Total	222	2,120	2,342	1,796	16,475	18,271
Unknown (not in total)	2,476	14,763	17,239	25,998	143,619	169,617

Data Source: RDS Report 1268a&c Updated 05/21/2012

Net Difference	May-12			June-11 to May-12		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	25	168	193	94	868	962
CarePlus Health Plan	-5	42	37	170	1,244	1,414
Fidelis Care	-1	-48	-49	-130	-660	-790
Health First	-43	-383	-426	-307	-3,661	-3,968
Health Plus	49	386	435	129	922	1,051
HIP/NYC	-8	32	24	-36	79	43
Neighborhood Health	17	115	132	73	363	436
United Healthcare of NY	-1	60	59	-38	101	63
Wellcare of NY	12	157	169	169	1,112	1,281
Total	45	529	574	124	368	492



New Member Transfer From Other Plans

	2011_06		2011_07		2011_08		2011_09		2011_10		2011_11		2011_12		2012_01		2012_02		2012_03		2012_04		2012_05		TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	0	1	1	5	51	263	16	194	20	174	23	203	17	189	13	207	19	194	20	255	30	242	38	296	2,471
CarePlus Health Plan	0	2	1	4	29	217	25	196	25	134	28	177	12	147	13	145	25	130	22	204	31	193	28	228	2,016
Fidelis Care	0	6	1	6	26	292	19	233	24	173	19	232	18	216	17	183	10	171	16	210	17	191	27	226	2,333
Health First	0	1	0	1	26	240	25	146	14	186	26	217	13	198	22	165	8	188	17	252	20	214	19	254	2,252
Health Plus	3	1	0	3	30	341	33	258	36	255	32	253	29	275	26	300	18	218	33	356	33	304	49	386	3,272
HIP/NYC	0	1	0	3	15	113	10	117	6	93	7	102	5	104	11	97	8	89	10	129	7	118	5	130	1,180
Neighborhood Health Pr	0	1	0	4	15	174	25	139	26	149	24	171	29	125	16	206	18	166	18	234	22	191	30	252	2,035
United Healthcare of NY	0	0	1	1	11	76	10	82	6	72	8	102	10	122	8	101	14	90	10	127	10	92	11	163	1,127
Unknown PLan	2,773	15,498	2,349	11,730	2,145	11,436	2,023	9,715	1,927	9,395	2,188	12,786	1,822	11,461	2,162	11,747	2,154	13,040	2,066	11,405	1,913	10,643	2,476	14,763	169,617
Wellcare of NY	0	0	0	1	21	157	11	125	20	146	28	142	15	125	19	138	14	99	31	122	23	148	15	185	1,585
TOTAL	2,776	15,511	2,353	11,758	2,369	13,309	2,197	11,205	2,104	10,777	2,383	14,385	1,970	12,962	2,307	13,289	2,288	14,385	2,243	13,294	2,106	12,336	2,698	16,883	187,888

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

May-2012

		Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12
Total Members	Prior Month	418,399	421,524	422,996	424,545	427,162	428,326	428,695
	New Member	19,131	17,008	17,963	18,468	17,387	15,892	20,359
	Voluntary Disenroll	2,589	1,855	2,046	1,988	2,030	1,886	2,100
	Involuntary Disenroll	13,417	13,681	14,368	13,863	14,193	13,637	13,951
	Adjusted	3	-25	-19	31	408	1,451	0
	Net Change	3,125	1,472	1,549	2,617	1,164	369	4,308
	Current Month	421,524	422,996	424,545	427,162	428,326	428,695	433,003
Medicaid	Prior Month	350,307	353,104	354,640	356,085	358,586	360,050	360,773
	New Member	15,535	14,082	14,372	15,362	14,270	12,893	16,787
	Voluntary Disenroll	1,952	1,520	1,460	1,631	1,685	1,533	1,731
	Involuntary Disenroll	10,786	11,026	11,467	11,230	11,121	10,637	10,850
	Adjusted	11	-16	-13	37	406	1,359	0
	Net Change	2,797	1,536	1,445	2,501	1,464	723	4,206
	Current Month	353,104	354,640	356,085	358,586	360,050	360,773	364,979
Child Health Plus	Prior Month	18,896	18,876	18,700	18,209	17,804	17,522	17,133
	New Member	775	572	431	434	526	515	500
	Voluntary Disenroll	43	37	21	36	29	28	25
	Involuntary Disenroll	752	711	901	803	779	876	904
	Adjusted	0	0	0	0	0	2	0
	Net Change	-20	-176	-491	-405	-282	-389	-429
	Current Month	18,876	18,700	18,209	17,804	17,522	17,133	16,704
Family Health Plus	Prior Month	35,336	35,555	35,552	35,862	36,281	36,218	36,346
	New Member	2,359	1,940	2,281	2,260	2,231	2,091	2,664
	Voluntary Disenroll	437	175	122	146	188	170	190
	Involuntary Disenroll	1,703	1,768	1,849	1,695	2,106	1,793	2,028
	Adjusted	-2	-2	-1	-2	-2	51	0
	Net Change	219	-3	310	419	-63	128	446
	Current Month	35,555	35,552	35,862	36,281	36,218	36,346	36,792

