

BOARD OF DIRECTORS MEETING
THURSDAY, MAY 24, 2012

A-G-E-N-D-A

Call to Order - 4 pm	Dr. Stocker
1. Adoption of Minutes: April 19, 2012	
<u>Chairman's Report</u>	Dr. Stocker
<u>President's Report</u>	Mr. Aviles
>>Action Items<<	
<u>Corporate</u>	Dr. Stocker
2. RESOLUTION authorizing the President of the New York City Health and Hospital Corporation to negotiate and execute a contract with Microsoft Health Solutions Group 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 \$16.1 million for a five year term, with two consecutive one-year options to renew, for a total term of 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. (Med & Professional Affairs / IT Committee – 05/24/2012) EEO: Approved / VENDEX: Pending	
<u>South Manhattan Network</u>	
3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a license agreement with MetroHealth Homes Housing Development Fund Corporation (HDFC) for the early stages of construction of housing for low income elderly and/or disabled persons on the campus of Metropolitan Hospital Center using funds advanced by the Corporation subject to reimbursement upon execution of a long term lease with the HDFC. (Capital Committee – 05/14/2012) VENDEX: Pending	Ms. Youssouf
4. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a sublease with MetroHealth Homes Housing Development Fund Corporation (HDFC) as nominee for Metro East 99 Street LLC (the LLC in such capacities being referred to together with the HDFC as the Tenant) for the development of housing for low income elderly and/or disabled persons on the campus of Metropolitan Hospital Center . (Capital Committee – 05/14/2012)	Ms. Youssouf
<u>Queens Health Network</u>	
5. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable license agreement with the New York City Police Department for use and occupancy of space to operate radio communications equipment at Elmhurst Hospital Center . (Capital Committee – 05/14/2012)	Ms. Youssouf
<u>Southern Brooklyn/Staten Island Network</u>	
6. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a contract with the New York Power Authority for an amount not to exceed \$7,000,000 for the planning, pre-construction, design services, construction, procurement, construction management and project management services necessary to replace the existing boiler plant at Coney Island Hospital . (Capital Committee – 05/14/2012)	Ms. Youssouf
<i>(over)</i>	

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<p><u>MetroPlus Health Plan, Inc.</u></p> <p>7. RESOLUTION approving amendment of the Bylaws of MetroPlus Health Plan, Inc. to facilitate establishment of a Managed Long Term Care Plan and to better enable MetroPlus to conduct its business. (MetroPlus Board – 05/08/2012)</p> <p>8. RESOLUTION approving amendment of the Certificate of Incorporation of MetroPlus Health Plan, Inc. to facilitate establishment of a Managed Long Term Care Plan and to better enable MetroPlus to conduct its business. (MetroPlus Board – 05/08/2012)</p> <p><u>Committee Reports</u></p> <ul style="list-style-type: none"> ➤ Capital ➤ Community Relations ➤ Finance ➤ Medical & Professional Affairs / Information Technology ➤ Strategic Planning <p><u>Subsidiary Board Report</u></p> <ul style="list-style-type: none"> ➤ MetroPlus Health Plan, Inc. <p><u>Facility Governing Body / Executive Session</u></p> <ul style="list-style-type: none"> ➤ Jacobi Medical Center ➤ North Central Bronx Hospital <p>>>Old Business<< >>New Business<<</p> <p>Adjournment</p>	<p align="center">Mr. Rosen</p> <p align="center">Mr. Rosen</p> <p align="center">Ms. Youssouf Mrs. Bolus Mr. Rosen Dr. Stocker Mrs. Bolus</p> <p align="center">Mr. Rosen</p> <p align="center">Dr. Stocker</p>
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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (hereinafter the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 19th of April 2012 at 4:00 P.M. New York time, pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Dr. Michael A. Stocker
Rev. Diane E. Lacey
Mr. Alan D. Aviles
Josephine Bolus, R.N.
Dr. Vincent Calamia
Dr. Christina L. Jenkins
Dr. Adam Karpati
Ms. Anna Kril
Mr. Robert F. Nolan
Mr. Bernard Rosen
Ms. Emily A. Youssouf

Ian Hartman-O'Connell was in attendance representing Deputy Mayor Linda Gibbs, Amanda Parsons was in attendance representing Commissioner Thomas Farley and Linda Hacker was in attendance representing Commissioner Robert Doar, each in a voting capacity. Dr. Stocker chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on March 22, 2012 were presented to the Board. Then, on motion made by Dr. Stocker and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on March 22, 2012, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

Dr. Stocker received the Board's approval to convene an Executive Session to discuss matters of quality assurance and personnel.

Dr. Stocker received the Board's approval for Dr. Vincent Calamia to serve on the Medical and Professional Affairs Committee and for Emily Youssouf to serve on the HHC Capital Corporation Subsidiary Board.

Dr. Stocker updated the Board on approved and pending Vendex and will report on the status of pending Vendex at the next Board meeting.

Dr. Stocker announced that a public hearing will take place on May 9, 2012 at Metropolitan Hospital Center.

PRESIDENT'S REPORT

Mr. Aviles' remarks were in the Board package and made available on HHC's internet site. A copy is attached hereto and incorporated by reference.

INFORMATION ITEM

Mr. Bert Robles, Senior Vice President and Chief Information Officer reported on the progress of the ICIS project and the integration and upgrading HHC's electronic medical records system.

BOARD COMMITTEE REPORTS

Attached hereto is a compilation of reports of the HHC Board Committees that have been convened since the last meeting of the Board of Directors. The reports were received by the Chairman at the Board meeting.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Stocker reported that the Board of Directors as the governing body of Elmhurst Hospital Center and Queens Hospital Center reviewed, discussed and adopted each of the facility's reports presented.

In addition, the Board had reviewed the annual evaluation of Alan D. Aviles and gave him a rating of Superior.

Dr. Stocker also reported that the Board reviewed the Board self-evaluation tool in accordance with the 2009 Public Authorities Reform Act mandate.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:40 P.M.



Salvatore J. Russo
Senior Vice President/General Counsel and
Secretary to the Board of Directors

COMMITTEE REPORTS

Audit Committee – April 5, 2012

As reported by Ms. Emily Youssouf

Mr. Telano addressed the Committee by saluting them and stated that he only had three reports for this meeting. The first one is regarding Medical Surgical Inventory Controls at Harlem Hospital Center. He asked the Harlem representatives to approach the table.

Ms. Youssouf asked them to introduce themselves. They did as follows: Chris Provenzano, Associate Director of Audit and Contracts; Mark Sollazzo, Associate Director of Material Management and Gayle Lewis, Director of Purchasing.

Mr. Telano stated that we did a surprise physical count of the inventory at the storeroom and found that 80 percent of the items counted were incorrect and some of the items were not labeled properly on the shelves. There were some items kept outside the storeroom due to space limitations. Management was very proactive in their response to these issues. They did a full inventory count in February to insure that everything was accurate and then implemented regular weekly counts of items to insure that the on-hand amounts were accurate going forward. They will also conduct a space assessment of the storeroom to insure that going forward there would be no items left in the hall. A couple of the other items found were that when items are distributed to the units there was a lack of controls. The items being delivered were not being verified by the nurses and personnel on the floors. The storeroom was kept unlocked and people were using it as a cut-through from one unit to another. Also, items being delivered into the storeroom were kept outside unsecured. We believe controls were implemented and policy and procedures were put in place to correct those deficiencies.

Mr. Telano continued by stating that the last issue noted was about the borrowing and lending of supplies. At Harlem they transfer goods to Lincoln and Metropolitan frequently. If there is shortage, they decide to borrow and lend and we found that there was a lack of documentation on the Harlem end. We went to Lincoln and Metropolitan to obtain documentation, but Harlem did not have them. In most instances, the transactions were not input into the Harlem inventory system. If something was left out, it was not reflected in the inventory which probably resulted in some of the miscounts we found. Once again proper procedures were implemented to insure that it doesn't happen going forward.

Ms. Youssouf asked the Harlem representatives to be more specific as to the procedures in place.

Mr. Provenzano thanked Mr. Telano and his team and added that as someone who comes from audit we always look for audits as an opportunity to make corrective action plan. On the Harlem side there are a couple of unique situations that resulted in this audit. One is that Harlem has a unique setup in that there are four different storerooms. Lincoln only has one room that is gated where all the supplies are kept. At Harlem since there are four, it's more spread out and more difficult to keep track and until recently, inventory from Renaissance was also kept at Harlem. Another issue that Harlem has is with the construction going on, it blocks the street; therefore, the storeroom is being used as an access to get through to the main building.

Ms. Youssouf asked if that's the only way to get through. Mr. Provenzano responded that people have to walk all the way around the hospital so they walked through the receiving area to get to the elevators.

Mr. Youssouf asked if there is a way to consolidate the four rooms. Mr. Sollazzo responded that they are trying to get one space in the basement allocated to them to keep everything in one area.

Dr. Stocker asked if the new building affects any of this. To which Mr. Provenzano responded that it probably does because there's going to be some space freed up and he hopes Administration designates some of the space to them.

Ms. Youssouf asked what did he mean by designates? Mr. Sollazzo added that he has not received anything in writing from administration. Then Ms. Youssouf asked if there was anyone here from administration?

Dr. Steven Lawrence introduced himself as Chief Operating Officer at Harlem Hospital and said that the modernization project has many aspects to it. One of the opportunities that we will be afforded with the opening of the New Patients Pavilion (NPP) is an opportunity to consolidate all of the radiological series on the fifth floor, which is currently where the ORs are and where part of radiology is now. Currently the one corner of the basement is where nuclear medicine is housed. Nuclear medicine will be relocated on the fifth floor, thus allowing us to vacate a significant part of the area where they currently reside. In addition to some adjacent and vacant locker room space to it, that would then impose for us an opportunity to be able to consolidate materials management. It has architectural challenges in terms of layout with C-100. A full blown study has not been done as to what it's going to require readying that space for this purpose; it's something that's actively been discussed.

Ms. Youssouf stated that she would like to have a follow-up so they'll know what the study says but it's very concerning that there was no security or control mechanisms in place for an inventory. She added that they would like to see how that's going to be fixed and how quickly that

can be achieved. Mr. Provenzano added that the Central Office Breakthrough Project is being utilized. They're looking at the inventory and how things flow and par levels on the unit and how things get stocked. Mr. Sollazzo added that Kings County was the pilot and Harlem is the first.

Mr. Stocker asked if they had ever run out of items and had not known. Mr. Provenzano said that it has happened and that he hopes with the new Director in place, things will get better.

Mrs. Lewis stated that the shortcut is saving about five blocks of walking. Once we move, we can put a secure system in place and the shortcut will not be used.

Mrs. Bolus asked what they are doing in the meantime. To which Ms. Lewis responded that they are working with hospital police to have key access so it will not be readily accessible to staff other than material management staff.

Ms. Youssouf stated that since there are four storerooms, would it be possible to swap what's in the walkway to the other one that's vacant. Mr. Provenzano stated that that storeroom was always kept locked, but due to the construction, people go through it all the time. Sometimes the door is left open when a delivery is going on. The staff sees the door open and they go through it that's what Audits observed.

Mrs. Bolus asked when the shortcut is taken away, what will the staff do? Dr. Lawrence responded that the alternative is using the tunnels. The 136th Street location is currently blocked off; it used to be a through street from Lenox Avenue to 5th Avenue. There is a police gate at the entrance to 136th Street, however, staff working in Kuntz or in the old nurses' residence, rather than go through the tunnels they just find it easier to go out to 136th Street, cross the street and go through the receiving dock. Dr. Lawrence continued by stating that the condition still exists but we are getting a proposal now to put the card ID access on the back door.

Dr. Stocker asked if the new building will open in the summer. Mr. Lawrence answered yes, however due to some funding challenges, delays in demolishing the old nurse's residence, it will still house staff. There will always be a temptation rather than go through the tunnel.

Dr. Stocker added that a permanent solution is needed.

Ms. Youssouf asked that since one storeroom is not being used, why not move what's in the walkway now to that room?

Mr. Sollazzo responded that the walkway area is a receiving dock, not inventory. It's a loading dock where all the merchandise comes in. Some may be for inventory some of it might be direct purchases that go to other departments throughout the facility.

Ms. Youssouf asked if once the inventory is delivered, it usually sits there for a while. Mr. Sollazzo answered that when the vendor drops it off, we try to get it downstairs as soon as possible.

Mrs. Bolus asked how soon is as soon as possible? Mr. Sollazzo responded that usually about an hour.

Ms. Youssouf added that lack of inventory control can be a big money loser for any institution.

Mr. Provenzano stated that they have addressed all the issues in the report. We developed forms when they issue products to lend or borrow. The documentation is accurate so we know what came in and out. We don't have the same people signing off and have removed all staff that did not have access to E-Com.

Dr. Stocker stated that that sounds good, but if you don't have good inventory control, you are going to have surpluses of some things and run out of other stuff and not know it.

Mr. Sollazzo added that the borrowing is not an everyday event. It happens with a manufacturer back-order.

Ms. Youssouf stated that it seems that the people borrowing keep good records according to Mr. Telano and you would think that the lender would keep good records as well.

Mr. Sollazzo said that since the audit and while the auditors were there we developed a form that I and my assistant sign off. Ms. Youssouf responded that she would like Mr. Telano to go back sooner than six months for another visit and she would much appreciate the plan as soon as possible as to how this will be fixed.

Dr. Stocker asked if they distribute the surpluses around the system. Mr. Sollazzo stated that if there is a large surplus, they do one of two things. They relinquish it or put it out to see if anyone else needs it.

Mr. Provenzano stated that the goal is to set the right new max level so that they know exactly when a certain low is hit and automatically order new product. Ms. Lewis added that they need to know the right par levels so that they know exactly what they're using and monitor it.

Mr. Antonio Martin addressed the Committee on a request they had made at the last meeting which was to look at some of the best practices. Aside from bar coding there is a unit called Pixus which is a sort of automated machine where you go out and take out the material that you need and it sort of registers so it knows who takes it out. It's proved to be cost effective but it is expensive. There are vendors that will do the pars for you. You need to pay them more money but they will manage your inventory for you. He said that he has not looked at it completely but there are other options out there that he is going to look at.

Ms. Youssouf asked when they can come back with a plan. To which Dr. Lawrence responded to allow him two months.

Mrs. Bolus added that they do a lot of good work and the Committee appreciates it.

Mr. Telano continued with the next audit which was the Purchasing Audit at Coler-Goldwater. This turned out to be a very good review and there is only one issue to discuss. He asked the Coler-Goldwater representatives to come to the table.

Mr. Jeff Rogoff, introduced himself as AED of Materials Management and stated that the scope of the audit also pertained to Gouverneur purchasing; therefore, he has limited responsibility in terms of who is processing inventory. Mr. Telano stated that the only issue found was regarding for-payment-only purchases (FPOs) which we find at all of the sites. Ms. Youssouf asked him to explain what does that mean? Mr. Telano stated that its invoices being paid before a purchase order is developed and generated.

Ms. Youssouf asked if we are paying bills before we order something. To which Mr. Telano responded no.

Ms. Zurack added that there are certain items that don't flow through the normal procurement process. It's supposed to be used in only certain circumstances for example when we pay the City for a water bill.

Mr. Rogoff stated that a more likely example would be certain lease payments or service repairs. For reasons of encumbering funds, we issue requisition and purchase orders. What happens is, the department initiating the requisition forgets, it falls off the radar screen, a whole quarter goes by, there is no purchase order in place for that quarter. The invoice comes in after the fact and in order to pay the invoice, there must be a valid purchase order so accounts payable then has the mechanism against which to pay it.

Ms. Youssouf asked if there some kind of tickler that can be set up for those situations? To Mr. Rogoff responded that yes, there can be and looking back over a couple of years we issued memoranda to all department heads.

Mrs. Bolus asked how often it happens. Mr. Rogoff answered that it happens too often and we go out and reinforce it with the department heads.

Ms. Youssouf asked if there could be tickler put in place. Mr. Rogoff said that it is a good point and that's what they'll do. Ms. Youssouf addressed Mr. Telano and asked him to check up on that and to let them know when that happens.

Dr. Stocker asked if this audit was done before the new purchasing procedure. Mr. Rogoff responded that in his response he takes the finding in the spirit it was given. He thanked Mr. Telano in terms of best practice. It used to be a requirement on OP 10-24 which no longer exists and has been superseded by the revised OP 100-5 which came in January. The Committee should know that there is no requirement on the books that requires the signing off on this. We reviewed the recommendation and accepted it.

Dr. Stocker stated that other people have pointed that out and asked him his thoughts about the new procurement operating procedure. Mr. Rogoff thanked him for the opportunity and said that it needs to be said that there has been a tremendous amount of work done on supply chain transformation in HHC which is an incredibly good thing. There has been so much change that the revised OP 100-5 is a welcome change. We've had OPs on the books that were anachronisms and a throwback to days of manual systems and had no basis in current operation.

Dr. Stocker added that when they read them they couldn't figure them out either. Mr. Rogoff stated that there has been an incredible amount of work, not only work quality but quantity work to turn the train around. It's a work in progress and we have to work with it and have been given the tools we didn't have before. If this audit was done today, it would come out as best practice and that's why we did not rebut it.

Dr. Stocker asked him how he would change 100-5. Mr. Rogoff responded that he would need time to work with it. He said that in a constructive way he thinks we all have to be very careful about what we think appears as if we have control is semblance of control which does not give controls and hinders. To encumber ourselves needlessly by saying it's too low so people have to get involved with levels that they should not have to. Let the systems do the work for you. The nature of the business is to delegate, not to control but to empower, delegate and let the systems, particularly the current systems, do exactly what they are designed to do and do it very well.

Dr. Stocker said that they would appreciate any suggestions he may have and that he is not the first person to bring up the issue of control of FPOs.

Ms. Youssouf stated that she would love to hear his suggestions as well as the concept, not hinder but also to try to have controls just in case there is an outlier of nefarious behavior somewhere. Mr. Rogoff responded absolutely.

Dr. Stocker asked that what level of supervision he would use for FPOs. Mr. Rogoff said that they delegate, currently he is the one signing off, but his time could be used better. Since the finding was given in good faith, we take it seriously and we want to keep it at that level for now. The Corporation has a lot of best practices going on and we should adopt it at a corporate level and set a standard.

Ms. Zurack added that a requirement was put in OP 40-5 that executive directors sign FPOs because the principle was that it should be a very, very rare occurrence. She thinks that what this audit and this conversation are saying is that they should be a very, very rare occurrence. If authority is given at a much lower level in the organization the temptation to simply use FPOs where they were not meant to be used would increase.

Mrs. Bolus asked if it's going to be a rare occasion, should numbers be assigned for each facility. To which Ms. Zurack responded that this strategy should be corporate-wide, except where those circumstances FPOs are meant for zero. Probably through Breakthrough efforts, the hospital might be able to figure out how this never happens.

Mr. Rogoff stated that he thinks there are circumstances where they may not be able to avoid an FPO. Mrs. Bolus added that they have to be rare.

Ms. Zurack stated that both OP 100-5 and OP 30-5 allow a level of flexibility and reasonableness for those rare occurrences. If they become common occurrences they become a problem.

Mr. Martin added that he thinks everybody is right in a sense. He does not think the executive director needs to be saddled with the FPO and that's his personal feeling having been there beforehand. He also said that Ms. Zurack is right, that if it's done right they should be rare occurrence. In a number of different facilities they have an encumbrance committee where all of the different purchase orders go through. At least it gives you a sense of the transit. It's another idea of what you may be able to do to help resolve the issue.

Mr. Telano continued by stating that the last report was a purchasing audit at Woodhull. He asked the representatives to step up to the table. In the interim Mr. Martin congratulated Mr. Rogoff on having only one outlier.

The Woodhull representatives introduced themselves as follows: Jackie Gelly, Network Director of Purchasing and Zaheer Baig, Controller.

Mr. Telano stated that two primary issues were noted in this review. Once again FPOs and the other issue were the credits related to goods that were returned. The credits were not being taken because accounts payable was not being notified about those items. Management took the necessary steps and instituted policy to insure that it doesn't occur anymore. He believes the credits were processed. Ms. Gelly said that there were not processed, that they are working on that because they only received the POs on Monday, but immediate action was taken.

Ms. Youssef asked what kind of change they had to make. Ms. Gelly responded by saying that she took over the responsibility of the Returned Goods Advices. It was under the leadership of materials management, but it's now under the leadership of purchasing. They have developed internal policies which hold four departments accountable, Purchasing, Materials Management, RNs and Receiving. A meeting is scheduled for April 20th with all departments and requesters to inform them of the new policy.

Dr. Stocker asked if she had anything to add to the conversation in particular about PO 100-5. Ms. Gelly said that she totally agrees with her colleague Mr. Rogoff. She personally believes it's preventable and it should be special circumstances. The new operating procedure will allow them to do more and although they are not going back to traditionally blanket orders, she believes that if they have a blanket order that is itemized and have the description of when and how much, it will solve that problem.

Dr. Stocker addressed Mr. Telano and stated that it might be worth just auditing and wonders how much variation there is between facilities in number of FPOs, the total number and what they're about. Mr. Telano responded that he will look into that.