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

May-2012

		Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12
HHC	Prior Month	2,972	2,996	2,986	3,099	3,123	3,108	3,110
	New Member	42	20	285	37	30	17	0
	Voluntary Disenroll	2	0	153	0	0	0	0
	Involuntary Disenroll	16	30	19	13	45	15	14
	Adjusted	-3	-4	-3	0	12	26	0
	Net Change	24	-10	113	24	-15	2	-14
	Current Month	2,996	2,986	3,099	3,123	3,108	3,110	3,096
SNP	Prior Month	5,430	5,496	5,543	5,666	5,722	5,727	5,750
	New Member	207	165	243	190	135	132	160
	Voluntary Disenroll	39	37	36	41	28	42	41
	Involuntary Disenroll	102	81	84	93	102	67	91
	Adjusted	-1	-1	-1	-2	-6	17	0
	Net Change	66	47	123	56	5	23	28
	Current Month	5,496	5,543	5,666	5,722	5,727	5,750	5,778
Medicare	Prior Month	5,458	5,497	5,575	5,624	5,646	5,701	5,583
	New Member	213	229	351	185	195	244	248
	Voluntary Disenroll	116	86	254	134	100	113	113
	Involuntary Disenroll	58	65	48	29	40	249	64
	Adjusted	-2	-2	-1	-2	-2	-4	0
	Net Change	39	78	49	22	55	-118	71
	Current Month	5,497	5,575	5,624	5,646	5,701	5,583	5,654

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an Affiliation Agreement with the State University of New York/Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at Kings County Hospital Center ("KCHC") for a period of one year, commencing July 1, 2012 and terminating on June 30, 2013, consistent with the general terms and conditions and for the amounts as indicated in Attachment A to provide the parties adequate time to conclude negotiations for a new agreement;

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

WHEREAS, the Corporation has entered into affiliation agreements pursuant to which various medical schools, voluntary hospitals and professional corporations provided General Care and Behavioral Health Services at Corporation facilities; and

WHEREAS, the current Affiliation Agreement with SUNY/HSCB, to provide General Care and Behavioral Health services expires on June 30, 2012; and

WHEREAS, it is necessary for the President to have the managerial flexibility to insure that the rights of the Corporation remain protected during the negotiation process; and

WHEREAS, a summary of the financial terms of the extension is set forth in Attachment A, and

WHEREAS, the Community Advisory Board of KCHC has been consulted and apprised of such proposed extension; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, now desires that SUNY/HSCB continue to provide General Care and Behavioral Health Services at KCHC.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation is hereby authorized to negotiate and execute an Affiliation Agreement with State University of New York/Health Science Center at Brooklyn, for the provision of General Care and Behavioral Health Services at Kings County Hospital Center, for a period of one year, commencing July 1, 2012 and terminating on June 30, 2013, consistent with the general terms and conditions and for the amounts as indicated in Attachment A; to provide the parties adequate time to conclude negotiations for a new agreement; and;

BE IT FURTHER RESOLVED, that the President is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

ATTACHMENT A

Summary of Financial Terms and Conditions for Contract Extension

KINGS COUNTY HOSPITAL CENTER

Fiscal Year	Annualized Cash Rate
FY 2013	**$18,932,602**

- Affiliate reimbursement will be cost-based, subject to line item reconciliation
- All changes to budget must be approved by the facility and Central Office as per policy
- Payments are subject to adjustment due to new initiatives for expanded programs or services, elimination or downsizing of programs, services or other reductions, market recruitment, retention-based salary adjustments, service grants or other designated programs consistent with the terms of the agreement

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an extension to the Affiliation Agreements with the Physician Affiliate Group of New York, P.C. ("PAGNY") for the provision of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center ("Lincoln"), Morrisania Diagnostic and Treatment Center ("Morrisania"), Segundo Ruiz Belvis Diagnostic and Treatment Center ("Belvis"), Jacobi Medical Center ("JMC"), North Bronx Central Bronx Hospital ("NCB"), Harlem Hospital Center ("Harlem"), Renaissance Health Care Network Diagnostic and Treatment Center ("Renaissance") and Coney Island Hospital ("CIH") for a period of three months, commencing July 1, 2012 and terminating on September 30, 2012 with a funded option for another three months commencing October 1, 2012 and terminating on December 31, 2012, to provide the parties adequate time to conclude negotiations for a new agreement;

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

WHEREAS, the Corporation has entered into affiliation agreements pursuant to which various medical schools, voluntary hospitals and professional corporations provided General Care and Behavioral Health Services at Corporation facilities; and

WHEREAS, the current Affiliation Agreements with PAGNY at Lincoln, Morrisania, Belvis, JMC, NCB, Harlem, Renaissance, and CIH will expire on June 30, 2012; and

WHEREAS, prior to the expiration date, the Corporation recognizes the need to revise the current agreements to provide for improved contract management and service delivery; and

WHEREAS, the Corporation and PAGNY have met to discuss and to clarify principles of a new agreement; and

WHEREAS, it is necessary for the President to have the managerial flexibility to insure that the rights of the Corporation remain protected during the negotiation process; and

WHEREAS, a summary of the financial terms of the extension is set forth in Attachment A, and

WHEREAS, the respective Community Advisory Boards of Lincoln, Morrisania, Belvis, JMC, NCB, Harlem, Renaissance and CIH have been consulted and apprised of such proposed general terms and conditions; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, now desires that PAGNY continues to provide General Care and Behavioral Health Services at Lincoln, Morrisania, Belvis, JMC, NCB, Harlem, Renaissance and CIH.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation ("the Corporation") is hereby authorized to negotiate and execute an extension to the Affiliation Agreement with the Physician Affiliate Group of New York, P.C. ("PAGNY") for the provision of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center ("Lincoln"), Morrisania Diagnostic and Treatment Center ("Morrisania"), Segundo Ruiz Belvis Diagnostic and Treatment Center ("Belvis"), Jacobi Medical Center ("JMC"), North Bronx Central Bronx Hospital ("NCB"), Harlem Hospital Center ("Harlem"), Renaissance Health Care Network Diagnostic and Treatment Center ("Renaissance") and Coney Island Hospital ("CIH") for a period of three months, commencing July 1, 2012 and terminating on September 30, 2012 with a funded option for another three months commencing October 1, 2012 and terminating on December 31, 2012, to provide the parties adequate time to conclude negotiations for a new agreement; and

BE IT FURTHER RESOLVED, that the President is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

ATTACHMENT A

Summary of the Financial Terms and Conditions for Contract Extension between the New York City Health and Hospitals Corporation ("the Corporation") and the Physician Affiliate Group of New York, P.C. ("PAGNY") for the Provision of General Care and Behavioral Health Services at Lincoln Medical and Mental Health Center ("Lincoln"), Morrisania Diagnostic and Treatment Center ("Morrisania"), Segundo Ruiz Belvis Diagnostic and Treatment Center ("Belvis"), Jacobi Medical Center ("JMC"), North Bronx Central Bronx Hospital ("NCB"), Harlem Hospital Center ("Harlem"), Renaissance Health Care Network Diagnostic and Treatment Center ("Renaissance") and Coney Island Hospital ("CIH")