Mr. Telano continued with the audits in progress – some of these reports have been issued but due to timing he was not able to present them at this meeting. The Outpatient Revenue final report was issued and the follow-up audit at Sea View regarding the Representative Payee Accounts Social Security Income was also issued last week. The other audits listed are in various stages of review.

Dr. Stocker stated that GHX, the system and its implementation will be going to the Medical & Professional Affairs/IT Committee towards the end of the year and it would be useful to combine it with whatever the results of the audit are. Mr. Telano stated yes.

Mr. Telano continued by stating that on page 7 is the external audit, regarding the State Comptroller's audit of Overtime. After being silent for almost 20 months, they issued the final draft report in February 2012. The audit originally took place in the first quarter of 2010 and we had another exit conference with them just to refamiliarize ourselves with the issues and where they stood on things and also present our point of view. We sent out the responses to them on March 23rd and are waiting for the final report.

Mr. Telano stated that was the end of his report. Ms. Youssef thanked him and turned it over to Mr. Wayne McNulty for a compliance update.

Mr. McNulty saluted the Committee and HHC staff. He began his presentation with a staffing update. Mr. McNulty informed the Committee that the Office of Corporate Compliance ("OCC") was required, on an annual basis, to submit a staffing plan to the President for review and approval. He continued by pointing out that the OCC table of organization/staffing plan attached to the Corporate Compliance Report ("Report") was approved by Mr. Aviles earlier in the week. He informed the Committee that the vacant Associate Compliance Officer ("ACO") position in the North Bronx Healthcare Network was filled, noting that the selected candidate will start on April 16th. Mr. McNulty stated that there was one vacant position in the Southern Brooklyn/Staten Island Network; he commented that the recruitment process for this position had begun. Mr. McNulty further commented that he anticipated filling this position in mid-May.

Mr. McNulty then continued with item number two on the Report agenda - - the OCC Workplan. He reminded the Committee that at they were previously informed that the OCC was performing risk assessments on all of the calendar year ("CY") 2011 Workplan items. He stated that the OCC developed risk assessment and audit tools regarding these Workplan items. He further stated that the risk assessment and audit tools would be implemented by sending out question sets to the process owners and the expert owners of the corresponding business operations. Mr. McNulty anticipated that that by mid- April or towards the end of April his office would start to get responses back to the aforementioned tools. He provided that the level of risk associated with each item would be determined and plans for remediation would be initiated. Mr. McNulty informed the Committee that the Workplan items remained unchanged since the last Report to the Committee.

Dr. Stocker stated that in the survey of the Board it was asked if anybody wanted different input. He asked if we got any different input about questions. Mr. McNulty responded "no."

Mr. McNulty continued by moving to item number three (3) on the Report agenda - - the Public Authorities Accountability Act ("PAAA"). He stated that the OCC, the Office of Legal Affairs, and the Office of the Chairman had begun assessing HHC's compliance with PAAA. Mr. McNulty provided that PAAA governs the roles and responsibilities of board members and the board members' acknowledgment of their fiduciary duties and board member training. He added that PAAA also covers board committees and the creation of the Audit Committee, Finance Committee, and Governance Committee as well as the membership of those committees. He continued by stating that PAAA also requires that public authorities, such as HHC, to submit to the State Authorities Budget Office ("ABO") an annual report. He further continued by stating that, pursuant to the PAAA, HHC is required to place certain information on its public website for transparency purposes. He informed the Committee that attachment three (3) of the Report was an example of a risk assessment audit tool. He noted that this audit tool was crafted for compliance with PAAA. He concluded by stating that the risk assessment concerning PAAA compliance was coming to an end, highlighting that the findings at this juncture were favorable. He stated that a corresponding plan of correction would be implemented if the subject risk assessment revealed deficiencies.

Ms. Youssef asked if he has to file this or something with the public authorities and when is it due? Mr. McNulty responded by explaining that were certain items required to be filed by March 31st. With regard to these items, he stated that he discussed these items with the Department of Finance and such items have been filed. Mr. McNulty noted that other items required filing in September. Mr. McNulty explained that depending on the information item, there are different points in the year that filing is required. When required, Mr. McNulty told the Committee that the filing occurs through a web-based system called PARIS. Mr. McNulty further explained that basically every item requested on the list in PARIS must be filed in order to be in compliance. Mr. McNulty stated that he was informed that all information that was due on March 31st was filed (through PARIS).

Ms. Youssef asked what he meant by informed. Mr. McNulty answered that he spoke to Danielle Koster in the Finance Department and that he and Ms. Koster went over every single item. He stated that Ms. Koster informed him that all information required to be submitted by (March) 31st would in fact be submitted. He stated that the ABO would be performing audits related to PAAA compliance. To prepare for these audits, he informed the Committee that he is preparing a binder of all the different PAAA requirements to ensure that HHC has evidence of compliance with every single PAAA provision.

Ms. Youssef asked if he gets copies of everything from Finance. Mr. McNulty responded absolutely, everything on the PARIS website and HHC's website would be put into the aforementioned binder.

Ms. Youssef asked if he gets both electronically and hard copies? Mr. McNulty said yes and continued by adding that he would collect evidence of: (1) board member and board member designee training; and (2) completion of board evaluations.

Mr. McNulty said that he will report back to the board and the Audit Committee at the next meeting as to the final outcome of the assessment.

Mr. McNulty moved to the next item on the Report agenda which was updating written policies and procedures. At the last meeting he informed the Committee that they were working on developing HHC's Principles of Professional Conduct ("POPC"). He provided that employees sign a pledge card when they are first hired. He commented that he planned to expand that practice by requiring employees to certify that they are aware of the POPC during annual compliance training. He elaborated that the POPC would be in the form of a policy and procedure that would outline HHC's commitment to ethical conduct and complying with all rules, laws and regulations, not only in the area of fraud and abuse, but also equal employment, record management, patient confidentiality, employee confidentiality, employee safety, and conflicts of interest. He pointed

out that Attachment six (6) of the Report was an interim draft POPC. Mr. McNulty anticipated that the POPC would be reviewed and finalized by the next Committee meeting.

Mrs. Bolus asked a question pertaining to item three on the Report - - PAAA compliance. Mrs. Bolus requested that when HHC posts the salary of the Board Members and members of the executive staff making more than \$100,000 annually, such posting should reflect that she is not compensated for her Board Member services. Ms. Youssouf and Mr. McNulty acknowledged Mrs. Bolus's point on the matter. Mr. McNulty reminded the Committee that the subject disclosure requirement was language contained in the State's guidance but indicated that he would highlight those individuals on the list who do not earn an HHC salary.

Ms. Youssouf, turning back to the POPC, asked if HHC had a POPC before. Mr. McNulty responded that although a POPC existed in a pledge card form, supplementation of the same was necessary. He continued by stating that HHC has a Code of Ethics that applies to HHC affiliates and members of the community advisory board and auxiliaries. He further continued by stating that HHC is governed by Chapter 68 of the New York City Charter, which applies to board members, officers, and HHC employees. Notwithstanding the aforementioned, he advised the Committee that HHC does not have a code of conduct or professional code of ethics as required under the 1998 OIG (Department of Health and Human Services Office of the Inspector General) guidelines.

Ms. Youssouf asked if it has to be distributed to everybody or is it accessed via the internet. Mr. McNulty responded that the POPC has to be on the Compliance intranet at the minimum, and, pursuant to PAAA, possibly HHC's public website.

Mr. McNulty, moving to the next item on the report, informed the Committee that the Executive Compliance Workgroup formed a Subcommittee on Compliance and Quality. He informed the Committee that the subject Subcommittee was scheduled to meet for the first time later that day. Mr. McNulty went on by describing the member constitution of the Subcommittee: the Corporate Compliance Officer; the Chief Medical Officer; the Deputy Chief Medical Officer; the Chief Nursing Officer, the Corporate Risk Manager, the General Counsel; and the Senior Assistant Vice President for Quality Management. He explained that the Subcommittee would examine compliance issues that touch the areas of quality, medical necessity and credentialing, and patient documentation. He added that compliance in these areas were required under New York State Mandatory compliance program regulations and were also recommended in the OIG guidelines.

Mr. McNulty continued by discussing the CY 2012 OIG Workplan. He informed the Committee that the OCC would be performing a risk assessment and mitigation plan with regard to new items present on the OIG plan. He stated that his office was targeting May for completion of identifying the actual items that would be looked at in 2012. He anticipated that approximately 15 to 20 items would undergo the risk assessment process for determination for inclusion on the HHC CY 2012 Workplan.

Mr. McNulty turned to item number seven (7) on the Report agenda. He told the Committee that compliance training of HHC staff and personnel was switched to the PeopleSoft System; thus, use of an outside vendor for the same was no longer required.. Mr. McNulty continued by providing that the first module created was the physicians' module, which he stated should be ready for use in mid-April. He stated that other training modules would probably be created including modules for the staff who are involved with billing and a module for the Board of Directors.

Mr. McNulty moved along by discussing item number eight (8) on the Report agenda - - the implementation of nursing facilities compliance programs. He asked the Committee to take a look at Attachment "7" of the report, which highlighted that the OIG put in its work plan that it would be looking at whether or not nursing homes are complying with OIG 2000 and 2008 compliance guidance documents. Mr. McNulty told the Committee that the OCC was doing an assessment of HHC's nursing facility compliance with those specific guidance documents. He reminded the Committee that individual nursing facility compliance committees have convened. He stated that the OCC met with Coler-Goldwater and it went very well. He stated that the OCC would meet with all the other nursing facilities throughout the Corporation and the focus will be on not only risk assessments on the work plan but with the OIG 2000 and 2008 guidance documents.

Ms. Youssouf asked if he finds that this policy is very different than what is already being done. Mr. McNulty answered that there was some overlap with the written policies and procedures that already being worked on. But he added that the nursing facility guidance documents are very particular in nature and its scope was much broader than the hospital guidance documents from 1998 and 2005.

Mr. McNulty continued by discussing the next item on the agenda - - HHC's Code of Ethics and HHC's Bylaws with the regard to conflicts of interests. He pointed out that the Code of Ethics was inconsistent with the Bylaws. He explained that the Bylaws provide that Chapter 68 of the New York City Charter covers all employees of HHC and that the Code of Ethics only covers the affiliates and members of the community advisory boards and the auxiliaries. As a result, Mr. McNulty stated the Code of Ethics would be amended to reflect the same consistent with HHC's Bylaws.

Mr. McNulty continued with the last item on the Report agenda, which was the monitoring of excluded providers. Mr. McNulty informed the Committee that he had no self-disclosures to report to the Committee. He did, however, inform the Committee that the OCC learned in February that a nurse employee at Woodhull was on the Office of the Medicaid Inspector (OMIG) list of excluded individuals. He explained that the nurse was placed on the list on 2/8/2012 and was discovered on 2/28/12. He noted that the nurse was separated from services on the 29th of February. He informed the Committee that the OCC was currently examining the extent of effective claims to determine whether self-disclosure and

repayment to the appropriate government authorities were necessary. Mr. McNulty provided that the OCC had a 60-day window to make any necessary reports and repayments to government authorities.

Mr. McNulty stated his report was concluded.

Ms. Youssouf asked if there were any questions.

Mrs. Bolus asked if our new way of vacancy control board examining all history of people coming to apply for work would have picked up that nurse beforehand. Mr. McNulty responded no. Mr. McNulty stated that HHC's employment application requires applicant's to certify whether they are on the excluded provider list. He provided that each month the Information Technology department reviews the list of all employees and matches this list with the excluded provider lists of OIG, OMIG, and the General Service Administration ("GSA") found on their respective websites. Mr. McNulty stated that once an initial match is found, the OCC proceeds by verifying the match by reviewing the social security number pertaining to the match to make sure an exact match is present.

Mrs. Bolus asked that if according to the date, is it picked up within five days? Mr. McNulty responded that it took two (2) weeks.

Mrs. Bolus asked why he thinks we will be penalized. Mr. McNulty responded that sometimes, if only a short period of time has lapsed, government authorities don't ask for any money back. He stated that for a two-week period the government authorities would probably ask HHC to return some money back if the subject nurse was providing services that HHC billed for.

Mrs. Bolus asked how often the list is reviewed. Mr. McNulty answered that IT looks at the OIG and OMIG list every 20th of the month.

Mrs. Bolus stated that that's why two weeks got in there. Mr. McNulty said yes and added that the list provided by IT is a comparison. He expanded by stating that if there were twenty (20) individuals who matched the names on the government excluded provider lists all of these individuals would have to be matched by entering their respective social security numbers because OIG will not give IT the social security numbers of individuals on the excluded providers list. Mr. McNulty commented that in the future the OCC would look to utilize a vendor that is experienced in providing this type of service; he further expanded by stating that the utilization of such a vendor would undoubtedly allow OCC to know about excluded providers at an earlier date.

Ms. Youssouf asked if the vendor would be doing this on an ongoing basis. Mr. McNulty responded yes.

Ms. Youssouf thanked them for the report.

Then she asked if there was any old or new business. Hearing none, she asked for a motion to adjourn.

The Board seconded. The meeting adjourned at 1:18 pm.

Mrs. Bolus stated that today was a day they had so much information that it was fantastic, she thanked everyone for a marvelous job and that it was appreciated.

Equal Employment Opportunity (EEO) Committee – April 10, 2012 **As reported by Reverend Diane Lacey**

Manasses C. Williams, Assistant Vice President, Affirmative Action/EEO briefed the Committee on the Equal Employment Opportunity Commission's (EEOC) 2011 report on discrimination cases. He reported that for 2011 the EEOC saw a 0.03% percent increase (99,922 to 99,947) from the previous year charges filed. He further stated that charges based on retaliation, sex, age and disability were the leaders in most frequent filed claims, with retaliation as the number one complaint filed.

2011 Facility Discrimination Complaints Update

Gail Proto, Senior Director, Affirmative Action/EEO reported on the discrimination complaint status of the twelve network/facilities that were analyzed. The report shows that the overall number of open complaints in the Corporation decreased from 153 in 2010 to 150 in 2011 a decrease of 3 or 2%. New complaints decreased from 282 in 2010 to 202 in 2011. Two hundred and sixty-two cases were closed in 2010 and 208 in 2011. Counseling sessions over the period decreased from 200 in 2010 to 182 in 2011.

The results also showed that allegations filed in 2011 showed a significant increase in five of the fourteen allegations tracked and a decrease in the remaining nine.

Finance Committee – April 3, 2012
As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Marlene Zurack informed the Committee her report would include two items first of which would be an update of HHC's cash on hand which as reported last month was at 33 days compared to 42 days currently. The increase is due to several supplemental Medicaid payments that were received the end of March 2012. However, HHC is expected to end the fiscal year with approximately 30 days of cash on hand. Secondly, at the last Committee meeting, extensive reporting was given on a reform proposal that was being crafted by the State Department of Health (SDOH) through the Indigent Care Task Force. The proposal which was scheduled to be added to the State budget but instead was debated and discussed as part of the session; and if adopted a separate bill would be required.

Dr. Stocker asked what if that action was likely to occur. Ms. Zurack stated that it is less likely than getting it into the budget; however, if there is a commitment to the proposal, there is sufficient time for it to be done.

Dr. Stocker asked if there would be any fallout from the various parties as a result of it not getting into the budget. Ms. Zurack stated that it was put forth extremely late and was literally drafted as a proposal as such the State was only willing to go forward if there was 100% support but there were some issues that were not resolved. One of which was raised by New York City.

Ms. Youssef asked what the time frame is for getting the proposal done. Ms. Zurack in concluding her report stated that the session ends at the end of June 2012 but could be extended to August 2012.

Ms. Brown, Senior Vice President, Corporate Planning/HIV Services, Intergovernmental Relations, & Community Health stated that in essence that while there had been many months of the Indigent Care workgroup working on the details, the group itself did not as Ms. Zurack indicated get the full proposal in sufficient time and there were some stakeholders that were not necessarily aligned with what was being proposed. Therefore, the Administration did not want to take a proposal without every stakeholder agreeing to be committed to the State legislatures. Consequently, the proposal was not seen by the legislators. The overall timing involved in the process of educating the legislators would have required more lead time than what had been allotted.

Key Indicators/Cash Receipts & Disbursements Reports
As of February 2012

Acute discharges and Diagnostic & Treatment Center (D&TC) visits have improved over the last couple of months in comparison to the prior year but remain below last year's levels. Acute discharges are down by 4.7% and D&TCs visits are down by 5.5%. Nursing home days continue to be below last year's by 5.2%.

Dr. Michael Stocker asked if there are any major changes from month to month and whether those changes are variations or trends.

Mr. Fred Covino stated that acute discharges improved by 5% in January down to 4.7% currently and the D&TC visits were at 6% last month and has improved to 5.5% through February 2012. It is a trend with the exception of last month the acute discharges have improved every month since the beginning of the year and the D&TCs have followed that same trend. Continuing the reporting, the ALOS, all of the facilities with the exception of Lincoln and Coney Island are within 3/10 of the corporate average. Coney Island is 4/10 day greater than the expected ALOS while Lincoln is 4/10 less than the expected average LOS. The CMI is up by .25% that is on top of a 10.5% increase over the last two years. Currently, in comparison to last year there are five facilities that have improved and six facilities are down compared to last year. Through February 2012, FTEs are down by 203 compared to the beginning of the fiscal year and down by 560 FTEs compared to January 2011. The bulk of that reduction is in environmental services, clerical titles and aides/orderlies. Receipts are \$25.9 million better than budget while disbursements are \$38.2 million better than budget for a net positive total of \$64.1 million.

Ms. Emily Youssef asked if disbursements are better or worse. Mr. Covino stated that expenses are under budget. A comparison of cash receipts and disbursements to the prior year actual for the same period as of February 2012, receipts are \$447 million worse than last year primarily due to the timing of DSH/UPL payments which are down by \$392 million and appeals and settlements are also down by \$56.6 million due to timing; however, an additional \$800 million is expected by year-end. Appeals & settlements are down due to a take-back this year for a 2009 rate adjustment. Last year a \$30 million Medicare settlement for a prior FY was received. These are all major offsetting factors. Expenses are \$76.8 million worse than last year of which \$67 million of that is due to the timing of City payments that will catch up by year-end. Overall receipts and disbursements are \$524 million worse than last year for the same February period. A comparison of the current year budget against current year actual inpatient receipts are up by \$10.3 million due to an increase in Medicare inpatient receipts. Outpatient receipts are up by \$11.8 million due to an increase in Medicaid managed care collections. There was a \$27 million retroactive payment from MetroPlus and all other payments are up by \$3.9 million.

Commissioner Robert Doar asked why inpatient Medicaid receipts are down and Medicare is up.

Mr. Covino stated that Medicare is up due to an increase in non-Periodic Interim Payment (PIP) payments which are not consistent from year to year that would include the Medicare Part B and prior year settlements that are significantly higher than last year's baseline.

Commissioner Doar commented that the increase in Medicare is not related to an increase in utilization of Medicare patients but rather an accounting adjustment for prior years.

Mr. Covino stated that for the inpatient that was correct and that the adjustments for utilization will happen afterwards.

Commissioner Doar asked whether that also applied to Medicaid. Mr. Covino stated that Medicaid came in less than anticipated and that utilization as reported last month as part of the Financial Plan update, there was an adjustment in utilization due to a significant decline in workload since the beginning of the FY.

Commissioner Doar asked if the expectations were that Medicaid managed care would be higher. Mr. Covino stated that Medicaid managed care must be reviewed in conjunction with the risk pool settlements in order to understand the impact and that would not be available until the end of the year.

Ms. Zurack added that there is need to look at both the inpatient and outpatient together in order to get the full impact which on the outpatient side, Medicaid managed care is up which is where the expected growth should be and in this instance is better than expected. Programmatically, the outpatient growth is where the shift would be expected to occur.

Mr. Bernard Rosen asked if from a budgeting perspective, the DSH/UPL total of \$715 million is reflective of an adjusted budget. Mr. Covino stated that it is not but rather the original budget.

Ms. Zurack added that the Mr. Covino was referring to an adjustment that was made to the financial plan.

Mr. Rosen stated that the reference was to the \$715 million decline reflected on the report for the DSH/UPL compared to last year and whether the \$715 million was budgeted assuming it would be lower.

Mr. Covino stated that compared to last year, as previously mentioned, DSH/UPL payments totaling \$800 million are expected and budgeted for the current FY; therefore while the report reflects a decrease in that category compared to last year, by year-end that will change upon receipt of those funds.

Mr. Rosen added that by year-end the budget would be over \$1 billion for DSH/UPL. Mr. Covino stated that it would be \$1.5 billion. Continuing with the reporting, PS expenses year-to-date (YTD) are \$3.6 million over budget. Fringe benefits are \$4 million better than budget due to the timing of health insurance payments. There is a \$38 million surplus in Other Than Personal Services (OTPS) expenses due to a rollover of funds into the current FY and the timing of IT projects.

Ms. Youssouf asked if the expectations are that those funds would be spent before the end of the FY. Mr. Covino stated that in term of IT it's not clear at this time if those funds will be spent by year-end but the rollover in OTPS is somewhat of a built-in surplus due to the cash caps. Finalizing the reporting, all other categories are essentially on budget YTD. Net of receipts and disbursements through February 2012, there is a \$64 million surplus.