- Affiliate reimbursement will be cost-based, not to exceed departmental spending limits
- All changes to budget must be approved by the Joint Oversight Committee (JOC) at the facility and Central Office approval as per policy
- The Corporation retains the right to bill all patients and third-party payers for services rendered, except that the Affiliate will continue to bill for its direct patient care activities (Part B) through the Faculty Practice Plan at Lincoln, JMC (for outpatient Medicaid services only), NCB (for outpatient Medicaid services only), Harlem and CIH
- Payments are subject to adjustment due to new initiatives for expanded programs or services, elimination or downsizing of programs, services or other reductions, market recruitment, retention-based salary adjustments, service grants or other designated programs consistent with the terms of the agreement

Proposed Contract Costs
FY 2013 Three Month and Six Month Funded Options

Facility	Contract Budget 3 Month	Contract Budget 6 Months	Contract Budget Annualized
Lincoln Medical and Mental Health Center	$20,040,862	$40,081,725	$80,163,449
Morrisania Diagnostic and Treatment Center	$569,648	$1,139,296	$2,278,592
Segundo Ruiz Belvis Diagnostic and Treatment Center	$148,645	$297,289	$594,578
Jacobi Medical Center	$24,149,322	$48,298,644	$96,597,287
North Bronx Central Hospital	$8,987,180	$17,974,360	$35,948,720
Harlem Hospital Center	$16,623,568	$33,247,137	$66,494,273
Renaissance Health Care Network Diagnostic and Treatment Center	$864,599	$1,729,199	$3,458,397
Coney Island Hospital	$16,206,561	$32,413,123	$64,826,246
Total*	**$87,590,385**	**$175,180,771**	**$350,361,542**

***** The Board previously approved an affiliation agreement in June 2011 for PAGNY at Metropolitan Hospital Center that included a six-month extension until 12/31/12 at an annual rate of $55,381,355.

Business Continuity Program Update

Service Management Office

Michael Keil – AVP IT Service Management Office

June 14, 2012

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

EITS Business Continuity Program (BCP) Review

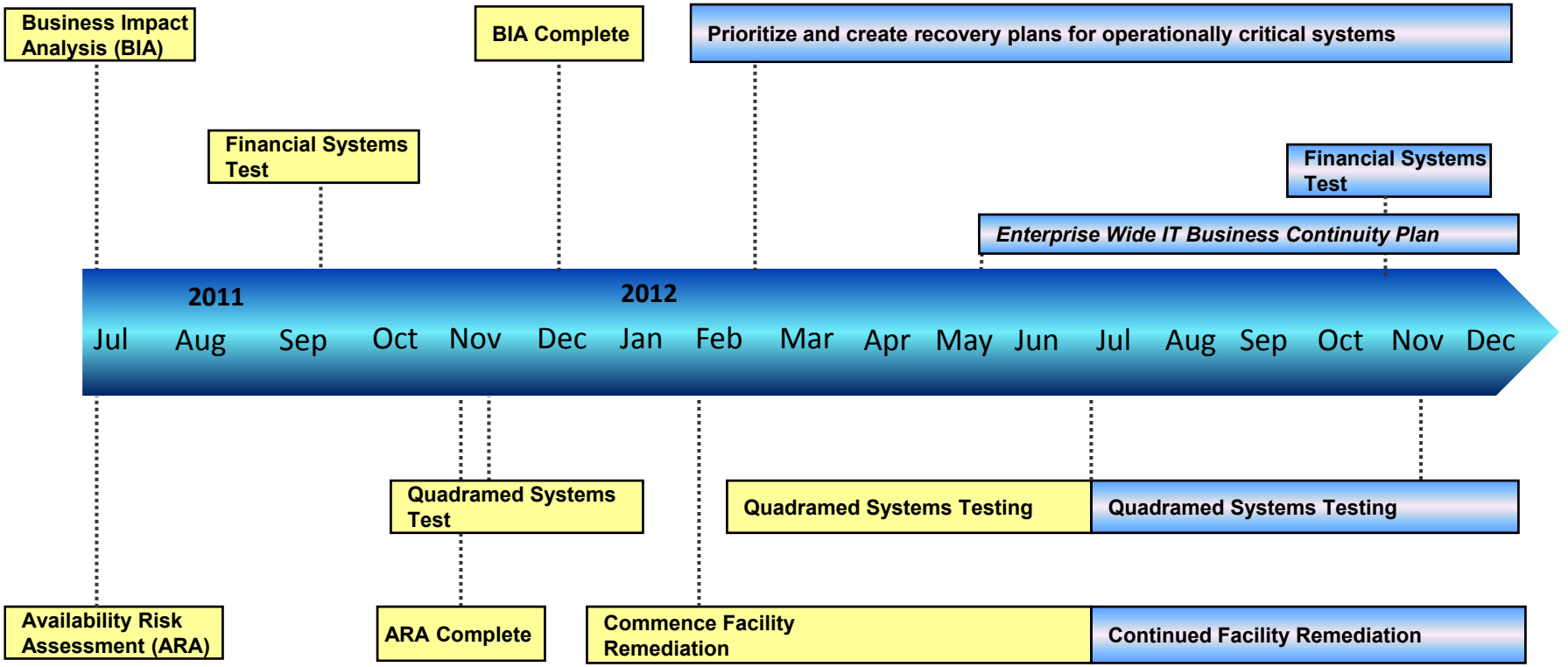
The foundation for a Business Continuity program is comprised of several components:

- Establishing a Disaster Recovery (DR) testing methodology to apply repeatable procedures throughout all IT infrastructure.
- Identifying and preparing for the threats and vulnerabilities at our facilities. Availability Risk Analysis (ARA).
- Understanding the Operationally Critical Business processes and the IT resources required. Business Impact Analysis (BIA).
- Establishing a DR recovery prioritization chart with Recovery Time Objectives (RTO) & Recovery Point Objectives (RPO).
- Conducting periodic tests to ensure the quality of the program meets the needs of the organization.

Business Continuity Program

Program Time Line

Yellow Indicates Completed



NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

Availability Risk Assessment (ARA) Review

- An on site physical review of each facility with a focus of determining potential points of failure.
- Identified external threats due to forces of nature, mankind, etc.
- Identified local Infrastructure threats, highways, rail etc.
- Completed on 11 Hospitals & 2 Datacenters in October 2011.

ARA Risk Status To Date

248 Identified Risks at the 11 hospitals & 2 Data Centers

- 7 Risks require Capital investment
  - Work is in progress to quantify the costs
  - Prioritization of projects to follow
- 241 Remaining Risks 56% Are Completed To Date (134)
  - 36% are to be completed by EOY 2012 (87)
  - 8% are to be completed by EOY 2013 (20)
  - Identified mitigation plans in place

Business Impact Analysis (BIA) Process Flow

- Selection of Business process and individuals
  - Utilized Industry standards and SunGard comparative value model
  - Identified and surveyed SMEs from each process
- Sampling approach
  - Representative and diverse to represent NYCHHC process environment
  - 41% participation rate
- Workshop approach
  - Review Initial jointly (NYCHHC/SunGard) created survey data
  - On-site meetings held with Process SMEs
- Use of residual impacts
  - RTO determined by several factors including financial impact and current mitigation factors resulting in a minimized exposure
- BIA Process Goal
  - Show Impacts over time on HHC clinical and administrative processes
  - Process Recovery priorities
  - Technology Recovery needs