Information Item:

Medicaid Eligibility Report - As of February 2012

Ms. Maxine Katz stated that the Medicaid inpatient Eligibility report as of February 2012 comparing last year actual to the current year, Medicaid applications submitted are down from last year's submission; however, upon further review of the outcomes to determine if the Breakthrough efforts as part of the various RIEs that were undertaken have impacted the workflow, a review of the data from January 2012 to February 2012, Medicaid submissions are higher by 3,000 more applications. Eligible decisions are 2,600 more than the prior month and the percentage of eligible decisions are higher. The percentage of eligible decision compared to January 2012 to February 2012 is at 89% which is an increase in the number of eligible decisions and the applications submitted. However, as reported last month, PCAP applications compared to prior month are down by 1,000. Based on further review of PCAP submissions, there is a decline in OB and ambulatory care visits and a decline in discharges as well. There is a shift in Medicaid fee for service of a downward trend. For example in FY 10 Medicaid fee-for-service outpatient visits were 25% of the total and in FY 11 it dropped to 21% and is projected at 20% for the current FY 12 in comparison to the Medicaid managed care which has been showing a steady increase; 52% in FY 10, 58% in FY 11 and projected at 60% this FY 12 which is reflective of a slight shift. Additionally there has been an increase in managed care enrollment due to a significant increase in marketing by MetroPlus and HealthFirst from the point of entrance of the patient. As a result of those efforts, the opportunity for HHC staff to do an application has declined but the number of insured patients has increased.

Ms. Youssouf added that more patients are coming in with insurance which is a benefit for HHC. Ms. Katz added that because of those enrollment efforts, there is less opportunity for the staff to process applications. Additionally, there is a decrease in the self-pay population; 17% in FY 10, and 15% in FY 11 and projected the same for this year FY 12.

Ms. Youssouf commented that it is not necessarily less opportunity but rather a benefit to HHC to have more patients insured which translates to a decrease in the self-pay population. Going forward in terms of adding value to the reporting, it would be helpful to the Committee in understanding the various changes or shifts if those trends cited by Ms. Katz were added to the report. Additionally, an explanation for the increase or decrease in applications submitted and eligible decisions would also be extremely useful, which as shown on the report there is an increase in both the eligible and ineligible decisions.

Ms. Katz stated that an explanation for that increase was not readily available but that she would review the data and report back to the Committee on the findings. Additionally the payor mix report which is reported quarterly to the Committee would be presented next month and will show those shifts in payors that she had reported.

Dr. Stocker asked Ms. Katz if based on her reporting submissions are down year over year and in some of the variations some of the facilities are doing less than last year. However, on a month to month basis Medicaid eligibility decisions and applications submitted are increasing as a result of the various Breakthrough events.

Ms. Katz stated that basically that somewhat summarized the trends and that there has been an improvement from month to month. Some of the improvements that were previously discussed will be reflected in the data in the months ahead. The facilities have been made major improvements in their processes, particularly to capture the patient upon arrival in the emergency room and based on those improvements, productivity has increased.

Dr. Stocker stated that there is a significant decrease in the request for additional information and there is an increase in eligible decisions. Based on those trends it is possible for next month to have a report reflecting some of those trends for the Committee in addition to some of the factors that may be contributing to some of the improvements, such as automation, staff efficiency, etc.

Ms. Katz stated the trend report could be done for next month and that overall there has been an improvement in the submission of applications.

Ms. Zurack asked if there was any additional automation. Ms. Katz stated that there had not been any and that HHC has not put any more inpatients on the automated system.

Dr. Stocker asked what the basis of that decision was. Ms. Katz stated that it was a joint decision between HHC and Human Resources Administration (HRA), whereby neither one was ready to move more in that direction. Nonetheless the applications through all of the training, HRA has participated in some of the events that were held on education and the required documents versus holding back applications due to various interpretations of the requirements for submission with the application that were subsequently relaxed by HRA. That education has improved the process significantly in terms of the quality of the application that is being submitted.

Dr. Stocker asked if there is an explanation for the variation between facilities and whether it would be useful to review variation by facility from month to month in order to provide the Committee with an understanding of the efforts in terms of improvements that have been made by the individual facility.

Ms. Katz stated that it would be worthwhile to have to do that analysis of the variations. Recently there was a Rapid Improvement Event (RIE) and while it was enterprise it was done at Bellevue. Based on that RIE, Bellevue has done made a concerted effort to focus on cases that should increase their application submission rate. Several applications were identified for submission based on that review.

Mrs. Bolus asked if Medicare would be included in the tracking.

Ms. Zurack stated that HHC does not do enrollment for Medicare.

Ms. Youssouf asked if the variances in the eligible and ineligible decisions should equal the variance in the number of applications submitted.

Ms. Zurack stated that the numbers are based on different time frames and therefore would not add to that total.

Ms. Youssouf stated that the report is FYTD. Ms. Zurack stated that it is but there is a lag from when the applications are submitted to when a decision by HRA is received back on whether the application is eligible, ineligible or need more information. The Medicaid applications submitted reflect actual applications submitted from July 2011 through February 2012, whereas, the Medicaid decisions are from as far back as three months ago. Some application required a longer time frame and there are those applications that require additional information and are processed sooner. The data reflects caseload; therefore, the numbers will not reconcile from to month basis given that the data is not the same as debits and credits.

Mr. Rosen added that the data shows that there are certain trends.

Ms. Zurack stated that there has been a decline in admission and to have an increase in the eligible decisions while admissions are declining is a positive trend. Although there is a negative trend in PCAP there is a positive trend behind the data and that is that there are more patients coming to the facilities with insurance which is also a very positive trend. In getting back to Dr. Stocker's question, the results from the Bellevue RIE that took place weeks ago will not be reflected in the data until the final June 2012 report is issued and report at the September 2012 Finance Committee. On the flip side, an RIE was held at Queens in November 2011 and given the time frame for the catch-up from the lag, there should have been some improvements reflected in the data. However, as reflected on the report through February 2012, the data does not reflect any major changes. It is important to note that discharges are down significantly at Queens.

Ms. Youssouf added that the report is a comparison of two different fiscal years which would reflect a trend and based on Ms. Zurack's explanation which appears to be plausible; however, it is not clear at this time what the Committee should be getting from the report.

Dr. Stocker stated that the report shows that more applications are better as well as more insured patients.

Ms. Youssouf stated while that might be evident from the report, it does not reflect the explanation give by Ms. Zurack which makes understanding the report extremely difficult.

Mr. Rosen added that it is very difficult to understand when the numbers do not reconcile given the impact of the time frame for the submission of the applications.

Ms. Zurack stated that the report provides an incentive for the hospitals to focus on the Medicaid application process flow and outcomes; therefore it's important not to under-estimate the value of the report.

Dr. Stocker asked if there is value in having the individual facilities report to the Committee.

Ms. Zurack stated that what might be useful to the Committee in understanding the lag and the flow would be to have those hospitals that have made improvements report to the Committee their individual metric on improvements.

Dr. Stocker stated that the information would vary from facility to facility such as Queens to the other facilities.

Ms. Zurack stated that perhaps Queens could present at next month's meeting to which Dr. Stocker agreed.

Ms. Bolus asked if there is any assistance that HHC can provide to the Medicare individuals to determine if its program can help them in understanding the Part B implications.

Dr. Stocker stated that MetroPlus has an aggressive program for assisting Medicare individuals.

Mr. Rosen stated that the Medicare program at MetroPlus has increased significantly and there are plans for further growth which should provide assistance for that population.

Medical & Professional Affairs / Information Technology Committee

March 22, 2012 – As reported by Dr. Michael Stocker

Chief Medical Officer Report:

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

Health Home Implementation Update

The process for COBRA and CDP transition into HHC Health Home has been designed in collaboration with current providers and Office of Ambulatory Care Transformation; with identified capacity to absorb most of the initial group of Health Home patients with existing staff. At this time, NYSDOH focus and priority for Health Home roll-out is on the highest acuity patients with outreach services projected to begin sometime in April with small targeted groups of patients in the Brooklyn and the Bronx. We await the State's response to our application for Health Home designation in Manhattan and Queens.

Comprehensive Care Plan Information System

A Request for Proposals (RFP) was recently released to seek vendors to develop a comprehensive interoperable Care Planning System that would facilitate viewing and documentation access to all providers of a patients' care team, including those in and outside HHC. The system would provide a vehicle for capturing patients care needs and self-management goals, as well as the care teams activities and interventions supporting the patient's ability to meet those goals. In addition the system will support patient tracking, consent management and medical flags,

triggers and alerts. The Care Plan Management System will be regarded as a component of the medical record with plans for creating bi-directional interfaces to the electronic health record (HER).

Panel Management System (PAMS)

PAMS was built by ICIS and designed to assist Patient Centered Medical Home (PCMH) practices to establish and maintain the integrity of physician panels, has been deployed to all PCMH sites. Training of PCMH practices on the use and application of the system has been completed, and all sites are currently using PAMS to reconcile physician panels and ensure that patients are accurately and reliably assigned to their physician panel.

HHC Connectx

Excellent progress continues. Currently there are 3,700 community providers using HHCAdvantage, HHC's web-based referral management system; 75% of referrals from community practices and organizations are being received on-line and managed by HHC Connectx Referral Services staff at each of our facilities. Use of HHCAdvantage has facilitated the exchange of patient referrals and consultation requests from community providers to HHC facilities in a secure HIE environment and has provided a tool for the safe and efficient management, processing, tracking and completing referral requests.

Dr. Stocker inquired as to whether the community physicians (non-HHC affiliated) with MetroPlus are connected with the HHC Connectx system. Dr. Saperstein responded that most of their physicians are connected to the HHC Connectx system to ensure continuity of care. Dr. Stocker further inquired as to what percentage of the MetroPlus community physicians are looped into the Connectx system. Dr. Saperstein responded that they have a total of 13,000 providers, so about one third of total providers are connected. In general if a patient is being seen by an HHC provider the inpatient admissions to HHC are about 80% for that group of member. For the community providers it was 60% at last look – but 55-60% of readmissions at last look are coming back from community referrals. In the orientation and contracting process, they must commit to an HHC facility – once a quarter we review – and have terminated doctors as they did not meet in network referrals. In general if a patient is being cared for by a primary care perspective from an HHC provider the inpatient admissions into HHC are about 80% for that group of members.

Clinical Ethics Committees

With expert assistance from Ms. Nancy Dubler, there is further strengthening of the clinical ethics consultation service at each of our facilities. The Clinical Ethics Council is made up of the chairs of each of the facility committees, and this Council is guiding the ongoing education and training of their members and overseeing the peer review of the quality of the consultations being performed. This is a vital service to assist in timely resolution of clinical decision making, often at the end of life, to reduce suffering or anguish for patients and their families.

MetroPlus Health Plan, Inc.

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee.

Dr. Saperstein informed the Committee that the total plan enrollment as of March 1, 2012 was 425,439. Breakdown of plan enrollment by line of business is as follows:

Medicaid	356,923
Child Health Plus	17,823
Family Health Plus	36,265
MetroPlus Gold	3,089
Partnership in Care (HIV/SNP)	5,693
Medicare	5,646

Dr. Saperstein 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. In addition, he provided a graph showing net transfers for the month of February 2012 for Medicaid and Family Health Plus (FHP). Dr. Saperstein informed the Committee that over the last year, 5,662 members left MetroPlus to go to Health First. He conducted a collaborative study with Maxine Katz, Senior Assistant Vice President, Revenue Management, to ascertain how many of the members stayed at HHC. The last time this study was conducted it showed that 19% remained at HHC – the preliminary number for the most current year is 20.8% - therefore 80% of the population that leaves MetroPlus goes to Health First and does leave the HHC system. Committee members inquired as to whether these patients leave HHC due to access issues. Dr. Saperstein stated that in the past, access was not noted as an issue, that those members wanted to see a doctor outside of HHC. Dr. Saperstein will try to survey the members that recently left to ascertain the reason (s).

Dr. Saperstein provided the Committee with the new population carve in timeline from the Medicaid Redesign Teams Managed Care Benefit and Population Expansion. This report summarizes all of the current fee for service populations that are being carved into Medicaid managed care programs in the next nine months. Below are brief summaries of these populations, which are all effective April 1, 2012:

- *Individuals with End Stage Renal Disease (ESRD)*: Recipients with ESRD will no longer be exempt from enrolling in a Medicaid managed care plan. Current Medicaid recipients with ESRD will have 30 days to choose a Medicaid managed care plan. Anyone who fails to choose a plan within 30 days will be automatically assigned to a plan.
- *Homeless individuals*: Where identifiable, SDOH will make an effort to target families with children prior to enrolling single individuals and childless couples. Individuals who are living on the street will be targeted last to allow sufficient time to educate this harder to locate population.
- *Individuals receiving services through the Chronic Illness Demonstration Program (CIDP)*: CIDP providers will be assisting recipients in choosing a health plan that includes the providers that the individual is currently seeing.
- *Infants born under 1200 grams or disabled under 6 months of age*: Infants born on or after April 1, 2012 with a birth weight of less than 1200 grams and infants under six months of age who are disabled will no longer be excluded from enrolling in a Medicaid managed care plan. Infants born prior to April 1st that are already enrolled in fee-for-service will remain in fee-for-service until they are six months old, at which time their guardians will be required to choose a plan.
- *Individuals with characteristics and needs similar to those receiving services through an Long Term Home Health Care Program (LTHHCP), Care at Home (CAH) program, Traumatic Brain Injury (TBI) program, Nursing Home Transition and Diversion (NHTD) waiver program and the Intermediate Care Facilities for the developmentally disabled program (ICF/DD)*: Beginning in April 2012, the state will begin to enroll individuals who "look like" participants in the LTHHCP waiver program and are not currently enrolled in the program.

There are additional benefits and populations that are being carved into Medicaid managed care, and those include:

- *Dental*: Effective July 1, 2012 plans will be responsible for dental benefits.
- *Skilled Nursing Facility services*: Effective October, 2012 plans will provide benefits for residents of residential health care facilities – nursing homes.
- *Early Intervention services*: Effective January 1, 2013, plans will provide benefits for individuals in the Long Term Home Health Care Program. These individuals will have the ability to opt out of mainstream managed care and enroll in the managed long term care program.
- *Consumer Directed Personal Assistance Program (CDPAP)*: This program is designed for elderly or disabled residents that require and are eligible to receive home care, personal care or skilled nursing services and wish to maintain control over whom provides these services. SDOH just informed plans that this change was postponed for the time being.

The U.S. Centers for Medicare and Medicaid Services (CMS) has informed the Plan that they will perform a financial audit for contract year 2010. MetroPlus, within the last year, completed a successful audit for 2008 in which the auditors reported no material findings and three minor observations, all related to true out-of-pocket costs (TrOOP) that should not occur again since CMS has now automated these TrOOP processes.

CMS has not yet provided a start date for the audit. The 2008 audit took about six months for the auditors to complete.

The New York State Department of Health (SDOH) issued a revised date for requiring dual-eligible individuals, 21 and older, who need more than 120 days of non-institutional long term care services to enroll into a managed long term care (MLTC) plan. The implementation date, originally scheduled for April 1, 2012, is now July 1, 2012. This revised schedule is subject to receiving approval from CMS.

The SDOH is requiring that all Medicaid Health Plans transition coverage of dental services into the benefit packages by July 1, 2012. MetroPlus has been engaged in a Negotiated Acquisition for an appropriate vendor to cover our dental benefit. Two vendors pre-qualified, DentaQuest, MetroPlus' current vendor, and Healthplex. Both vendors were carefully reviewed and Healthplex was chosen as the vendor. The annual estimated costs will be approximately \$56 million for dental services and up to \$5 million for administrative costs. This contract was approved by the MetroPlus Finance Committee in February and MetroPlus Board on March 13th. It is being presented today to the HHC Board of Directors for approval.

Chief Information Officer Report:

Bert Robles, Chief Information Officer provided the Committee with an update on the Networking Infrastructure Refresh Program. In February 2011 the Board of Directors approved a capital spend of \$25.3 million for a network infrastructure refresh program. This funding was to be used to upgrade and maintain Phase I of a five (5) year network infrastructure refresh program which will assist the Corporation in accommodating application growth, increasing bandwidth for faster application response times and maintaining stability.

The components of this upgrade include (but are not limited to) routers, switches, wireless access points, IPT phones, network cabling and uninterrupted power supplies. All of these networking components interconnect together allowing hospital Local Area Networks (LAN) the ability to share various different business, clinical and data applications over the Wide Area Network (WAN) both within HHC and over the Internet.

Applications such as QuadraMed (QCPR), Siemens (Unity) and the Corporate messaging system (GroupWise email) would not be able to function unless these networking components are functioning and in place. This infrastructure upgrade is also required in order for the Corporation to communicate with our patients and business partners. In addition, this hardware is required to support new technologies for such initiatives as a new clinical Electronic Medical Record (EMR) and payroll/ time keeping systems. These systems and several others all require a robust data communication system in order to operate efficiently.

As of today, Enterprise Information Technology Services (EITS) has encumbered \$12.1 million and has another \$7.9 million of pending purchases orders associated with this upgrade. EITS is on track to use remaining balance by the end of Fiscal Year 12 and we will be requesting additional funding to start Phase II.

We have completed upgrading the network and wireless infrastructure at Gouverneur Healthcare Services, Queens Hospital Center and Coney Island Hospital. Work is underway at Elmhurst Hospital Center, Lincoln Medical & Mental Health Center, Harlem Hospital Center, Metropolitan Hospital Center, Segundo Ruiz Belvis Diagnostic & Treatment Center, Morrisania Diagnostic & Treatment Center, Woodhull Medical & Mental Health Center and Cumberland Diagnostic & Treatment Center. EITS projects that by the end of Calendar Year 2012 the upgrade will be completed at all 8 locations.

One factor impacting the progress of this project has been the readiness of the environmentals (power and cooling) at the facilities. We are now taking a joint approach with the Office of Facilities Development (OFD) to engage architectural/engineering resources to address this in a more comprehensive, Corporation-wide way, rather than the site-by-site approach which was not proving to be efficient or effective.

This past winter, the issue of Public CIO which is technology leadership in the public sector publication there is an article in which two of the IT employees are featured. The article is titled "Duty calls: Balancing Military Service and a Civilian Career Pays Off for These IT Professionals" and features Craig Franklin, Deputy CIO at North Bronx Healthcare Network, who has served in the Air Force Reserve for 23 years and Corey Cush, Assistant Vice President, Infrastructure Services who was an active-duty soldier and has served 22 years in the Army National Guard. Both Mr. Franklin and Mr. Cush are outstanding individuals at HHC who have been able to balance both serving in the military and working at HHC.

Information Items:

Update on Research at HHC

Presenting to the Committee was Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer and Christiana Coiro, Director, Office of Research Administration. Ms. Coiro began her presentation by stating why research should be supported at HHC. It is critical to our mission: *"To join with other health workers and with communities in a partnership which will enable each of our institutions to promote and protect health in its fullest sense -- the total physical, mental and social well-being of the people."* by matching the health services research body of knowledge to the needs of HHC's patients.

Ms. Coiro then presented a snapshot of HHC's research activity to the Committee as follows: 402 protocols approved in 2010; 425 protocols approved in 2011; as of March 9, 2012, 79 protocols were approved; there are active protocols at 10 facilities; and 67 federal grants were received in FY 2011 with total award funding of \$6.5 million.

Starting in 2012 for the first time we started coding studies to capture the different types of research being conducted at HHC. The categories are: Chart review and data runs; questionnaires, survey's and interviews; health services research; and clinical trials, interventions, medication intervention and devices. Ms. Coiro shared the January and February 2012 types of studies with the Committee, along with a chart demonstrating the types of research per facility.

Starting in 2010, research has under gone many changes. The HHC research approval process was streamlined, the application was shortened, made certain steps of approval process concurrent, and added a pre-approval step; enhanced research administration office; formed a HHC Research Council comprised of experts throughout HHC to guide the research agenda; contracted with Biomedical Research Alliance of New York (BRANY) to be the Corporate Institutional Review Board (IRB); embarked in a five year partnership with the New York University (NYU) called the NYU-HHC Clinical Translational Science Institute (CTSI) whose focus is on translational research engaging the community in some of the clinical research activities and to train and groom a new generation of clinical and translational researchers. There are eight HHC facilities involved: Bellevue Hospital Center; Coler-Goldwater Specialty Hospital and Nursing Facility; Coney Island Hospital; Gouverneur Healthcare Services; Kings County Hospital Center; Lincoln Medical and Mental Health Center; Metropolitan Hospital Center; and Woodhull Medical and Mental Health Center; and received an Agency for Healthcare Research and Quality (AHRQ) grant in 2010 which funded Corporate-wide research conference that was held in October 2010 at Lincoln.

As we move forward we are taking on even more: a strategic research plan was draft with the following goal: "to enhance HHC's infrastructure and processes to support financially sustainable research in collaboration with regional academic partners, industry and other sponsors, as well as the communities served by HHC facilities; in the process of upgrading the electronic research approval system; strengthening CTSI

partnership with NYU; revising the Corporate research operating procedure; developing a public website for research; and enhanced educational offerings.

Ms. Coiro described the following short-term goals that will be achieved over the next one to three years: to develop HHC research infrastructure, with streamlined resources and easy and efficient processes to maximize quantity and quality of research programs; a set of HHC research priority areas based on the priorities and health needs of NYC communities, including identifying opportunities unique and specific to HHC in areas such as health services delivery, cost effectiveness, comparative effectiveness and clinical translational research in collaboration with research stakeholders; community-based and translational research collaborations with academic and community partners; an assessment of barriers to participation in clinical research at HHC sites; a mechanism for dissemination, presentation and publication of results; put in place an evaluation plan to evaluate the impact of the Strategic Research Plan; and develop a mechanism to identify strengths and weaknesses in existing HHC systems and rapidly implement changes to advance the successful implementation of research opportunities.

Ms. Coiro concluded her presentation by describing the long-term goals that will be achieved in years three through five: increased funding to sustain the research infrastructure, creation of research centers of excellence and expertise in specific research areas based on health needs of New Yorkers; the establishment of a human research protections program at HHC and the Association for the Accreditation of Human Research Protection Programs (AAHRPP) accreditation; an evaluation of the impact of HHC research on health outcomes and public health of New Yorkers and patients generally; and a culture that values and maximizes human research subject protection and creates mechanisms to facilitate, monitor and enhance research compliance and human research participant protections.

Dr. Isaac Weisfuse, Deputy Commissioner, NYC Department of Health and Mental Hygiene, inquired as to whether research is conducted at multiple HHC sites and whether the researchers conduct the research on HHC time, and is it grant funded. Ms. Coiro responded that yes, the graph previously displayed included multiple site research. Dr. Wilson responded that there is funded and un-funded research currently occurring at HHC. Un-funded research is whereby residents doing projects that associated with their residency program which are in essence the chart review project Ms. Coiro noted earlier. On the funded research side, part of the researcher's time is funded, but there are multiple difficulties such as how we track and monitor their time especially when they already have a full-time job. We used the Office of Internal Audits in 2010-2011 to understand where there were difficulties in the process and documentation and we found that things were in pretty good shape and deficiencies were corrected. In response to Dr. Stocker's inquiry, Ms. Coiro explained that research projects being done at one facility go through that Affiliate IRB for approval. In the case when there is no Affiliate IRB associated with a facility, the BRANY IRB would be used. When a research project is being conducted at multiple HHC sites, it would go to the BRANY IRB for approval.

Chronic Disease Management and Preventive Services at HHC

Presenting to the Committee was Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer and David Stevens, MD, Senior Director, Office of Healthcare Improvement. The current state chronic illness control can be summarized as: we have accurate data in some metrics which has driven sustained improvement in a number of areas; improvements have reached a 'plateau'; control rates vary across facilities; and we need more data in order to expand the scope of improvements. The two aims are: 1) accurate and timely data in all priority areas to drive improvement efforts and reduce disparities; and 2) dissemination of best practices such as Patient Centered Medical Home (teamwork, training, coordination of care), information technology (registries and decision support), and advances in healthy lifestyle support.

In terms of reporting the data there are two definitions: 1) standard is the National Average Performance for Commercial HMOs nationwide; and 2) a benchmark is the 90th percentile of National Commercial HMOs.

Dr. Stevens described the slide that contains the Corporate-wide preventive services and chronic illness control dashboard. Across the top of the table the columns illustrate the standard, the benchmark, percentage of HHC patients at target in 2011 & 2010, percentage of facilities at standard in 2011 & 2010, and the percentage of facilities at benchmark in 2011 & 2010 with the chronic disease condition listed on the left side of the table. Dr. Stevens highlighted some of the dashboard components. HHC's rate for blood pressure control in diabetes management was at 36% in both 2010 and 2011, compared to the Standard of 33% and the benchmark of 42%. Eight-two percent of HHC facilities met the standard in 2011 compared to 64.7% in 2010. In 2011, 12% of the facilities met the benchmark compared to 24% in 2010. For LDL control the standard is 48% and the benchmark is 57%. In 2010, 70.6% of HHC facilities met the standard compared to 88.2% in 2011. In 2010, 24% of HHC facilities met the benchmark compared to 47% in 2011. For mammography screening the standard is 71% and the benchmark is 80%. In 2011, 71% of HHC facilities met the standard and 12% met the benchmark. The newer data components that will be added to the dashboard include: non-cancer prevention such as HIV/know your status; behavioral health screening such as depression, tobacco use; and other chronic illness control such as asthma control and depression management.

Dr. Steven then presented histograms that drill down the performance of individual facilities. For blood pressure control, the facilities that improved were Cumberland D&TC, Bellevue Hospital Center, Lincoln Medical and Mental Health Center and East NY D&TC – the remaining facilities either remained flat or slightly worsened. For LDL eight out of the fifteen HHC facilities improved, the others remained flat or slightly worsened.

Moving beyond the plateau: bring lowest performers into the 'Pack' by adoption of readily available best practices and identify unique challenges; and moving up the whole 'Pack' where the bell curve is pretty tight already by targeting different barriers with new tools such as the PCMH model

("It takes a village" – enlist all team members); proven approaches to lifestyle change; and closer follow-up of uncontrolled patients (care management, non-physician driven pathways). Using the data to drive improvement by identifying disparities and variations facility-to-facility; subpopulations within a facility; and provider-to-provider within a facility -- and by measuring the impact of interventions.

The new areas of focus in prevention and chronic illness in 2012 include heart failure (reduce readmissions); geriatric syndromes (fall risk, dementia); adolescent wellness (obesity, reproductive health); drug/alcohol "hazardous" use; and obesity/overweight (children, adolescent, adult). The 2012 priority areas for improved data collection/reporting are: depression management in primary care; preventive measures in diabetes mellitus (eye/kidney/ feet); colorectal screening (screening/quality rate); and prevention composite (vaccines, screening).

Strategic Planning Committee – April 3, 2012

As reported by Josephine Bolus, RN

SENIOR VICE PRESIDENT REMARKS

Committee Chair, Josephine Bolus, RN informed the Committee that the Senior Vice President Remarks would be deferred until next month, upon Ms. Brown's return.

Information Items:

*New York State Health Home and HHC
Ross Wilson, M.D., Senior Vice President/Chief Medical Officer
Office of Medical and Professional Affairs*

Dr. Wilson informed the Committee that he was asked to address the Health Home initiative particularly from a strategic point of view. He defined Health Home as a model of care coordination designed to improve the care of patients, particularly those with chronic illness or serious and persistent mental illness. He explained that the State would focus its Health Home efforts on Medicaid high utilizers.

Dr. Wilson reported that the Affordable Care Act (ACA) provides funding for the Health Homes initiative, through a New York State plan amendment that was recently approved by CMS. He noted that the implementation of the Health Home was very complicated. It alters the relationship with community providers and health systems; the relationship between patients and care managers; and it potentially alters the relationships between care plans and delivery systems. The Health Home has some significant implications for what a future delivery system might look like if the health care delivery system were to move in the direction of Medicaid Accountable Care Organizations.

Dr. Wilson reported that the ACA established the authority for states to develop these plans and to receive federal reimbursement for Health Home services. He noted that the direction of improving care for Medicaid high utilizers would continue to be a priority, whether it is a clinical priority, or whether it is a financial priority or a combination of both. He noted that this will be an issue for not only New York State but the whole country. He explained that Health Home services will be based on providing better care management for patients who are sicker or who are needier.

Dr. Wilson reported that, in New York State, the thinking started with the 5.4 million Medicaid recipients. Specifically, which recipients account for the greatest cost to the state and for which improvements in care delivery could be made. Dr. Wilson described the breakdown of New York State Medicaid cost enrollees as the following:

- 50,000 developmentally disabled recipients account for a cost of \$6.8 billion
- 200,000 long term care recipients account for a cost of \$10.5 billion
- 400,000 behavioral health recipients account for a cost of \$6.3 billion; and
- 300,000 chronic medical patients account for a cost of \$2.4 billion

Dr. Wilson emphasized that New York State's Health Home initiative is focused on chronic medical and behavioral patients. The other groups of recipients will be targeted for other Medicaid redesign activities and other plans. They are not part of the health home at the present time. Dr. Wilson commented that, as of now, the long term care group may well be feeding into a future health home model that the state is now discussing, which demonstrates how dynamic things are. When the state's rules were examined, it was projected that there would be 128,000 patients eligible for Health Home services across the Corporation. Accordingly, plans were made based on that large number. Dr. Wilson reported that the number that HHC may be given may be less than 10 percent of that original estimate. At the moment, HHC is trying to determine what the size of the program will be. Specifically, will it be 5,000 – 10,000 patients or 130,000 or more patients.

Dr. Wilson reported that HHC applied for and received Health Home designation for the Bronx, along with Montefiore Hospital, Visiting Nurse Service and Bronx Lebanon Hospital. He explained that HHC's application is a joint delivery system and health plan application with up to 50 community partners. HHC has applied and achieved Health Home designation in the borough of Brooklyn. HHC is one of four designated Health Homes in Brooklyn. HHC is the only Health Home that appears in both boroughs. HHC has also applied for Health Home designation for the boroughs of Manhattan and Queens. The results of those applications should be received within several weeks.

Dr. Wilson shared with the Committee a state bulletin on the status of the Health Home initiative that had been updated on January 27, 2012. The bulletin highlights that the Health Home applications for Manhattan and Queens were due on February 15th with implementation beginning on April 1st. Dr. Wilson noted that the deadline for implementation had passed with no announcement of the designated Health Homes.

Dr. Wilson informed the Committee that the State is having complex conversations and discussions about how to pay for the initiative. Dr. Wilson reported that the State, at one stage, had planned to place a half million patients in Health Homes but the target number has been revised to be a lot smaller. They are now concentrating on the sickest groups, to be determined by an acuity score by diagnosis or a CRG acuity score. That is, the highest risk based on an algorithm which will predict the likelihood that patients would require hospitalization. Another component will be that patients have had little or no reliable contact with ambulatory care. That is, patients are using the emergency room as their main source of care.

Dr. Wilson stated that the key to the whole process is the case manager who will work with each patient to help them navigate their health care system. Dr. Wilson reported that the State had estimated that a case manager's cost would be \$71,000 and that a case manager could be a registered nurse or a social worker. Additionally, the state had made various other cost projections around program administration and capital requirements, which has been determined by HHC to be insufficient to run the program. He informed the Committee that HHC had estimated the cost of administering this program and discussions are continuing with the State on this issue. Dr. Wilson commented that HHC was not in the position to start a new program if HHC would be paid less than what it would cost us to run that program.

Dr. Wilson shared the State's metrics for determining the program's efficacy. Success will be defined by a reduction in hospitalizations, preventable ER visits and nursing home admissions. He reported that the metrics for monitoring and reporting, resulting from improved care management and care coordination, will be reduced hospitalizations, inpatient stays, ER visits, with some or no impact on nursing home admissions. This is the model by which this program will pay for itself in the longer term in a capped managed care environment.

Dr. Wilson described the state's algorithm for assigning the first wave of patients to HHC. The State's criteria include:

- Higher predictive risk for negative event (inpatient, nursing home, death)
- Lower or no ambulatory care connection
- Provider loyalty (ambulatory, case management, ED and inpatient)
- Geographic factors

Dr. Wilson emphasized that these patients will be a very high acuity group of patients. Dr. Wilson informed the Committee that HHC has had experience across the Corporation, over the last two years, with a high acuity group of patients through its Chronic Illness Demonstration project led by Maria Raven, MD at Bellevue Hospital Center. This is a very successful program that started at Bellevue Hospital and expanded to include Elmhurst Hospital Center and Woodhull Medical and Mental Health Center. Through this program, HHC demonstrated its ability to improve care for a very sick group of patients. Approximately 50% of the patients enrolled in the Demonstration project had precarious housing. A majority of these patients had a mental health diagnosis and most had a social disability. Dr. Wilson reiterated that HHC is fully aware that the Health Home initiative is an incredibly intense activity but HHC has the knowledge and experience on how to manage these patients in terms of case managers, supervision, transportation, access to housing etc. He noted that HHC's discussions with the State had been predicated on the lessons learned through the Chronic Illness Demonstration Project. A key finding of the Demonstration project is that for every 100 patients that HHC was assigned, HHC was able to locate approximately 25% of these patients. Of that group, HHC has been successful in engaging most of these patients in the program.

Dr. Stocker asked if the dollars go directly to the providers and not filtered to the health plan. Dr. Wilson clarified that the dollars go both ways. That is, it is directed to the health care delivery system and depended on whether or not patients are enrolled in managed care or in the fee-for-service program. Dr. Wilson added that, if a patient is enrolled in managed care, like MetroPlus Health Plan, that health plan would obtain an additional per member per month financial component that would come through the plan to the delivery system. Dr. Wilson clarified that the case manager will work for and will be co-located with the providers. Dr. Stocker inquired if this is a good thing. Dr. Wilson responded that, this is one of the tensions that had been created through this model. He explained that managing care had always been a function of health plans and the delivery system. This model is now forcing a review of this interface with many questions to address including:

- Who is actually responsible for managing care?
- What should the plan and the delivery system do in the longer term?
- Who will be better and more efficient at it?

Dr. Stocker commented that most physicians are very removed from the case managers that health plans employ. Dr. Wilson responded that the case manager in the Health Home model has a closer relationship with the primary care doctor and the other providers engaged in the patient's care. Case managers are active participants in negotiating the patient's health plan and the health goals. They help to break down the barriers that patients may have accessing care. Essentially, the case manager in this model is working more closely with the delivery system to advocate for the patient. Dr. Stocker stated that it is to be presumed that other doctors would like this model. Dr. Wilson responded affirmatively and stated that HHC's doctors are attracted to this model because their relationship with the utilization and case management at the health plans is not generally close and occurs generally when things are not going to go well, which is not always a positive experience.

Dr. Wilson concluded his presentation by sharing a diagram with the Committee. He stated that diagram showed that health home is just one of the many initiatives that HHC is doing across the Corporation that is more suited to honor patients' needs and also the health reform law. The diagram showed a health care system which is designed to make a relationship with patients over time connected through primary care. In the center of the diagram is the Primary Care Medical Home or PCMH initiative, which is a redesign of primary care, which is an ongoing across the corporation. Dr. Wilson reported that HHC had achieved NQCA designation at the highest level (level 3) at all HHC's primary care sites. He added that the primary care site is where patients connect to HHC's system and it is where the whole patient assessment is made and where the whole patient's view is set.

Dr. Wilson discussed many other changes/initiatives including:

- HEAL 17 is an initiative to connect schizophrenic patients with to primary care through the use of technology.
- FQHC designation project is focused on converting HHC's D&TCs into a federally qualified health centers (FQHC).
- MetroPlus Health Plan's changes including the new managed long term care initiative and its work with the homeless and other changes.
- PAGNY initiative focuses on how HHC employs its physicians and getting them aligned with the direction HHC is going.
- Care Management initiative, led by Dr. Sullivan, focuses on inpatient and ED case managers and managing the case management
- ICIS project focuses on the change in the electronic health record and information systems.

Dr. Wilson stated that these all fit together and navigating all them is a bit of a task; and the Health Home is one of these initiatives.

Dr. Stocker asked is all these various programs could be coordinated in a coherent way. Dr. Wilson responded affirmatively and stated that it is a deep struggle. He added that, at the moment, identifying the right platform/mechanism to do this is not yet finalized. However, it is the subject of ongoing and broader discussions on the strategic direction of the organization. Dr. Wilson noted that, historically, HHC's structure had dictated its function. However, the structure that is needed is not yet delineated. Over the next couple of years, HHC will know the right structure. He added that structure is only one part of HHC's capacity to manage these programs; and that HHC's current structure enables it to manage these initiatives at the current time but this will change five years from now.

Dr. Stocker asked what the big academic hospitals were doing. Are they having conversations like this? Dr. Wilson responded that they are a little concerned about this issue. This is not where they have traditionally focused their research, teaching or revenue generation initiatives. It is untested territory for them.

Dr. Stocker commented that, if the big academic medical center got engaged in this, they would be forced to generate a lot of new primary care capacity in this kind of system. Dr. Wilson reported that this is one implication and the other is what they would do with their inpatient facilities.

Mrs. Bolus asked for a status update on the FQHC project. Ms. Green, HHC's Senior Assistant Vice President for Corporate Planning Services provided an update.

2012-13 State Fiscal Year Enacted Budget Overview

Wendy Saunders, Assistant Vice President, Office of Intergovernmental Relations

Ms. Saunders informed the Committee that, on March 30, 2012, the 2012-13 State Fiscal Year Budget was passed. This is the second year in a row that the State budget was passed on time. Ms. Saunders reported on key items within the enacted 2012-13 State Budget that were of interest to HHC. She reported that the budget closed a \$2 billion deficit and that the enacted budget:

- Continues the second year of 2 year agreement on Medicaid
- Increases overall spending in Medicaid by 4% with no significant new Medicaid cuts
- Continues budget cuts from 2011 with a total impact of \$174.5 Million to HHC (excluding reductions due to new nursing home reimbursement system) with no inflation factor for providers and a 2% across-the-board rate cut.
- Extends the Global Cap on Medicaid spending by one additional year (three years total)
- Includes 4.2% increase in Medicaid spending for 2013-14
- Continues SDOH's "superpowers" should spending exceed projections
-

Ms. Saunders stated that spending is on target through January 2012, and enrollment increases must be covered under the Global Cap.

Ms. Saunders highlighted the Medicaid Redesign Team's (MRT's) proposals that had been included in the State's enacted budget. The MRT proposals:

- Provide new benefits for Medicaid patients and eliminates ineffective benefits
- Create a Supportive Housing Reinvestment Program and provides new funding for Affordable Housing
- Require language accessible prescriptions
- Expand data collection for disparities
- Create Primary Care Service Corps

- Provide targeted increase for Fair Hearings for move to mandatory enrollment in managed long term care
- Require managed care plans and Managed Long Term Care Plans to offer Consumer Directed Personal Care
- Provide enrollment assistance for Medicaid patients enrolling in mandatory managed long term care
- Phase in State takeover of growth in local share of Medicaid spending
- Phase in State takeover of Medicaid Administration
- Allow electronic asset verification for certain Medicaid patients
- Consolidate NYC Children's Psychiatric Centers
- Allow for up to 400 bed closures and consolidations in SOMH facilities after notification of Legislature and Mayor
- Establish a framework for SDOH and SOMH to jointly operate Behavioral Health Agencies (can waive requirements/deem compliance)
- Extend the Comprehensive Psychiatric Emergency Program (CPEP) for four years (2016)
- Replace 2012 nursing home bed-hold provision with new rules for adult residents to be issued by SDOH (\$ 40 million savings). HHC impact to be determined
- Extend the potentially preventable readmissions cut until 2013 and allows SDOH to implement an adverse events policy in outpatient settings
- Allow SDOH to include CMS quality measures for potentially preventable complications

Ms. Saunders reported on key Legislative proposals that were adopted as part of the State's enacted budget. These proposals:

- Create a Workgroup on Medically Fragile Children
- Create a Prescription Pain Awareness Program, including development of a CME program for health care providers and new reporting on opioid overdoses
- Institute "prescriber prevails" for atypical antipsychotics
- "Grandfather" existing providers in the Excess Medical Malpractice Liability Pool and requires a study by 11/1/12
- Require SDOH to report on transition to mandatory managed long term care
- Require SDOH to develop transition and continuity of care requirements for mandatory managed long term care
- Require SDOH to consult with stakeholders on reimbursement for nursing homes' capital costs in managed long term care
- Require SDOH to facilitate the use of triage systems in emergency rooms and report results

Ms. Saunders also highlighted those proposals that were rejected and not included in the enacted budget. These proposals include:

- No changes for reimbursement of charity care/ Disproportionate Share Hospital (DSH) funding
- No Health Benefits Exchange legislation. Governor has indicated he may issue an Executive Order to create a New York Exchange
- No new authority for SDOH to close facilities or replace Operators or Board Members for repeat violations, significant mismanagement or criminal activity
- No closure of Kingsboro Psychiatric Facility
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****** End of Report ******

**ALAN D. AVILES
HHC PRESIDENT AND CHIEF EXECUTIVE
REPORT TO THE BOARD OF DIRECTORS
APRIL 19, 2012**

**HHC MEDICAL SIMULATION CENTER ATTRACTS INTERNATIONAL INTEREST
WITH COURSE TAUGHT BY SIMULATION GROUP FROM HARVARD**

For the second year running HHC's Institute for Medical Simulation and Advanced Learning -- IMSAL -- will host a medical simulation instructor course taught by faculty from the Center for Medical Simulation, a global leader in the field of healthcare simulation. The course will be held next week -- April 24 to 27 -- at the IMSAL center located on the campus of Jacobi Medical Center in the Bronx. IMSAL first hosted the course in January 2011. Like last year's course, this one was sold out well in advance and has attracted attendees from around the world.

Titled "Simulation as a Teaching Tool," the course is a four-day intensive immersion in healthcare simulation for those educators seeking to create high-quality healthcare simulation programs. Drawing on the disciplines of aviation, healthcare, psychology, experiential learning and organizational behavior, participants will learn how to teach clinical, behavioral and cognitive skills through simulation. Participants will explore simulator-based teaching methods applicable across the healthcare education spectrum, including undergraduate and graduate medical, nursing and allied health domains. Daily formats include simulation scenarios, lectures, small and large group discussions, case studies and practical exercises with feedback.

As well as participants from HHC hospitals and other facilities in New York state, the course will be attended by simulation educators from Chile, Lebanon, Singapore and, in the US, California and Minnesota, including two attendees from the Mayo Clinic.