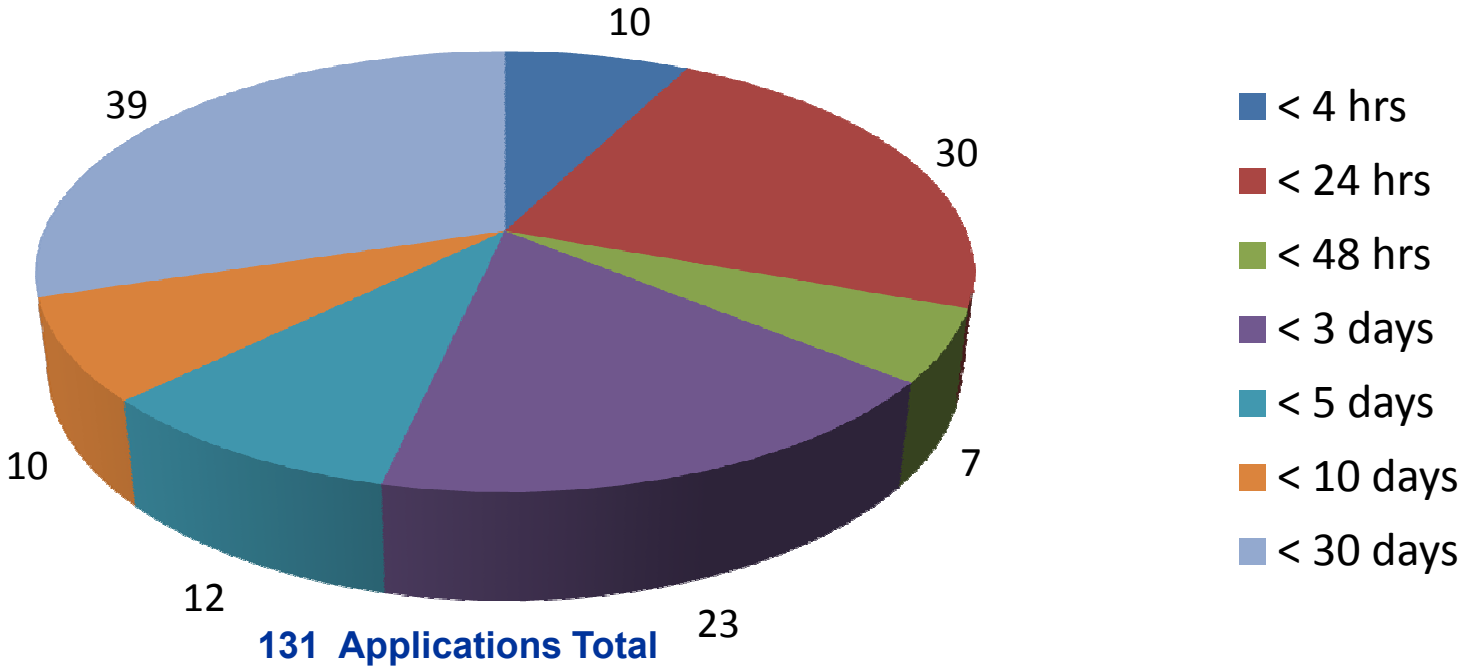
Business Process Details

Business Process	Hospital Function
Admissions / Discharge	Clinical Operations
Ambulatory Care	Patient Care / Clinical Operations
Emergency Department	Patient Care / Clinical Operations
Facilities	Administration
Finance	Administration
Food Services	Patient Care
Human Resources	Administration
Materials Management	Administration
Nursing	Patient Care
IT	Administration
Hospital Administration	Administration
Specialty Care	Patient Care
Pathology / Laboratory	Patient Care
Pharmacy	Patient Care
Radiology	Patient Care
Revenue Management	Administration
Surgery	Patient Care

Application Profile

The distribution of time-critical applications shows 30.5% of the applications with an under 24 hour RTO; Original preliminary finding stated 44% which was higher than the norm. These final findings are more in line with industry standards.

NYCHHC RTO Distribution Over Time



131 Applications Total

Application Name by Tier and Proposed RTO

Ongoing Investments Made To Ensure Tier 0 Infrastructure Is Available

Tier One Apps (RTO < 4 Hrs.)	Tier Two Apps (RTO > 4 < 24 Hrs.)
Bed Tracking – Teletrac Whiteboard Allscripts Sunrise Record Manager (SRM) HMED QCPR Cisco Call Manager / Telephone Systems Ensemble Openlink Unity Patient Management & Scheduling Webterm	PACU Manager Picis (Ingenix) TraceMakers / TraceMasters VUE EKG GE Muse Canopy 3M Health Data Management (HDM) MedRec Resources Dictation System TalkStation (TalkTech) Voice Recognition Voicebrook Applications Groupwise Email Quest Interface Thermo Shandon WITT System; Cathlab Reporting WITT MetaSystem (Metafer) Abbott PWEB3 Data Management System AS-OBGYN Software Advia Central Link; Advia LabCell Beckman Coulter BioRad CoPath Dade Microscan FACSCanto PACS – AGFA IMPAX PACS – SECTRA TAMTRON OAM OPUS ISM Pharmacy Management System ORSOS (QDX / One-Call) pTRAC