HHC will promote the visit by co-hosting a live Twitterview (interview on Twitter) to discuss the growing importance of healthcare simulation and its applications. Katie Walker, Director of IMSAL and Dr. Jeffrey Cooper, Executive Director at the Center for Medical Simulation will participate on Monday, April 23 from 12:30-1:30. People who are interested in following the conversation or asking questions can follow our Twitter handle @HHCnyc and the hashtag #medsim.

FEDERAL UPDATE

Starting Monday, March 26, the US Supreme Court heard three days of oral arguments regarding the constitutionality of certain provisions of the Patient Protection and Affordable Care Act (ACA). The arguments addressed the central issue of the constitutionality of the individual mandate, which requires nearly all individuals to buy health insurance, some getting economic subsidies to do so. The Court heard additional arguments on whether, if the individual mandate were ruled unconstitutional, other parts of the law must also fail. The

Court also heard arguments on whether the ACA provision expanding the Medicaid program for the poor, by requiring all states to cover individuals at 133% of poverty or below, is constitutional. The Court is not expected to issue its decision until June.

On March 29, the House adopted Chairman Paul Ryan's proposed Budget Resolution for Federal Fiscal Year 2013. This Resolution will not be taken up in the Democratically-controlled Senate. This week, House Committees are starting to work on details to achieve the budget cuts. As noted last month, the Ryan Budget would dramatically reshape the Medicare and Medicaid programs. Chairman Ryan would change Medicaid into a federal block grant program, giving the states more latitude in designing their programs but federal spending on Medicaid would be slashed by \$810 billion over ten years, a larger cut than the \$771 billion cut in proposals Ryan made last year. One estimate is that block granting Medicaid in this way would reduce New York State's funding by \$141 billion over 10 years and reduce hospital funding in NYS by 30 percent. The Ryan budget would also repeal the Affordable Care Act, including the Medicaid expansion components.

HHC TESTIFIES FOR CITY COUNCIL ON TREATMENT OF PATIENTS WITH ALZHEIMER'S DISEASE

HHC Senior Vice President LaRay Brown testified on April 3rd before the New York City Council Committees on Aging and Health about services provided in HHC hospitals for patients with Alzheimer's Disease. She covered HHC's extensive geriatric medical services, featuring special programs at Elmhurst, Lincoln, Woodhull, Metropolitan and Harlem hospitals. She also discussed the many programs to treat dementia-related symptoms at our nursing homes at Coler-Goldwater, Sea View and McKinney. She emphasized the importance of staff training as part of HHC's plan to provide compassionate care to all our patients. Her testimony ended with a few words about HHC's palliative care programs as an important resource for care to patients with Alzheimer's Disease.

HHC JOINS CITY HEALTH DEPARTMENT TO ANNOUNCE CITYWIDE INCREASE IN COLONOSCOPY RATE

The New York City Health Department and HHC announced on April 5th that in just under a decade New York City's colonoscopy rate has increased by 62 percent, signaling a major step forward in the fight against one of the most common – and deadliest – cancers. The city's average colonoscopy rate is now 67 percent, up from 42 percent in 2003 when New York City first began tracking colonoscopy rates. During this time, a citywide push to increase screening rates has also eliminated racial disparities. In 2010, colonoscopy rates in the Asian community were on par with African-Americans, whites and Hispanics for the first time.

However, the colonoscopy rate among Russian-speaking New Yorkers trails behind the citywide rate and the City will work with community partners to better understand the reason for the lag and find ways to increase colon cancer screenings. The announcement was

made at Coney Island Hospital, which serves many patients from the Russian-speaking community.

A colonoscopy procedure is considered the gold standard of colon cancer prevention, since it can detect precancerous growths in the colon or rectum and remove them before they become life-threatening. Since 2003, HHC has increased the number of colonoscopies provided to New Yorkers by almost 400 percent.

HHC AND ST. GEORGE'S MEDICAL COLLEGE ANNOUNCE CITYDOCTORS SCHOLARSHIP PROGRAM

On April 4th, I joined Deputy Mayor Linda Gibbs and St. George's University Chancellor Dr. Charles Modica to announce the CityDoctors medical scholarship program that will, over the next five years, provide tuition based scholarships worth more than \$11 million to New York City residents who aspire to become doctors. Those who otherwise meet the academic admission criteria to St. George's and who commit to give back to the community by practicing primary care medicine at one of our hospitals may be eligible for a scholarship. The first class of CityDoctors scholarships will be awarded this summer and fall to 25 New Yorkers who have demonstrated academic excellence and financial need. Dr. Ira Jay Bleiweiss and Dr. Tita Castor, alumni of St. George's who currently practice medicine in New York City, joined us to announce the scholarship program at Metropolitan Hospital Center.

The CityDoctors scholarships are part of a renewed five year agreement, effective January 2012, between SGU and HHC to support a medical student clerkship program. As HHC's exclusive international medical school affiliation partner, SGU's future annual payments to HHC for the training of third and fourth year medical students is expected to exceed the \$6 million paid in 2011.

HHC'S STAFF AND PATIENTS DEDICATE THEIR LIFE-SAVING MAMMOGRAMS TO LOVED ONES

Nearly every woman at HHC knows or knew of someone with breast cancer and throughout the month of May, HHC's staff and patients will participate in an education campaign to increase awareness about the benefits of mammograms. Our 2012 Mammogram Campaign asks, "Who do you dedicate your mammogram to?" and features photos of staff and patients with their loved ones along with a compelling message about their individual dedications. To increase participation, we will designate a wall or bulletin board in our facilities for patients and employees to post a note about their dedications, and invite women to post their dedications on Facebook or Twitter. We will also place posters and postcards in high-traffic areas of the facilities promoting the importance of mammograms. The HHC Mammogram webpage will be updated to include powerful videos and written testimonials from our patients and employees about the importance of mammograms. All year long, birthday cards will be mailed directly to the homes of female employees when

they turn 40 to remind them about the benefits of breast cancer prevention, screening and early detection.

Breast cancer kills about 1,260 women in New York City every year and still 23% of women 40 and older have not had a recent mammogram. HHC recommends that women 40 years or older get a mammogram every 1-2 years.

HEALTH HOME CERTIFICATION FOR HHC

HHC was one of three Health Homes certified in Queens by NYSDOH this month. The other two certified providers in Queens are Community Healthcare Network and North Shore/Long Island Jewish. DOH has not yet announced the providers selected to operate Health Homes in the borough of Manhattan.

While negotiations for care coordination rates between HHC and NYSDOH have not been finalized, HHC has received a list of Health Home eligible patients for the boroughs of Brooklyn and the Bronx from DOH. A preliminary analysis indicates that about 41% of the patients on the list have touched HHC's Medical Homes and that 24% have been in contact with our Behavioral Health services. In addition, 65% of these patients have touched HHC Emergency Services and 70% have been admitted to HHC hospitals in Brooklyn and the Bronx. An estimated 6-10% are homeless.

Outreach and engagement services for this group of eligible patients will be initiated after rates have been finalized and a contract between the State and HHC has been executed.

SOCIAL WORK MATTERS

During Social Worker Awareness month in March, HHC acknowledged the work of the more than 800 social workers in our hospitals, health centers and nursing homes. We rely on social workers to provide counseling, develop safe discharge planning, and connect patients with needed services when they return to their families and communities. As we enter the era of healthcare reform, HHC will be focused on transforming the way we deliver care in a way that demands a holistic approach to the needs of every individual who seeks our services. This will require more care coordination across our own facilities and among other community providers to ensure we can connect patients to a whole array of needed support services. We have always relied on our social workers to meet these needs, and now the need for them is greater than ever.

What social workers do and how they do it really does matter a great deal to HHC and the communities we serve. I know that the Board joins me in saying to all the social workers in HHC hospitals, health centers and nursing homes -- thank you. Your work on our healthcare teams is a vital part of our commitment to deliver high-quality, patient-centered care to all New Yorkers.

HHC VOLUNTEERS -- PEOPLE IN ACTION

This week, HHC joins the entire country during National Volunteer Week, April 15-21, to celebrate and thank the volunteers whose efforts help so many. More than 8,000 volunteers in our hospitals and nursing homes donate more than 1 million hours each year to provide care and comfort to our patients.

It's hard to imagine a more fitting description than this year's National Volunteer Week theme, "Celebrating People in Action." HHC volunteers are not people who simply talk. They really step forward and act on their desires to give back to community, freely donating their time and expertise each day. Our volunteers serve as foreign language interpreters, offer spiritual comfort, transport patients to religious services, and perform important personal services for patients, like reading aloud or writing letters. Their example of service is truly an inspiration to us all.

DOCTORS' DAY RECOGNITION

On Tuesday, I was honored to attend a breakfast at which HHC recognized 28 physicians for their leadership and commitment to advancing the mission of our public hospital system and providing the highest quality healthcare to New Yorkers.

Awards were presented at the annual HHC National Doctors' Day Ceremony at Metropolitan Hospital Center in Manhattan. The award winners, some of whom have served their communities for several decades, mirror the rich ethnic diversity of our City. The testimonials to their compassion, empathy and commitment to patients remind us that patient-centered care begins with a deep human connection between the caregiver and patient.

Also included among our Doctors' Day Award winners is a group of seven primary care physicians who work with our patients in the communities we serve. They represent HHC's relationship with doctors outside the public hospital system who work closely with us to manage the care of our patients. These doctors embrace and advance HHC programs that improve patient safety and improve the effectiveness of our treatment of prevalent chronic diseases, such as asthma and diabetes, in children and adults.

These exceptional men and women contribute significantly to the well-being of our city and are helping to make HHC a national model of safe, efficient, and patient-centered health care delivery. They represent the remarkable talent among the several thousand HHC doctors who are committed to excellence and deeply care about our mission to serve New Yorkers regardless of their ability to pay or immigration status.

DR. IRVING BERLIN -- OUTSTANDING HHC MEDICAL LEADER

It is with great sadness that I acknowledge the loss that HHC suffered when Dr. Irwin Berlin died unexpectedly on Friday, March 30th.

Dr. Berlin was the Chief of the Pulmonary-Critical Care Medicine Division at Elmhurst Hospital Center. He was not only a compassionate care-giver but also a spirited public health advocate, especially on issues related to tobacco control and clean air. He took great pride in his work with first responders following September 11th, both as a physician and as an advocate for their care. He was one of the guiding lights of our WTC Environmental Health Care Center, and provided care to New Yorkers affected by 9/11.

Dr. Berlin was also the Chair of HHC's Critical Care Task Force and served as a leader in many national and local organizations. Dr. Berlin was a volunteer for the American Lung Association for over 30 years, and held both national and local positions. Some of his recent activities included his work as Board Chair of the New York chapter of the American Lung Association, and Chair of the Government Relations Committee of the American College of Chest Physicians (ACCP). He was active in health care reform and regulatory issues that affect physicians and their patients, and spoke out assertively on these and other important issues.

He will be greatly missed.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

Lincoln Art Exchange Program, Iris R. Jimenez-Hernandez & Edith Garcia Velazquez, Lincoln Hospital, WABC-TV, 4/15/12

Colonoscopy Awareness Campaign in Russian Community, Dr. Terence Brady, Coney Island Hospital, News 12 Brooklyn -TV, 4/5/12

\$11M in Medical School Scholarships for Prospective Primary Care Docs, HHC, 1010WINS - Radio, 4/5/12

NYC Colonoscopy Rates

More New Yorkers Getting Checked for Colon Cancer, Alan D. Aviles, HHC, Norwood News, 4/11/12

NYC colonoscopy rate jumps 62%, saving lives, HHC, Staten Island Advance, 4/5/12 (Also covered in Sheepshead Bites, Becker's ASC Review)

Colonoscopies Save Lives, Arthur Wagner, Dr. Terence Brady, Coney Island Hospital, Komsomolskaya Pravda in America, 4/13-19/12

Cancer is Not a Joke: Have you had a Colonoscopy?, Arthur Wagner, Coney Island Hospital, V Novom Svete (In the New World), Russian-language newspaper, 4/17/12

To preserve and prolong our lives: Colonoscopy as an early diagnostic tool, Coney Island Hospital, Yevreiskiy Mir (Jewish World- Russian newspaper), 4/12-19/12

Colon Cancer: Early Detection Can Save Your Life, Dr. Sulaiman Azeez, Lincoln Hospital, The Bronx Free Press, 3/14/12

More News

City Hospitals Reach \$11 Million Scholarship Deal With Medical School in Grenada, The New York Times, The New York Times, 4/4/12
(Also covered in DNAinfo.com, Wall Street Journal/AP, World Journal, Crain's Health Pulse, WFUV Radio)

HHC Appoints New Director to Lead Learning Institute, Katie Walker, IMSAL, Advance for Nurses Magazine, 3/26/12

El Diario's Distinguished Women 2012, Iris R. Jimenez-Hernandez, Generations +/- No. Manhattan, Lincoln Hospital; Elizabeth Guzman, Metropolitan Hospital, El Diario, 4/15/12

Minority executives and their peers tout the benefits of broader representation in the C-suite, Modern Healthcare, Dr. Raju, HHC , 4/7/12

HHC Receives Funding for Affordable Housing for Patients, Crain's Health Pulse, 4/16/12

What's Your Multilingual Online Strategy, HHC, Health Leaders, 3/21/12

\$3.5 million allows hospital to purchase linear accelerator, Kings County, Nurse.com, 3/19/12

Call it doctor-doctor privilege, Lincoln Hospital, New York Daily News, 3/22/12

Ceremony salutes "Black Angels" of Sea View, Sea View Hospital, Staten Island Advance, 3/26/12

Diabetics on firm footing, Diabéticos con paso firme, Dr. Ivan Gonzalez, East NY D&TC, El Diario, 3/26/12

Communication and Teamwork Are the Steps to Patient Safety, HHC, NAPH, March 2012

Health Problems Plague City Cab Drivers, Marcelo Villagran, Maria Ramos, Lincoln Hospital, Gotham Gazette, March 2012

NYC Council Members Present Check to Cancer Care Center, Kings County Hospital, Advance for Nurses Magazine, 3/26/12

MetroPlus injects health into HHC's bottom line, Crain's Health Pulse, 3/30/12

Take care with asthmatic children, Cuidado con niños asmáticos, Dr. Luis Rodriguez, Woodhull, El Diario, 4/2/12

Lincoln's Art Exchange Program, Lincoln Hospital, MD News, April 2012

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Microsoft Health Solutions Group 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 \$16.1 million for a five year term, with two, consecutive, one-year options to renew, for a total term of 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.

WHEREAS, the Corporation seeks to enter into a contract to provide a care information system to support care coordination services in the HHC facilities throughout the five boroughs of New York City; and

WHEREAS, a Request for Proposal ("RFP") was issued on March 19, 2012 in accordance with the Corporation's operating procedures; and

WHEREAS, the selection committee rated the proposal using criteria specified in the RFP, and the committee recommended the Microsoft Health Solutions Group to be awarded the contract; and

WHEREAS, the Corporation enters into a contract of five years with two, consecutive, one -year renewal options; and

WHEREAS, the overall responsibility for monitoring the contract shall be under the Senior Vice President, Information Services and the Senior Vice President/Corporate Chief Medical Officer, Division of Medical & Professional Affairs.

Now, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation ("the Corporation") be and hereby is authorized to negotiate and execute a contract with the Microsoft Health Solutions Group to provide a care plan information system to the New York City Health and Hospitals Corporation. 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 \$16.1 million for a five year term, with two, consecutive, one-year options to renew, for a total term of seven years; 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.

Executive Summary

Proposed Contract with Microsoft Health Solutions Group

The Office of Ambulatory Care Transformation and Clinical Information Systems of the New York City Health and Hospitals Corporation (“HHC”) are proposing to enter into a contract with Microsoft Health Solutions Group (“Microsoft”) to provide a customized care plan information system, software, support, and maintenance for the provision of care coordination services to support the Patient Centered Medical Home and Health Home programs in HHC’s facilities. This system will enable HHC to identify, manage, collect data on patient cohorts as well as individual patients, and then analyze that data for quality of care and clinical outcomes.

To this end, the customized care plan information system will enable HHC to improve patient outcomes through improved care [plan] management and care coordination for Medical Home patients inclusive of high cost, high need Medicaid enrollees.

A Request for Proposal (“RFP”) was issued on March 19, 2012 in accordance with the Corporation’s operating procedures. Ten proposals were submitted and evaluated by a selection committee using criteria specified in the RFP. Five of the proposals did not meet the minimum requirements as specified in the RFP. Each of the remaining qualified vendors demonstrated their systems for the committee. On the basis of the submitted proposal and system performance, Microsoft’s proposal and system was ranked the highest overall and was deemed the most advantageous to HHC by the committee.

The contract shall be for a period of five years with two consecutive one-year options in an amount not to exceed \$16.1 million covering a population scaling up to 500,000 patients. (See cost analysis detail). The two consecutive one-year options for optional years 6 and 7 will be exercisable solely by HHC. These funds will be utilized to provide payment to Microsoft for development, support, maintenance, training, and implementation of the care plan system.

In addition, the resolution requests authorization for the President to make adjustments to the contract amounts, providing such adjustments are consistent with HHC's financial plan, professional standards of care, and equal employment opportunity policy.

HHC and Microsoft have come to a mutual understanding of Microsoft’s licensing fees, scope of work and time frames for completion of deliverables

Microsoft will assume full responsibility for the satisfactory completion of all work performed.

Costs Analysis

Fixed Patient Population

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Enrollment Assumptions	50,000	50,000	50,000	50,000	50,000	
Software Licensing	\$2,140,000					\$2,140,000
Support & Maintenance (base)		\$428,000	\$428,000	\$428,000	\$428,000	\$1,712,000
Implementation	\$1,043,000					\$1,043,000
Language support	\$125,000					\$125,000
Training	\$42,800	\$21,400	\$21,400	\$21,400	\$21,400	\$128,400
Professional Services	\$150,000	\$50,000				\$200,000
Server/Storage/Infrastructure	\$100,000				\$100,000	\$200,000
Total	\$3,600,800	\$499,400	\$449,400	\$449,400	\$549,400	\$5,548,400

Expanded Patient Population

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Enrollment Assumptions	50,000	100,000	250,000	350,000	500,000	
Software Licensing	\$2,140,000	\$1,550,000				\$3,690,000
Pricing						
Tiered						
next 50,000		\$200,000	\$200,000	\$200,000	\$200,000	\$800,000
next 150,000		\$-	\$600,000	\$600,000	\$600,000	\$1,800,000
next 100,000		\$-	\$-	\$300,000	\$300,000	\$600,000
next 250,000					\$450,000	\$450,000
next 500,000						
Support & Maintenance (base)		\$428,000	\$428,000	\$428,000	\$428,000	\$1,712,000
20% of license fees			\$160,000	\$220,000	\$310,000	\$690,000
Implementation	\$1,043,000					\$1,043,000
Language support	\$125,000					\$125,000
Training	\$42,800	\$21,400	\$21,400	\$21,400	\$21,400	\$128,400
Professional Services	\$150,000	\$50,000				\$200,000
Server/Storage/Infrastructure	\$100,000				\$100,000	\$200,000

Total	\$3,600,800	\$2,249,400	\$1,409,400	\$1,769,400	\$2,409,400	\$11,438,400
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Option Years

	YEAR 6	YEAR 7
Enrollment Assumptions	500,000	500,000
Software Licensing		
Tiered Pricing		
next 50,000	\$200,000	\$200,000
next 150,000	\$600,000	\$600,000
next 100,000	\$300,000	\$300,000
next 250,000	\$450,000	\$450,000
next 500,000		
Support & Maintenance (base)	\$428,000	\$428,000
20% of license fees	\$310,000	\$310,000
Implementation		
Language support		
Training	\$21,400	\$21,400
Professional Services		
Server/Storage/Infrastructure		
Total	\$2,309,400	\$2,309,400

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: CARE PLAN INFORMATION SYSTEM
Project Title & Number: Care Plan Information System; DCN 1995
Project Location: 125 Worth Street, Room 410, New York, New York 10013
Requesting Dept.: Office of Ambulatory Care Transformation
Number of Respondents: TEN (10)
(If Sole Source, explain in Background section))
Range of Proposals: \$ 16.1 million to \$ 17.6 million
(Proposal costs were based on **500,000 patients**)

Successful Respondent: Microsoft Corporation Health Solutions Group

Contract Amount: \$ 16.1 million

Contract Term: 5 Years with 2, 1-year options to renew

Minority Business Enterprise Invited: X Yes If no, please explain:

Funding Source: General Care Capital
 Grant: explain
X Other: Central Budget/ENT IT General Operating Fund

Method of Payment: Lump Sum Per Diem Time and Rate
Other: The awarded contract vendor would receive monthly payment for invoiced work.

EEO Analysis: Microsoft Corporation is a non-Minority/Women's Business Enterprise. However, it has received an approved status.

Compliance with HHC's McBride Principles? X Yes No

Vendex Clearance Yes No X Pending

(Required for contracts in the amount of \$100,000 or more awarded pursuant to an RFP, NA or as a Sole Source, or \$100,000 or more if awarded pursuant to an RFB.)

Background (include description and history of problem; previous attempts, if any, to solve it; and how this contract will solve it):

NCQA PCMH Recognition and Health Home Programs require utilization of interoperable care plans to improve care outcomes of Medical Home patients including Medicaid enrollees with multiple and complex needs that drive high volume and high cost utilization of services. Currently, HHC does not have any technology within its infrastructure to address this requirement.

The care plan information system is a dynamic web-based tool, used by the patient, their involved family members, primary care providers, members of the extended care team (e.g., psychiatrists and other behavioral health providers, emergency physicians, physical therapists, home care nurses) Community Based Organizations, and ancillary staff. It aids both patients and their extended care teams to manage and coordinate the medical and non-medical services and resources the patient may require to be successful in reaching their goals.

Was the proposed contract presented at the Contract Review Committee (CRC)? (include date):

The proposed contract will be presented at the May 23, 2012 CRC meeting.

Has the proposed contract's scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC? If so, please indicate how the proposed contract differs since presentation to the CRC.

No, there have been no changes to the proposed contract's scope of work, timetable, budget, contract deliverables or the accountable person since presentation to the CRC.

Selection Process (attach list of selection committee members, list of firms responding to RFP or NA, list of firms considered, describe here the process used to select the proposed contractor, the selection criteria, and the justification for the selection:

Selection Committee Members and responding firms' lists are attached hereto.

All RFP responses were reviewed in three rounds.

- **First round:** Vendors must have met two minimum, pass/fail requirements:
 - i. Vendors must have previous experience in health information technology;
 - ii. Vendors must be in agreement to comply with Attachment C, "Vendor Contract Agreement: e-collaborative SHIN-NY"
- **Second round:** Vendors having met both minimum pass/fail requirements must *also* have an existing care plan information system product.
- **Third round:** Vendors having met both first *and* second round requirements moved on to the third round i.e., the "short list". Vendors on the short list were:
 - i. CareTeam Connect, Inc.
 - ii. GSI Health
 - iii. Harris Corporation
 - iv. IBM
 - v. Microsoft, Health Solutions Group

Third round vendors were invited to conduct onsite demonstrations of their products before the entire evaluation committee.

- In preparation for the demonstrations, all responding vendors were sent simultaneously the same use case scenario to use during their presentations. The patient in the use case scenario, "Patient AM" is a patient with multiple conditions representative of the patients HHC typically serves.
- In addition, the evaluation committee debriefed after each vendor's demonstration to discuss the vendor's product capabilities to support our care plan information system needs.
- A scoring tool was developed was developed to evaluate submissions. The tool consisted of all the questions asked in the RFP. An orientation session was held on April 10, 2012 to educate selection committee members on how to use the evaluation tool.

- Finalists' scores were tabulated. On April 26, 2012 the selection committee identified the highest ranking vendor: Microsoft Health Solutions Group.

Scope of work and timetable first year of contract:

SCOPE OF WORK	DUE
Planning and initial design	2 months
Functional priorities to be implemented: <ul style="list-style-type: none"> • Implement a care plan information system with data element fields as identified in Attachment B of the RFP. • Implement capability to assign patients to care teams • Roster Management: Implement the capability to enroll patients and track their information as outlined in the NYS Tracking Sheet • Assessment capabilities - Capture patient assessment (baseline and subsequent) data, including a free text format for care coordination notes. • Encounter activity types – tracking capability for care coordination, billing, and reporting purposes • Encounter alerts - capability to alert care coordination and outreach teams 	3-6 months
Defining integration with EMR	6-8 months
(Alerts) Defining clinical decision support for patients and providers	
Population Health Management/Quality Improvement tools	
Patient portal with EHR integration	8+ months

Costs Analysis

Fixed Patient Population

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Enrollment Assumptions	50,000	50,000	50,000	50,000	50,000	
Software Licensing	\$2,140,000					\$2,140,000
Support & Maintenance (base)		\$428,000	\$428,000	\$428,000	\$428,000	\$1,712,000
Implementation	\$1,043,000					\$1,043,000
Language support	\$125,000					\$125,000
Training	\$42,800	\$21,400	\$21,400	\$21,400	\$21,400	\$128,400
Professional Services	\$150,000	\$50,000				\$200,000
Server/Storage/Infrastructure	\$100,000				\$100,000	\$200,000
Total	\$3,600,800	\$499,400	\$449,400	\$449,400	\$549,400	\$5,548,400

Expanded Patient Population

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Enrollment Assumptions	50,000	100,000	250,000	350,000	500,000	
Software Licensing	\$2,140,000	\$1,550,000				\$3,690,000
Tiered Pricing						
next 50,000		\$200,000	\$200,000	\$200,000	\$200,000	\$800,000
next 150,000		\$-	\$600,000	\$600,000	\$600,000	\$1,800,000
next 100,000		\$-	\$-	\$300,000	\$300,000	\$600,000
next 250,000					\$450,000	\$450,000
next 500,000						
Support & Maintenance (base)		\$428,000	\$428,000	\$428,000	\$428,000	\$1,712,000
20% of license fees			\$160,000	\$220,000	\$310,000	\$690,000
Implementation	\$1,043,000					\$1,043,000
Language support	\$125,000					\$125,000
Training	\$42,800	\$21,400	\$21,400	\$21,400	\$21,400	\$128,400
Professional Services	\$150,000	\$50,000				\$200,000
Server/Storage/Infrastructure	\$100,000				\$100,000	\$200,000
Total	\$3,600,800	\$2,249,400	\$1,409,400	\$1,769,400	\$2,409,400	\$11,438,400

Option Years

	YEAR 6	YEAR 7
Enrollment Assumptions	500,000	500,000
Software Licensing		
Tiered Pricing		
next 50,000	\$200,000	\$200,000
next 150,000	\$600,000	\$600,000
next 100,000	\$300,000	\$300,000
next 250,000	\$450,000	\$450,000
next 500,000		
Support & Maintenance (base)	\$428,000	\$428,000
20% of license fees	\$310,000	\$310,000
Implementation		
Language support		
Training	\$21,400	\$21,400
Professional Services		
Server/Storage/Infrastructure		
Total	\$2,309,400	\$2,309,400

Provide a brief summary of historical expenditure(s) for this service, if applicable.

Not applicable

Provide a brief summary as to why the work or services cannot be performed by the Corporation's staff.

HHC does not have existing technology needed to meet requirements for operating Health Home and Patient Centered Medical Home Programs.

Will the contract produce artistic/creative/intellectual property? Who will own it? Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

It is not anticipated that the contract will produce artistic/creative/intellectual property.

Contract monitoring (include which Senior Vice President is responsible):

- Ross Wilson, MD, Corporate Chief Medical Officer, SVP of Quality
- Bert Robles, SVP, Chief Information Officer
- Irene Kaufmann, Senior Assistant Vice President
- Paul Contino, Chief Technology Officer
- Inger Dobson Slade, Associate Director

Equal Employment Opportunity Analysis (include outreach efforts to MBE/WBE's, selection process, comparison of vendor/contractor EEO profile to EEO criteria. Indicate areas of under-representation and plan/timetable to address problem areas):

Microsoft Health Solutions Group submitted its Supply and Service Employment Report on May 1, 2012. As part of its submission, Microsoft attached a copy of its approval received from New York City on June 10, 2010 along with Part I of the Employment Report, a copy of its EEO statements, and a staffing plan including the signed and notarized Employment Report signature page. Its current submission has been approved as well.

Received By E.E.O. May 2, 2012
Date

Analysis Completed By E.E.O. May 3, 2012
Date

Manasses C. Williams, AVP
Name

ATTACHMENT A

CARE PLAN INFORMATION SYSTEM RFP, DCN 1995

Evaluation Committee Members:

1. Oladipo Alao, MD, MetroPlus Health Plan
2. Gary Belkin, MD, Behavioral Health
3. Paul Contino, Information Services
4. Louis Capponi, MD, Clinical Information Services
5. Mary-Ann Etiebet, MD, Office of Ambulatory Care Transformation
6. Terry Hamilton, HIV Services
7. Irene Kaufmann, Office of Ambulatory Care Transformation, Chair
8. Walid Michelen, MD, Generations Plus/Northern Manhattan Network
9. Peter Peacock, MD, Kings County Hospital Center

LIST OF FIRMS RESPONDING:

1. AllScripts, Inc.
2. CareTeam Connect, Inc.
3. Consilience Software
4. Epic
5. GSI Health
6. Harris Corporation
7. IBM
8. Microsoft, Health Solutions Group
9. QuadraMed
10. Tailwinds Associates.

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Inger Dobson Slade, Associate Director
Office of Ambulatory Care Transformation

FROM: Manasses C. Williams 

DATE: May 3, 2012

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Microsoft Corporation, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): Corporate-wide

Contract Number: _____

Project: Software and Installation Services

Submitted by: Office of Ambulatory Care Transformation

EEO STATUS:

1. Approved
2. Approved with follow-up review and monitoring
3. Not approved
4. Subject to EEO Committee Review

COMMENTS:

MCW:srf

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Inger Dobson Slade, Associate Director
Office of Ambulatory Care Transformation

FROM: Manasses C. Williams

DATE: May 3, 2012

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, iNetXperts Corp., dba Get Real Consulting, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): Corporate-wide

Contract Number: _____

Project: Software and Installation Services

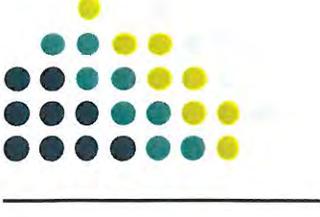
Submitted by: Office of Ambulatory Care Transformation

EEO STATUS:

1. Approved
2. Approved with follow-up review and monitoring
3. Not approved
4. Subject to EEO Committee Review

COMMENTS:

MCW:srf



Care Plan Information System

Ross Wilson MD, SVP & Chief Medical Officer,
Bert Robles, SVP & Chief Information Officer

HHC Board

May 24, 2012

Overview



- **Regulatory requirement and clinical need**
 - a person-centered web-based inter-operable care plan
 - supports care coordination services for HHC's Patient Centered Medical Home (PCMH) and Health Home (HH) patient populations
 - Is accessible to all members of the care team
 - documents, integrates, and tracks progress of patients' clinical and non-clinical health-care related needs, goals, and services (ranging from current medications and appointments to housing or entitlement needs)
- Electronic notification 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
- Can work effectively with a Personal Health Record and existing EHRs

Process

- RFP process through a selection committee
- Applications scored against:
 - ✓ Assessment Capability
 - ✓ Care Plan Capability
 - ✓ Alert Notification/Messaging Capability
 - ✓ Encounter Management
 - ✓ Enrollment Capability
 - ✓ Reporting
 - ✓ Technical System Architecture
 - ✓ Integration and Interface Capability
 - ✓ Understanding of Work; Soundness of Approach
 - ✓ Firm's Experience
 - ✓ Cost Proposal





Process II

- 50% of the submitted proposals that met the minimum criteria were invited to demonstrate their systems
- Short list of vendors:
 - CareTeam Connect, Inc.
 - GSI Health
 - Harris Corporation
 - IBM
 - Microsoft, Health Solutions Group
- Invited vendors were asked to demonstrate system for Care Coordination services for a diabetic patient with behavioral health conditions



Outcome

- Two vendors scored significantly higher, with Microsoft clearly highest
- The 7-year cost analysis for scaling up to 500,000 patients was similar for the two finalists
 - GSI: \$17.6 million
 - Microsoft: \$16.1 million
- Final selection was based on the system's functionality, implementation plan, embedded PHR solution, cost and fit with HHC's future EMR system
- Microsoft was the selected vendor

Timeline and Cost



- Estimated time to commence implementation:
 - planning and initial design: 2 months
 - care plan implementation: 3-9 months
- Estimated time to scale up to 500,000 patients: 5 years
- Total contract expenditure over 5 years: \$11.4 Million
- Expenditure in the first year would be:
 - \$3.6 Million Microsoft contract
 - \$300K HHC FTEs
- Two, one-year extensions would be available at the conclusion of 5 years at \$2.3 Million

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a license agreement with MetroHealth Homes Housing Development Fund Corporation (the "HDFC") for the early stages of construction of housing for low income elderly and/or disabled persons on the campus of Metropolitan Hospital Center (the "Facility") using funds advanced by the Corporation subject to reimbursement upon execution of a long term lease with the HDFC.

WHEREAS, the subject license agreement is proposed to permit construction of the building on the property to be licensed to begin before the licensed property can be subleased to the HDFC as nominee for Metro East 99 Street LLC (the "LLC" and in such capacities jointly the "Tenant") in the fall of 2012; and

WHEREAS, it is a priority of both the New York State Department of Health and of the Corporation to facilitate the discharge of residents in the Corporation's skilled nursing facilities to suitable housing if their medical needs can be best met in community based non-institutional settings; and

WHEREAS, there is an acute shortage of housing for low income elderly and/or disabled patients currently being treated in the Corporation's long term care facilities who no longer require skilled nursing care and could be discharged if suitable housing were available; and

WHEREAS, the Corporation leases its real estate properties from the City of New York under the 1970 Operating Agreement between the Corporation and the City of New York thereby making any further lease of such properties by the Corporation to a third party effectively a sublease; and

WHEREAS, under authority granted by separate resolution adopted in conjunction with this one, in or after September 2012 the Corporation will enter into a long term sublease with the Tenant for its development and operation of a building to house low income elderly and/or disabled residents of the Corporation's long term care facilities and whose medical needs can best be met in a community based and non-institutional setting; and

WHEREAS, the building to be constructed will initially receive its tenants from Coler-Goldwater Specialty Hospital and Nursing Facility ("C-G"); and

WHEREAS, to meet the Corporation's scheduled transfer of a portion of the operations of C-G to the North General Campus by the end of 2013, construction of the planned building must begin immediately to enable the discharge of the C-G patients appropriate for community based housing and long term care before such transfer and such construction cannot wait until the long term sublease goes into effect; and

**Page Two – Resolution
License Agreement – 99th Street Development**

WHEREAS, the construction of the proposed building will be financed through 4% tax credits, a mortgage loan made by the New York City Housing Development Corporation and a MRT mortgage loan of \$7.3 million made possible by an appropriation from the State of New York through the Department of Health; and

WHEREAS, the HDFC is willing and able to begin construction of the planned building immediately using funds advanced by the Corporation prior to Tenant having access to financing that will be available only after execution of the long term sublease; and

WHEREAS, it is expected that the preliminary stages of construction of the planned building that will take place between the beginning of June 2012 and the execution of the long term sublease in or after September 2012 will require funding of approximately \$2.8 million.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to execute a license agreement with MetroHealth Homes Housing Development Fund Corporation (the "HDFC") for the early stages of the construction of a building on the campus of Metropolitan Hospital Center (the "Facility") to house low income elderly and/or disabled individuals who are residents of the Corporation's skilled nursing facilities and who are appropriate for community based housing and long term care support.

The HDFC shall have use and occupancy of an approximately 20,000 square-foot parcel of land which currently is used as a parking lot on the northern side of 99th Street east of Second Avenue on the campus of Metropolitan Hospital Center. The HDFC shall initiate the first stages to construction of a ten story building having approximately 150,000 square feet containing approximately 176 units of housing. The units will be a mix of one bedroom and studio apartments with an apartment for a live-in superintendent. The building will house low income elderly and/or disabled individuals who had been residents of the Corporation's skilled nursing facilities whose needs are more appropriately addressed in home and community based settings.

The Corporation shall enter into a license with the HDFC for a term of not more than six months terminable by either party without cause on 27 days' notice and, in any event, upon the execution of a long term sublease by the Corporation and the Tenant for the sublease of the property. In recognition of the substantial benefit the project will bring to the Corporation and its patients, the HDFC shall not pay any occupancy fee to the Corporation. The license will commence immediately upon its execution which is projected for late early June 2012.

The Corporation will advance to the HDFC not more than \$2.8 million to pay for the early stages of the construction of the planned building. The budget for such early stages of construction is set forth as part of the Summary of Economic Terms attached to this Resolution. The early stages of construction shall consist of preparing the construction site by clearing it,

**Page Three – Resolution
License Agreement – 99th Street Development**

erecting fencing, performing indicated remediation of hazardous substances, driving piles to support the building and other early construction tasks.

The Corporation shall advance funding for the construction to the HDFC upon the Corporation's approval of invoices (which approval shall not be unreasonably withheld) describing in detail the work completed and the cost of such work by trade and professional. Such invoices shall be approved in a manner agreed upon by all of the Tenant's lenders, investors and regulators such that all such parties agree that upon execution of the long term sublease all advances by the Corporation shall be reimbursed. Such approvals shall not impose any liability on such parties but will indicate only that such work has been completed and would have been appropriate for funding in the normal course had the subleases and its financing already closed.

Upon the execution of the sublease, all amounts advanced by the Corporation to fund the construction shall be reimbursed to the Corporation by the HDFC, its investor or the bank extending construction financing to the project.

The HDFC shall indemnify the Corporation and the City of New York and shall provide adequate insurance against all liability arising from its use and occupancy of the property, naming the Corporation and the City of New York as additional insured parties.

SUMMARY OF ECONOMIC TERMS
EARLY CONSTRUCTION BUDGET

Construction Cost:	\$2,000,000.00
Contractor Price	
Owner's Cost	\$100,000.00
Contingency	\$100,000.00
<i>Subtotal</i>	<u>\$2,200,000.00</u>
Soft Cost:	
Borrower's Legal	\$110,000.00
Borrower's Engineer/Architect Fees	\$66,600.00
Bank's Engineer	\$6,500.00
Green Consultant	\$20,000.00
Owner's Rep (Construction Rep)	\$88,800.00
MTA Engineering Consultant ¹	\$64,000.00
RAP/remediation soft cost ²	\$96,000.00
Prevailing wage/MWBE Consultant ³	\$10,000.00
<i>Subtotal</i>	<u>\$461,900.00</u>
Carrying Costs:	
Insurance ⁴	\$150,000.00
Water and temporary power	\$3,500.00
<i>Subtotal</i>	<u>\$153,500.00</u>
<i>Total Cost</i>	<u>\$2,815,400.00</u>

¹ The project is within 100 feet of the 2nd Avenue Subway. Accordingly, the MTA requires that work be supervised by an MTA employee and the cost be billed to the developer on a daily basis.

² An environmental engineer must test material excavated when piles are driven and he/she approves the disposal of such material and supervises installation of a vapor barrier that will likely be required. The consultant reports to NYC Department of Housing Preservation and Development, NYC Department of Environmental Preservation and NYC Department of Environmental Conservation on these activities.

³ HPD HOME funds and the project-based Housing Assistance Program require certification of payment of prevailing wages of all construction trades and MWBE compliance. All payrolls must be certified.

⁴ General Commercial Liability Insurance and Builders' Risk insurance will be provided.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a sublease with MetroHealth Homes Housing Development Fund Corporation (the "HDFC") as nominee for Metro East 99 Street LLC (the "LLC" in such capacities being referred to together with the HDFC, as the "Tenant") for the development of housing for low income elderly and/or disabled persons on the campus of Metropolitan Hospital Center (the "Facility").

WHEREAS, it is a priority of both the New York State Department of Health and of the Corporation to facilitate the discharge of residents in the Corporation's skilled nursing facilities to suitable housing if their medical needs can be met in community based non-institutional settings; and

WHEREAS, there is an acute shortage of housing for low income elderly and/or disabled residents in the Corporation's skilled nursing facilities whose medical needs can best be met in community based, non-institutional settings and could be discharged if suitable housing were available; and

WHEREAS, the Tenant will develop and operate on the Facility's campus a building containing housing for low income elderly and/or disabled individuals who are residents in the Corporation's skilled nursing facilities and whose medical needs can best be met in community based, non-institutional settings, such development and operation to be subject to review and approval by the New York City Department of Housing Preservation and Development ("NYCHPD") and such other lenders, investors, or government agencies as may be required by the financing and structure of the project; and

WHEREAS, the Corporation leases its real estate properties from the City of New York under the 1970 Operating Agreement between the Corporation and the City of New York thereby making any further lease of such properties by the Corporation to a third party effectively a sublease; and

WHEREAS, a Public Hearing was held on May 9, 2012, in accordance with the requirements of the Corporation's Enabling Act, and prior to execution, the sublease will be subject to approval of the City Council and the Office of the Mayor.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to execute a sublease with MetroHealth Homes Housing Development Fund Corporation (the "HDFC") as nominee for Metro East 99 Street LLC (the "LLC" in such capacities being referred to together with the HDFC, as the "Tenant") for the development of housing on the campus of Metropolitan Hospital Center (the "Facility") for low

**Page Two – Resolution
Sublease Agreement – 99th Street Development**

income elderly and/or disabled individuals who are residents of the Corporation's skilled nursing facilities and whose medical needs can best be met in community based, non-institutional settings.

The Tenant shall have use and occupancy of an approximately 20,000 square-foot parcel of land which currently is used as a parking lot on the northern side of 99th Street east of Second Avenue on the campus of Metropolitan Hospital Center. The Tenant shall develop a ten story building having approximately 150,000 square feet containing approximately 176 units of housing. The units will be a mix of one bedroom and studio apartments with an apartment for a live-in superintendent. The building will house low income elderly and/or disabled individuals who had been residents of the Corporation's skilled nursing facilities and whose medical needs can best be met in community based, non-institutional settings.