BIA Summary of Findings

- Seventeen key business processes identified for sampling
- Received a survey response rate of 41%
- Over 100 Interviews held with multiple individuals/groups
- 49 Hospital departments represented
- 131 Systems/Applications clearly identified for RTO/RPO
- 80 Applications were discovered that were not in the EITS management purview (see Appendix A)

Disaster Recovery Maturity

No Disaster Recovery Program
No processes or testing for applications, successful recovery unlikely

Conduct BIA and Risk assessment

Initial
Process are Ad-hoc
No stable process environment
Dependence on people's competence, not proven process
Inability to repeat success

Focus on process and responsibility

Managed
Processes are planned in accordance with policy
Resources and responsibility allocated
People trained on the process
Process periodically monitored and controlled
Practices retained during time of stress

Set measurable objectives and process is rigorous and consistently applied

Defined
Processes are well defined and understood
Described in standards, procedures, tools and methods
Tailoring of enterprises policies to meet agency requirements

Adapt processes and align with objectives

Optimizing
Continuous improvement based upon measurements
Incremental innovative technology improvements
Relate process improvements to organizational objectives

Most Healthcare Organizations

HHC

- ARA Complete
- BIA Complete
- QCPR Plan Complete for each facility
- QCPR Partially Exercised

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

Business Continuity Program Next Steps

Disaster Recovery (DR) Program

- Solicitation has been awarded to AVALUTION for the Enterprise Wide IT/BCP Program
  - Draft project plan has been built.
  - Analyzing data from ARA & BIA projects.
- Availability Risk Assessment (ARA)
  - Present plan to be prioritized by Capital Committee.
- Business Impact Analysis (BIA)
  - Complete the recovery prioritization chart.
  - Validate Recovery Time & Recovery Point Objectives through testing and make changes.
- Continued testing on QuadraMed
  - Expand to more interfaces, multiple domains, etc.
- Continued DR planning with iCIS Planning team for new EMR.

Questions & Answers

Appendix A: BIA Applications Previously Not Tracked

- Access Database - Drug Trial and Research
- Access Database - Medication Errors Reporting Tool
- Advia Central Link; Advia LabCell
- Autolink (AutoMed FastPack EXP)
- Beckman Coulter
- BeHere
- BioRad
- Central Admixture Pharmacy System (CAPS)
- Compurite
- Compuserve
- Consolidated Fiscal Report (CFR) Software
- Craneware
- Customer Links
- Dade Microscan
- EFAS
- Ellucid
- Emdeon
- Enterprise Document Management (EDM) - Siemens
- ePACES
- eSolutions
- EVAT
- EVERS; Electronic Vital Events Registration System
- FACSCanto
- GHX Exchange
- HDX
- HMED
- HUGs
- ICR/2552 Software – KPMG
- INTELLIscribe and RPM (Remote Print Manager)
- Internet Access; Internet
- IOD PRISM System
- IRIS Program - KPMG (Intern & Resident Information System)
- Maintenance Connection
- Master Key Database
- MAX-OR
- McCormick & Dodge
- MedAssets
- Mediregs
- MedRec Resources Dictation System
- MEF
- MEMS
- Mental Health Supplemental Software
- Metasys / Backnet
- MetaSystem (Metafer)
- Monarch
- New Innovations
- Nspire
- NYC Immunization Registry
- NYC-HHS Connect
- NYSDOH
- OAM
- OHS System
- OMNIPRO
- Outlook
- PacMed
- PacsCube
- PACU Manager
- Patient Advantage Tracker Database
- Patient Diabetes Registry
- PDR/SRM
- Picis (Ingenix)
- Press Ganey
- ProLucent
- Provider Review
- PSYCKES
- pTRAC
- Q-Matic
- Reason
- Revenue Cycle Database
- SharePoint
- Siemens Lab Systems
- Tamtron
- Thermo Shandon
- VCB Gateway
- Vitek
- Voice Recognition
- Web 1000
- Web Publishing - DSS
- Webterm