The Corporation shall enter into a sublease with the Tenant for a term of ninety-nine (99) years. In recognition of the substantial benefit the project will bring to the Corporation and its patients, the Tenant shall prepay only a nominal rent to the Corporation. The sublease will commence immediately upon sublease execution which is projected for late September 2012.

The Tenant shall be responsible for all costs associated with the development and operation of its housing program. Pursuant to a license agreement between the HDPC and the Corporation to be authorized by separate resolution adopted in conjunction with this one, preliminary site preparation and foundation work will begin during June 2012 prior to sublease execution. Upon sublease execution such license shall terminate and the Tenant shall continue its construction under the sublease. All work will be in accordance with plans and specifications prepared by the Tenant, subject to approval by the Corporation, such approval not to be unreasonably withheld. Construction is anticipated to be concluded and the building ready for occupancy in December 2013.

The cost for all utilities provided to the building the Tenant will construct shall be the Tenant's responsibility provided that Tenant may pass the cost of utilities to the residents of the building. The Tenant shall also be responsible for all structural and nonstructural, interior and exterior maintenance of, and repairs to, the property.

The Tenant shall indemnify the Corporation and the City of New York and shall provide adequate insurance against all liability arising from its use and occupancy of the Demised Premises, naming the Corporation and the City of New York as additional insured parties.

EXECUTIVE SUMMARY

SUBLEASE AGREEMENT METROPOLITAN HOSPITAL CENTER METROHEALTH HOMES HOUSING DEVELOPMENT CORPORATION FOR THE BENEFIT OF METRO EAST 99 STREET LLC

OVERVIEW: The President seeks authorization from the Board of Directors to execute a sublease with MetroHealth Homes Housing Development Corporation (the "HDFC") for the benefit of Metro East 99 Street LLC (the "LLC" in such capacities being referred to together with the HDFC, as the "Tenant") for the development on the campus of Metropolitan Hospital Center of housing for low income elderly and/or disabled individuals who are residents of the Corporation's skilled nursing facilities and whose care can best be provided in community based, non-institutional settings.

**NEED/
PROGRAM:** It is a priority of both the New York State Department of Health and of the Corporation to facilitate the discharge of residents of skilled nursing facilities if their care can best be provided in community based and non-institutional settings. Many patients can be treated better in a residential setting where they can take charge of more aspects of their own lives and where they can be more fully integrated into the community. Medical, social work and behavioral health services can be brought to a resident, as appropriate, such that the resident continues to receive the services he or she requires despite having been discharged from a skilled nursing facility. Such care can be provided at substantially reduced cost compared with the cost of treatment in a skilled nursing facility. However, there is an acute shortage of housing for low income elderly and/or disabled residents. The construction of the project will directly address the need for such housing. The location of the project directly across from Metropolitan Hospital Center will facilitate the provision of appropriate services for the residents by Metropolitan Hospital staff.

TENANT: The principals of the managing member of the LLC are principals of SKA Marin. SKA Marin is an experienced developer of low income housing for seniors and disabled tenants. SKA Marin was the principal in the successful development of the Kings County Senior Housing development on the Kings County Hospital Center campus pursuant to a sublease with the Corporation approximately seven years ago.

The project will be financed with 4% low income tax credits, a loan made by the Housing Development Corporation in conjunction with the New York City Department of Housing Preservation and Development ("NYCHPD"), MRT financing and other private financing. Ongoing rents will be paid through project-based Section 8 vouchers issued by the New York City Housing Authority.

Page Two – Executive Summary
Sublease Agreement – 99th Street Development

Because of the HPD loan requirements, the lease will be made in the name of the HDFC but the LLC will have all of the rights of the Tenant to enforce the lease terms, to perform the Tenant's obligations and to be recognized as the "beneficial tenant." The LLC will be responsible for the performance of the Tenant's obligations.

TERMS:

The Corporation will enter into a sublease with the Tenant with a term of ninety-nine (99) years. The term of the sublease shall commence upon sublease execution. In recognition of the substantial benefit the project will bring to the Corporation and its patients, the Tenant shall prepay only a nominal rent to the Corporation.

The Tenant will be responsible for all costs associated with the development and operation of its housing program. The HDFC will begin construction pursuant to a license agreement to be issued in June 2012 pursuant to separate resolution adopted in conjunction with this one and that will terminate upon commencement of the sublease. Upon sublease execution construction shall continue on the project under the sublease. All plans and specifications of the project shall be subject to the prior approval of the Corporation which approval shall not be unreasonably withheld.

The cost for all utilities provided to the Demised Premises will be the responsibility of the Tenant provided Tenant may pass the cost of utilities to the building residents. The Tenant will also be responsible for all structural and nonstructural interior and exterior, maintenance of, and repairs to, the property.

The Tenant will indemnify the Corporation and the City of New York and will provide adequate insurance against all liability arising from its use and occupancy of the property, naming the Corporation and the City of New York as additional insured parties.

SUMMARY OF ECONOMIC TERMS

East 99th Street Apartments
 NY, NY
 176

3/26/2012

Units

SOURCES AND USES

SOURCES

	Total	Per Unit
Construction		
Construction Bond Amount ¹	\$29,200,000	\$165,909 ²
NYS MRT Second Mortgage	\$7,300,000	\$41,477
HPD Third Mortgage	\$7,000,000	\$39,773
4% Tax Credit Equity	\$1,759,812	\$9,999
NYSERDA	\$0	\$0
Developer Fee ³	\$6,549,664	\$37,214
TOTAL SOURCES⁴	\$51,809,476	\$294,372
Permanent	Total	Per Unit
HDC First Mortgage	\$15,157,306	\$86,121
NYS MRT Second Mortgage	\$7,300,000	\$41,477
HPD Third Mortgage	\$7,000,000	\$39,773
4% Tax Credit Equity	\$20,537,861	\$116,692
NYSERDA	\$0	\$0
Deferred Developer's Fee	\$1,814,309	\$10,309
Gap	\$0	\$0
TOTAL SOURCES	\$51,809,476	\$294,372

USES

Total	Per Unit
Acquisition Cost	\$0
Construction Cost	\$34,453,245
Soft Cost ⁵	\$10,806,567
Developer's Fee	\$6,549,664
TOTAL USES⁶	\$51,809,476

¹ Costs during construction reflect actual project needs as well as IRS requirements that bond proceeds be at least 50% of the total project development costs. At construction, short term and long term bonds are issued. Once construction is completed, permanent financing is put in place with the amount of initial debt being reduced by the equity raised by the sale of the 4% low income housing tax credits.

² The cost per unit compares favorably to new construction undertaken under prevailing wage requirements. There is some additional cost due to the use of piles to support the project. Piles are used to avoid the need to construct a foundation and this choice is made to avoid complications of possible ground water and additional costly remediation and disposal of hazardous material. The exact additional cost attributable to the use of piles is not yet established as geotechnical testing is not yet completed.

³ Of the full fee of \$6.5 million only about \$900K is paid on sublease signature. Of the rest, some is paid when the building fully occupied and some is deferred over 12 years with the exact amounts paid and deferred depending on the finances of the project. The above illustrates how this might work out with about \$900K paid on sublease signature, about \$3.8 million when tenants move in and about \$1.8 million deferred for 18 yrs.

⁴ Credit enhancement is provided by Citibank during construction. The State of New York Mortgage Agency (SONY-MA) provides permanent mortgage insurance when construction is completed.

⁵ Soft costs include \$500K to furnish all apartments as the residents lack funds to do so; \$300K to satisfy DOB engineering requirements; construction interest; negative arbitrage; fees to HDC; insurance, legal services; capitalized operating and replacement reserve requirements; etc.

⁶ Note that it is not yet settled which funder will be the source of the reimbursement of the \$2.8 million advanced by HHC. This will be negotiated and reflected in an appropriate agreement. Because the HHC funds will be used for construction, reimbursement could be made by HPD or HDC funds.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with the New York City Police Department ("NYPD" or "Licensee") for use and occupancy of space to operate radio communications equipment at Elmhurst Hospital Center (the "Facility").

WHEREAS, the NYPD desires to install radio communications equipment at the Facility to enhance the performance of its city-wide radio operations network, and the Facility has the space to accommodate the NYPD communications system; and

WHEREAS, the Licensee's radio communications system shall not compromise Facility operations, and it complies with applicable federal statutes governing the emission of radio frequency signals and, therefore, poses no health risk.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with the New York City Police Department ("NYPD" or "Licensee") for use and occupancy of space to operate radio communications equipment at Elmhurst Hospital Center (the "Facility").

The Licensee shall be granted use and occupancy of approximately fifty (50) square feet of space on the roof of the Main Building on the Facility's campus (the "Licensed Space"). The space shall be used by the Licensee for radio communications equipment. Public safety is enhanced by the system's operation, therefore the occupancy fee shall be waived. The Facility shall provide electricity to the Licensed Space. The operation and maintenance of the system shall be the responsibility of the Licensee.

The Licensee shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of its use of the Licensed Space.

The license agreement shall not exceed five (5) years without further authorization by the Board of Directors of the Corporation and shall be revocable by either party upon ninety (90) days written notice.

EXECUTIVE SUMMARY

LICENSE AGREEMENT NEW YORK CITY POLICE DEPARTMENT ELMHURST HOSPITAL CENTER

The President of the New York City Health and Hospitals Corporation seeks authorization to execute a revocable license agreement with the New York City Police Department ("NYPD") for use and occupancy of space to operate radio communications equipment at Elmhurst Hospital Center ("EHC").

The New York City Police Department desires to install radio communications equipment at the Facility to enhance the performance of its city-wide radio operations network. The Licensee's radio communications system will not compromise Facility operations, and it complies with applicable federal statutes governing the emission of radio frequency signals and, therefore, poses no health risk.

The NYPD will have use and occupancy of approximately fifty (50) square feet of space on the roof of the Main Building. Public safety is enhanced by the system's operation, therefore the occupancy fee will be waived. Elmhurst Hospital Center will provide electricity to the licensed space. The operation and maintenance of the system will be the responsibility of the NYPD.

The Licensee shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of its use of the Licensed Space.

The license agreement shall not exceed five (5) years without further authorization by the Board of Directors of the Corporation and shall be revocable by either party upon ninety (90) days written notice.

ANTENNA AGREEMENTS

Facility	Licensee	Occupancy Fee (\$)	Price/Square Foot (\$)	Board Approval
Elmhurst	NYPD	waived	n/a	TBD
Harlem	Con Edison	27,007	540	TBD
Coler	T-Mobile	52,840	264	2/2012
Goldwater	T-Mobile	50,087	254	2/2012
Goldwater	Sprint-Nextel	54,170	339	TBD
Lincoln	Sprint-Spectrum	80,812	269	9/2011
Coler	Sprint-Nextel	31,200	125	6/2011
Sea View	U.S. Government	7,939	52	7/2010
NCB	NYPD	waived	n/a	10/2009
Coler-Goldwater	Metro PCS	90,360	226	6/2009
Harlem	Con Edison	23,996	480	3/2007
Coney Island	U.S. Government	6,919	46	7/2007

Explanation of Charges:

Government entities typically pay lower occupancy fees for the space their antenna equipment occupies. The fees paid by private firms are heavily influenced by the degree to which the equipment will enhance system coverage in the area. Carriers are willing to pay a higher rate for those antenna sites where the installation significantly improves signal coverage.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a contract with the New York Power Authority ("NYPA") for an amount not-to-exceed \$7,000,000 for the planning, pre-construction, design services, construction, procurement, construction management and project management services necessary to replace the existing boiler plant at Coney Island Hospital (the "Facility").

WHEREAS, in March 2005, the Corporation, the City University of New York (CUNY), the New York City Board of Education, and the City of New York, through the Department of Citywide Administrative Services (DCAS), executed an agreement with NYPA (the "Encore Agreement"), pursuant to which NYPA would enter into separate and specific sub-contracts with each Customer to implement comprehensive energy efficiency programs whose primary purpose would advance the cost-effective retrofitting or replacement of said Customer's existing heating and cooling technology through energy efficient measures relating to their usage of electricity and non-electric energy consumption; and

WHEREAS, the existing boiler plant has been in service since 1936, and consists of two (2) 256 Boiler Horse Power ("BHP") high-pressure, water-tube steam boilers, and one (1) 510 BHP high-pressure, water-tube steam boiler manufactured in 1954 and are increasingly difficult to maintain and operate effectively; and

WHEREAS, said boilers burn No. 6 grade fuel oil that will no longer be permitted for combustion on or before 2015 due to state and local legislation banning its continued use; and

WHEREAS, adoption of the Mayor's "PlaNYC" initiative to the boilers must be significantly renovated or replace by 2015; and

WHEREAS, NYPA conservatively estimates that said boiler replacements will produce total annual energy cost savings of over \$1,200,000 and will reduce carbon emissions by approximately 11,100 tons, effectively eliminating the carbon equivalent emission of about 1,830 cars from operation; and

WHEREAS, the need to replace the existing boiler plant is funded through the Corporation's debt capacity and is recognized as requiring replacement as part of its Capital Plan.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and is hereby authorized to execute an agreement with the New York Power Authority ("NYPA") in an amount not-to-exceed \$7,000,000 to include all phases of work, inclusive of the planning, pre-construction, design services, construction, procurement, construction management and project management services necessary to replace the two (2) existing boiler units at Coney Island Hospital (the "Facility").

EXECUTIVE SUMMARY

CONEY ISLAND HOSPITAL NEW YORK POWER AUTHORITY (NYPA) BOILER PLANT REPLACEMENT

OVERVIEW: Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a contract with the New York Power Authority ("NYPA") for an amount not-to-exceed \$7,000,000. It includes the comprehensive planning, pre-construction, design services, construction, procurement, construction management and project management services necessary to replace the existing boiler plant at Coney Island Hospital (the "Facility"). This is a comprehensive, 'turnkey' project.

NEED: The existing boiler units currently provide service by burning heavier grade, number 6 fuel oil. The units have been in service for an extended period, and are operating inefficiently. Recent changes in environmental regulations will ban their combustion of No. 6 grade fuel oil by 2014/2015. Although recent changes to the environmental law permits a significant conversion extension from No. 6 to No. 2 grade fuel oil and/or natural gas to 2030, through retrofitting units to accept No. 4 fuel oil, the age and condition of the units make such an option impractical.

One unit has been in operation since 1936, and consists of two (2) 256 Boiler Horse Power (BHP) high-pressure, water-tube steam boilers, and one (1) 510 BHP high-pressure, water-tube steam boiler, manufactured in 1954. In addition to complying with recently enacted legislation regarding the combustion of No. 6 fuel oil, these replacements will increase efficiency and reliability, and will reduce energy costs and pollutants. The new units will permit, for the first time, the flexibility to operate on natural gas and No. 2 fuel oil. The facility will operate on a Firm Natural gas rate, which will optimize savings, and No. 2 fuel oil tanks will serve as service backups incase of emergency or service interruption. Together with two (2) other boiler replacement projects currently nearing design completion, this project was reviewed in a Value Engineering study conducted with the Mayor's Office of Management and Budget (OMB).

Finally, completion of this project satisfies recommendations advanced by OMB through its Assets Information Management System (AIMS) report.

SCOPE: Replacement of three (3) existing high pressure boilers with three (3) high pressure boilers, including but not limited to

- Replacement of existing de-aerator;
- Installation of new natural gas service;
- Conversion of existing No. 6 fuel oil tanks to No. 2 fuel oil tanks;
- Tie-in boiler controls to existing Building Management System (BMS) server; and,
- Replacement of existing steam traps in poor condition and a significant source of heat energy loss.

COSTS: Not-to-exceed \$7,000,000

FINANCING: HHC 2010 Series Bonds.

SCHEDULE: HHC expects NYPA to complete this project by February 2013.

RESOLUTION

Approving amendment of the Bylaws of MetroPlus Health Plan, Inc. to facilitate establishment of a Managed Long Term Care Plan and to better enable MetroPlus to conduct its business

WHEREAS, a resolution approved by the Board of Directors of the New York City Health and Hospitals Corporation (“HHC”) on October 29, 1998, authorized the conversion of MetroPlus Health Plan (“MetroPlus”) from an operating division to a wholly owned subsidiary of HHC; and

WHEREAS, MetroPlus has submitted an application to the Department of Health of the State of New York (“SDOH”) to establish a Managed Long Term Care Plan and;

WHEREAS, in reviewing that application, SDOH has identified a change necessary to the Bylaws of MetroPlus to require that the MetroPlus Board of Directors meet at least four times annually, once in each quarter, and;

WHEREAS, the Certificate of Incorporation of MetroPlus reserves to HHC the sole power with respect to amending the Bylaws of MetroPlus; and

WHEREAS, the Board of Directors of MetroPlus has approved a resolution recommending that the Board of Directors of HHC amend the Bylaws of MetroPlus to facilitate the establishment of a Managed Long Term Care Plan and to better enable MetroPlus to conduct its business;

NOW THEREFORE, be it

RESOLVED that Subsection (B) of Section 3 of Article V of the Bylaws of MetroPlus is amended to read as follows:

“(B) Regular Meetings. Regular meetings of the Board of Directors shall be held on a schedule determined annually by the Board of Directors. The Board of Directors shall assemble to conduct the business of the Corporation at least four times annually, once in each quarter, and shall for each such assembly provide prior notice to and shall include in each such assembly each enrollee or consumer representative and/or enrollee advisory council member elected or appointed to represent the Corporation’s enrollees.”

Executive Summary

In an effort to curb the approximate 13.6 billion dollar annual cost for long term care services, the New York State Department of Health (SDOH) is mandating enrollment into Managed Long Term Care (MLTC) plans as of July 1, 2012 for persons 21 and older in need of 120 days or more of service. An MLTC coordinates coverage with a patient's primary medical insurance. The MLTC will cover nursing home care, home care, personal care, meals and other ancillary services. The goal will be to keep members stable at home to avoid unnecessary nursing home stays.

MetroPlus has submitted an application to SDOH to establish and operate a MLTC. In reviewing the application, SDOH identified certain changes necessary to MetroPlus's Certificate of Incorporation and Bylaws. Specifically, the Certificate of Incorporation needs an expanded definition of the purposes and powers of MetroPlus to include the operation of an MLTC. The Bylaws need to articulate the requirement that the MetroPlus Board of Directors meet at least four times annually, once in each quarter (which has, in fact, been the practice of MetroPlus).

In addition, two other changes to the Certificate of Incorporation are appropriate at this time. One is simply to change the address of MetroPlus to its current location at Water Street. The other change concerns contracting authority. The current Certificate of Incorporation reserves to HHC the power to authorize MetroPlus to enter into contracts (other than with HHC or other health care service providers) when the annual value is in excess of one million dollars. To better enable MetroPlus to conduct its business and to be consistent with the new procurement guidelines issued by the HHC Board for HHC's procurement, MetroPlus seeks to raise the threshold of HHC's reservation of contracting from one million dollars to three million dollars.

BYLAWS

OF

METROPLUS HEALTH PLAN, INC.

DRAFT

AS AMENDED THROUGH **MAY 24, 2012**

[Proposed Change: Pg. 6 - § 3\(B\)](#)

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ARTICLE I

PREAMBLE

MetroPlus Health Plan, Inc. is a public benefit corporation created pursuant to Chapter 35, NYS Consolidated Laws and the New York City Health and Hospitals Corporation Act (L. 1969 C. 1016).

In order to provide for the orderly operation of the Corporation, the Member of the Corporation adopts the following By-Laws:

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ARTICLE II

NAME AND PLACE OF BUSINESS

Section 1. Name.

The name of the corporation is MetroPlus Health Plan, Inc. (the “Corporation” or “MetroPlus Health Plan”).

Section 2. Location.

The principal place of business of the Corporation shall be in the City of New York, County of New York, and the State of New York. The Corporation may have offices and places of business at such other places within the State of New York and shall be determined by the Member.

ARTICLE III

STATEMENT OF PURPOSES

The purposes of the Corporation include:

- (A) To provide and deliver high quality, dignified and comprehensive health care and treatment to individuals who are members of the MetroPlus Health Plan;
- (B) To extend equally to all those served, health services of a high quality, in an atmosphere of human care and respect;
- (C) To focus on the need for preventive primary care health services;
- (D) To operate in a manner consistent with the goals and objectives of the New York City Health and Hospitals Corporation and its mission to serve the people of New York City.

ARTICLE IV

MEMBERSHIP

The sole member of the Corporation shall be New York City Health and Hospitals Corporation (the “Member”).

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ARTICLE V

BOARD OF DIRECTORS

Section 1. General Powers.

The property, business and affairs of the Corporation shall be managed by the Board of Directors. In the management and control of the property, business, and affairs of the Corporation, the Board of Directors may exercise all of the powers of the Corporation except such as may be otherwise reserved by the law or these By-Laws or the Corporation's Certificate of Incorporation.

Section 2. Number and Qualifications of Directors.

- (A) Number. The number of members of the Board of Directors shall be nine (9) directors, including the two (2) *ex officio* members described below.
- (B) Qualifications. All members of the Board of Directors of the Corporation shall be at least twenty-one (21) years of age and at all times shall include: (a) three (3) directors selected by the Chairperson of the Board of Directors of the Health and Hospitals Corporation, one of whom shall serve as Chairperson of the Corporation's Board of Directors, subject to election by the Board of Directors of the Health and Hospitals Corporation; (b) one (1) director who is a member of the MetroPlus "mainstream" Health Plan and one (1) director who is a member of the MetroPlus "HIV SNP" Health Plan, each nominated by the Executive Director of the Corporation and elected by the Board of Directors of the Health and Hospitals Corporation; and (c) two (2) directors selected by the President of the Health and Hospitals Corporation from nominations forwarded to the President of the Health and Hospitals Corporation by the Senior Vice Presidents of the Networks of the Health and Hospitals Corporation and elected by the Board of Directors of the Health and Hospitals Corporation. The President of the Health and Hospitals Corporation or his or her designee, and the Executive Director of the Corporation, or their successors, shall be directors *ex officio*. Directors shall perform their Board responsibilities in person only and cannot perform such responsibilities by proxy or by

agent, except as otherwise provided in these By-Laws.

- (C) Term of Office. The directors of the Corporation, other than the directors who serve *ex officio*, shall be elected by resolution of the Board of Directors of the Health and Hospitals Corporation in accordance with Section 2(B) above and shall serve for staggered terms of five (5) years, subject to earlier removal as provided herein. Notwithstanding the foregoing, the term of the initial directors, other than the directors serving *ex officio*, shall be as reflected in Attachment A to these By-Laws. Directors will continue to serve until a replacement has been appointed.
- (D) Removal. Any Director of the Corporation selected by the President of the Health and Hospitals Corporation may be removed by the President of the Health and Hospitals Corporation, subject to the approval of the Board of Directors of the Health and Hospitals Corporation or the prior delegation of such authority by the Board of Directors of the Health and Hospitals Corporation. The Health and Hospitals Corporation Board of Directors may vote to remove a director for any reason.

Section 3. Meetings.

- (A) Annual Public Meeting. The Board of Directors shall hold an annual public meeting at such date, place and hour as shall be designated in the notice to the public of the annual public meeting. Such meeting serves as the annual meeting of the Board of Directors mandated by law. Such notice shall be given not later than thirty (30) days before the meeting.
- (B) Regular Meetings. Regular meetings of the Board of Directors shall be held on a schedule determined annually by the Board of Directors. The Board of Directors shall assemble to conduct the business of the Corporation at least four times annually, once in each quarter, and shall for each such assembly provide prior notice to and shall include in each such assembly each enrollee or consumer representative and/or enrollee advisory council member elected or appointed to represent the Corporation's enrollees.
- (C) Special Meetings. Special Meetings of the Board of Directors shall be held whenever

called by the Chairperson of the Board of Directors, the Executive Director or by four (4) directors. Any and all business may be transacted at a special meeting which may be transacted at a regular meeting of the Board of Directors.

- (D) Time and Place of Meeting. The Board of Directors may hold its meetings at such time or times and such place or places within or without the State of New York as the Board of Directors may, from time to time, by resolution determine or as shall be designated in the respect notices or waivers of notice thereof.
- (E) Notice of Meetings. Notices, beyond those required by law, of regular meetings of the Board or of any adjourned meeting need not be given. Notices of special meetings of the Board of Directors, or of any meeting of any committee of the Board of Directors, except the Executive Committee, which shall meet when deemed necessary, shall be mailed by the Secretary to each director or member of such committee, addressed to him or her at his or her residence or usual place of business, at least three (3) days before the day on which such meeting is to be held, or shall be sent by telegraph, facsimile, cable or other form of recorded communications or be delivered personally or by telephone not later than the day before the date on which such meeting is to be held. Such notice shall include the time and place of such meeting. Notice of any such meeting need not be given to any director or member of the committee, however, if waived by the director in writing or by telegraph, facsimile, cable or other form of recorded communications, whether before or after such meeting shall be held, or if he or she shall be present at such meeting and shall not protest the lack of notice to him or her prior thereto or at its commencement.
- (F) Quorum and Manner or Acting. A majority of the whole number of directors shall be present in person at any meeting of the Board of Directors in order to constitute a quorum for the transaction of business at any such meeting, and the vote of a majority of those directors present at any such meeting at which a quorum is present shall be necessary for the passage of any resolution or act of the Board of Directors, except as

otherwise expressly required by these By-Laws. In the absence of quorum for any such meeting, a majority of the directors present thereat may adjourn such meeting, from time to time, until quorum shall be present.

(G) Rules. Robert's Rules of Order shall prevail at all meetings of the Board of Directors except as otherwise herein provided.

(H) Order of Business. The order of business of each meeting of the Board of Directors shall be as follows:

1. Acceptance of the minutes of the last Regular meeting and all Special meetings;
2. Chairperson's Report;
3. Executive Director's Report;
4. Old and New Business;
5. Committee Reports;
6. Adjournment.

However, it shall be within the discretion of the person acting as chair of the meeting to deviate from the order of business herein provided.

(I) Organization. At each meeting of the Board of Directors, one of the following shall act as Chairperson of the meeting and preside thereat, in the following order of precedence: (a) the Chairperson of the Board of Directors; (b) the Vice-Chairperson of the Board of Directors; (c) the Executive Director; or (d) any director chosen by a majority of the directors present thereat. The Secretary or, in his or her absence, any person whom the Chairperson shall appoint shall act as Secretary of such meeting and shall keep the minutes thereof.

(J) Minutes of Meetings. Minutes of all meetings of the Board of Directors and its committees, including a record of attendance, must be kept. Upon approval, such minutes shall be signed by the Secretary and permanently filed and maintained in the principal office of the Corporation.

- (K) Action Without a Meeting. Any action required or permitted to be taken by the Board of Directors or any committee thereof may be taken without a meeting if all members of the Board of Directors or such committee consent in writing to the adoption of a resolution authorizing the action.
- (L) Video Conference. Any one or more members of the Board of Directors or any committee thereof may participate in a meeting of such Board or committee by means of a video conference or similar communications equipment allowing all persons participating in the meeting to hear and see each other at the same time. Participation by such means shall constitute presence in person at a meeting.

Section 4. Resignation

Any director, other than a director holding office *ex officio*, may resign at any time by giving written notice of resignation, including an effective date thereof, to the Chairperson of the Board of Directors. Any such resignation shall take effect at the time specified therein. If no effective date is specified therein, the resignation shall take effect thirty (30) days from the date of receipt of such notification by the Chairperson of the Board of Directors. Directors representing MetroPlus Health Plan members shall resign within thirty (30) days of their termination of MetroPlus Health Plan membership, whether such termination shall be voluntary or involuntary. A director holding office *ex officio* may only resign as a director upon termination or resignation of their employment by the Corporation.

Section 5. Vacancies and Removal.

All directors appointed to fill vacancies on the Board of Directors shall be nominated and appointed by the same process described in Section 2(D) as the director to be replaced. Whenever a director resigns or is removed, except for directors serving *ex officio*, the director shall be replaced by the Health and Hospitals Corporation by a director nominated and confirmed in the same manner as applied to the initial appointment of the departing director.

A director appointed to fill a vacancy shall be appointed for the unexpired portion of the term of his or her predecessor in office.

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ARTICLE VI

OFFICERS OF THE BOARD OF DIRECTORS

Section 1. Titles.

The officers of the Board of Directors shall be a Chairperson of the Board of Directors and a Vice-Chairperson of the Board of Directors. The Chairperson of the Board of Directors shall be nominated by the Chairperson of the Board of Directors of the Health and Hospitals Corporation and confirmed in the manner described in these By-Laws. The Vice-Chairperson shall be chosen by the Board of Directors from among themselves.

Section 2. Duties and Functions.

- (A) Chairperson. The Chairperson of the Board of Directors shall: (1) preside at meetings of the Board of Directors; (2) be an *ex officio* member of all committees; (3) appoint committees with the approval of the Board of Directors; and (4) perform such duties as from time to time may be assigned by the Board of Directors.
- (B) Vice-Chairperson. The Vice-Chairperson of the Board of Directors shall, if the Chairperson of the Board of Directors shall be absent or shall be unable to act, preside at all meetings of the Board of Directors. The Vice-Chairperson of the Board of Directors shall perform such duties as from time to time may be assigned by the Board of Directors.
- (C) Other Presiding Officers. In the event that both the Chairperson and the Vice-Chairperson of the Board of Directors may be absent, or in any other way may be unable to serve, then the Executive Director shall serve as Presiding Officer. If he or she is absent or is otherwise unable to serve, the Board shall, by majority vote of those present, pick a member to be Presiding Officer at that meeting.

ARTICLE VII
COMMITTEES

Section 1. General Provisions.

- (A) **Standing and Special Committees.** Committees of the Board shall be standing or special. A standing committee is one whose functions are determined by a continuous need. The function and duration of a special committee shall be determined by its specific assignment, as stated in a resolution of the Board of Directors creating it.
- (B) **Composition.** Each of the standing committees shall be composed of the Chairperson of the Board of Directors, the Executive Director, and at least one (1) member of the Board of Directors appointed in the manner hereinafter specified.
- (C) **Appointment.** The Chairperson of the Board of Directors shall annually appoint, with the approval of a majority of the Board of Directors, members of the Board of Directors to the standing committees.
- (D) **Committees Chairperson.** The Chairperson of each committee, both standing and special, shall be designated by a majority vote of the Board of Directors.
- (E) **Meetings.** Each standing committee shall meet as deemed necessary.
- (F) **Quorum.** A quorum, which shall be at least more than one-half of all the members of a committee, standing or special, shall be required for a committee to transact any business unless otherwise stated in these By-Laws.
- (G) **Committee Action.** All actions of a committee, standing or special, shall be taken by a majority vote of the members in attendance at a committee meeting.
- (H) **Board Committee Reports.** Each committee shall report to the Board of Directors, at its regular meetings, on all business transacted by it since the last regular Board of Directors meeting.
- (I) **Staff Committee Reports.** The Board of Directors shall establish a timetable for review and approval of key plan functions, including, but not limited to, financial reports and quality assurance reports. The schedule and types of reports required shall be sufficient

for the Board of Directors to accurately monitor the Corporation's financial and operational performance.

- (J) Special Committees. The Board of Directors may, by resolution passed by a majority of the whole number of directors, designate special committees, each committee to consist of two (2) or more directors, one of whom shall be the Chairperson of the Board of Directors, and each such committee shall have the duties and the functions as shall be provided in such resolution.

Section 2. Standing Committees.

The following committees shall be designated as standing committees:

Executive Committee

Finance Committee

Quality Assurance Committee

Audit & Compliance Committee

Section 3. Executive Committee.

- (A) Designation and Membership. The Executive Committee shall be composed of the Chairperson of the Board, who shall be the Chairperson of the Executive Committee; the Executive Director; and three (3) other members appointed by the Chairperson of the Board of Directors with the approval of the Board.
- (B) Functions and Powers. The Executive Committee, subject to any limitations prescribed by the Board of Directors, shall possess and may exercise during the intervals between meetings of the Board of Directors, the powers of the Board of Directors in the management of the business and affairs of the Corporation except for the power to fill vacancies in any committee of the Board of Directors. At each meeting of the Board of Directors, the Executive Committee shall make a report of all actions taken by it since its last report to the Board of Directors.
- (C) Meetings and Quorum. The Executive Committee shall meet as often as deemed necessary and expedient at such times and places as shall be determined by the Executive

Committee. Three (3) members of the Executive Committee shall constitute a quorum. The Chairperson of the Board of Directors shall preside at meetings of the Executive Committee and, in his or her absence, the Executive Director shall preside thereat. All members of the Board of Directors shall be duly notified prior to all Executive Committee meetings.

Section 4. Finance Committee.

The Finance Committee shall consist of members designated by the Board of Directors. The Senior Vice President for Finance and Revenue Management of the Health and Hospitals Corporation, or his or her designee, shall serve as an *ex officio* member of the Finance Committee. The duties and responsibilities of the Finance Committee shall be to act on behalf of the Board of Directors for purposes of monitoring the finances of the Corporation, including, without limitation, overseeing preparation of the budget of the Corporation, reviewing periodic financial statements of the Corporation, and monitoring the Corporation's financial performance.

Section 5. Quality Assurance Committee.

The Quality Assurance Committee shall consist of individuals nominated by the Executive Director and appointed by the Board of Directors. The Quality Assurance Committee shall act on behalf of the Board of Directors for purposes of discharging the governing body's obligations to oversee the quality assurance process for the Corporation. The Board of Directors shall, at least annually, assess the performance of the Quality Assurance Committee in fulfilling the governing body's quality assurance responsibilities. Any member of the Board of Directors may attend meetings of the Quality Assurance Committee and may refer any quality assurance issue for deliberation or for actions by the Quality Assurance Committee. Members of the Board of Directors may also discuss quality assurance issues or problems concerning the Corporation at any meeting of the Board of Directors.

The duties and responsibilities of the Quality Assurance Committee shall include the following:

- (A) Assuring that the Corporation is fulfilling mandates in the areas of quality assurance,

credentialing of physicians and dentists, overall operations and responsiveness to Federal, State and other regulatory surveillance and enforcement activities. This shall include oversight of efforts to review services in order to improve the quality of medical and dental care of members; and to insure that information gathered pursuant to the programs is utilized to review and to revise policies and procedures;

- (B) Assuring that there is a systematic and effective mechanism for communication among members of the Board of Directors in their role as members of the governing body, and the administration and medical staff serving the Corporation. This communication should facilitate direct participation by the governing body in quality assurance activities and other issues of importance as set forth above;
- (C) Monitoring the progress of contracted facilities; including the provision of services by individual providers, and at the Corporation towards meeting appropriate Corporation goals and objectives related to its health care programs; and
- (D) Reviewing quality assurance activities of the Corporation on at least a quarterly basis.

Section 6. Audit and Compliance Committee.

The Audit and Compliance Committee shall consist of independent members designated by the Board. The duties and responsibilities of the Audit and Compliance Committee shall be to:

- A) oversee the Corporation's financial reporting and compliance activities;
- B) monitor the effectiveness of internal controls and corporate compliance activities;
- C) review internal and external audit findings and recommendations;
- D) pre-approve all audit and permissible non-audit services;
- E) approve selection, retention or termination of independent auditors;
- F) monitor risk exposures and ensure adequate disclosure;
- G) oversee of compliance with laws and regulations;
- H) periodically meet with the Corporation's internal auditor and Compliance Officer;
- I) Conduct a bi-annual self-assessment to evaluate overall performance of the Committee.

ARTICLE VIII

OFFICERS OF THE CORPORATION

Section 1. Titles.

The officers of the Corporation shall be the Executive Director (and Chief Executive Officer), the Chief Financial Officer, the Chief Medical Officer, and a Secretary. The General Counsel of the Health and Hospitals Corporation shall act as general counsel to the Corporation.

Section 2. Appointment.

The Executive Director (and Chief Executive Officer) shall be chosen by the Board of Directors from persons other than themselves and shall serve at the pleasure of the Board of Directors. The Executive Director shall appoint all other officers of the Corporation. All such other officers are subject to removal by the Executive Director.

Section 3. Resignation.

Any officer may resign at any time by giving written notice of resignation, which may include an effective date therefor, to the Executive Director. Such resignation shall take effect when accepted by the Executive Director.

Section 4. Duties and Functions.

- (A) **Executive Director.** The Executive Director shall have general charge of the business and affairs of the Corporation and shall have the direction of all other officers, agents and employees. He or she shall, in the absence of the Chairperson of the Board of Directors and the Vice-Chairperson of the Board of Directors, preside at all meetings of the Board of Directors. The Executive Director may assign such duties to the other officers of the Corporation as he or she deems appropriate.
- (B) **Corporate Management.** The Executive Director may appoint a Chief Financial Officer, and a Medical Director. These individuals shall have such powers and duties as shall be prescribed by the Executive Director subject to approval by the Board of Directors.
- (C) **Secretary.** The Secretary shall keep the records of all meetings of the Board of Directors and the Executive Committee. He or she shall affix the seal of the Corporation to all

deeds, contracts, bonds or other instruments requiring the Corporate seal when the same shall have been signed on behalf of the Corporation by a duly authorized officer. The Secretary shall be the custodian of all contracts, deeds, documents and all other corporate records (except accounting records)

Section 5. Compensation of Officers.

Officers who are full-time employees of the Corporation shall receive reasonable compensation for their services, the compensation of the Executive Director to be determined by the President of HHC and the compensation of all other officers to be determined by the Executive Director.

ARTICLE IX
CONTRACTS, CHECKS, DRAFTS,
BANK ACCOUNTS, ETC.

Section 1. Execution of Documents.

The Board of Directors shall designate the officers, employees and agents of the Corporation who shall have the power to execute and deliver deeds, contracts, mortgages, bonds, indentures, checks, drafts and other orders for the payment of money and other documents for and in the name of the Corporation and may authorize such officers, employees and agents to delegate such power (including authority to redelegate) by written instrument to other officers, employees, or agents of the Corporation.

Section 2. Deposits.

All funds of the Corporation not otherwise employed shall be deposited from time to time to the credit of the Corporation or otherwise in such banks or trust companies organized in New York or national banks doing business in New York City as the Board of Directors shall determine.

ARTICLE X

BOOKS AND RECORDS

The books and records of the Corporation may be kept at such places within the State of New York as the Board of Directors may from time to time determine.

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ARTICLE XI

SEAL

The Board of Directors shall provide a corporate seal, which shall be in the form of a circle and shall bear the full name of the Corporation and the words and figures “Corporate Seal 1999 New York.”

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ARTICLE XII

FISCAL YEAR

The fiscal year of the Corporation shall end on the last day of December in each year.

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ARTICLE XIII

AUDITS

The Board of Director shall engage an independent certified or registered public accountant to make an annual audit of the Corporation.

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ARTICLE XIV

CONFLICTS OF INTEREST

Chapter 68 of the Charter of the City of New York defines a "code of ethics" which outlines the standards of conduct governing the relationship between private interests and the proper discharge of official duties of all employees and directors of the Health and Hospitals Corporation, including those who are working for the Corporation or who are directors of the Corporation. Chapter 68 embodies an extensive recitation of acts that constitute conflicts of interest and are thereby prohibited.

The Health and Hospitals Corporation has promulgated its own "Code of Ethics" which outlines the standards of conduct governing the relationship between private interests and the proper discharge of official duties of all personnel who are not covered by Chapter 68. Similar to Chapter 68, the Health and Hospital's Code of Ethics embodies an extensive recitation of acts that constitute conflicts of interest and are thereby prohibited. The Corporation has adopted the Code of Ethics with respect to its personnel and directors who are not subject to Chapter 68.

The Board of Directors is committed to recognizing the Corporation's responsibility to organizational ethics and expects, therefore, every employee and Board member to support and adhere to the principles and policies set forth in Chapter 68 and the Code of Ethics.

ARTICLE XV

WAIVER OF NOTICE

Wherever under the provisions of these By-Laws or of any corporate law of the State of New York, the Corporation, the Health and Hospitals Corporation, the Board of Directors, or any committee thereof is authorized to take any action or hold any meetings after call, notice, the lapse of any prescribed period of time, or any other prerequisite, such action may be taken or such meeting may be held without such call, notice, lapse of time, or other prerequisite if at any time before or after such action be completed, such requirements be waived in writing by every person entitled to notice or to participate in such action.

ARTICLE XVI

AMENDMENTS

These By-Laws may be altered or repeated by the vote of the Board of Directors of the Health and Hospitals Corporation at a regular meeting or at any special meeting.

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MetroPlus Health Plan, Inc.

*A wholly-owned subsidiary corporation of the New York City
Health and Hospitals Corporation*

Board of Directors

Name	Orig. Date of Appointment	End of Term Date
Bernard Rosen, Chair	May 18, 2000	May 26, 2015
Arnold Saperstein, M.D.	Ex officio/Executive Director, M+	
Antonio Martin	HHC President's Designee Chief Operating Officer	
Lloyd Williams	December 17, 2009	December 17, 2014
Tamira Boynes	February 26, 2004	February 26, 2014
Meryl Weinberg	January 29, 2009	January 29, 2014
Dan H. Still	May 18, 2003	July 24, 2013
Mendel Hagler	June 30, 2005	July 24, 2013
Margo Bishop	March 16, 2008	March 16, 2013

RESOLUTION

Approving amendment of the Certificate of Incorporation of MetroPlus Health Plan, Inc. to facilitate establishment of a Managed Long Term Care Plan and to better enable MetroPlus to conduct its business

WHEREAS, a resolution approved by the Board of Directors of the New York City Health and Hospitals Corporation (“HHC”) on October 29, 1998, authorized the conversion of MetroPlus Health Plan (“MetroPlus”) from an operating division to a wholly owned subsidiary of HHC; and

WHEREAS, MetroPlus has submitted an application to the Department of Health of the State of New York (“SDOH”) to establish a Managed Long Term Care Plan and;

WHEREAS, in reviewing that application, SDOH has identified certain changes necessary to the Certificate of Incorporation of MetroPlus; and

WHEREAS, MetroPlus has identified certain other changes to the Certificate of Incorporation of MetroPlus which would better enable MetroPlus to conduct its business; and

WHEREAS, the Certificate of Incorporation of MetroPlus reserves to HHC the sole power with respect to amending the Certificate of Incorporation of MetroPlus; and

WHEREAS, the Board of Directors of MetroPlus has approved a resolution recommending that the Board of Directors of HHC amend the Certificate of Incorporation of MetroPlus to facilitate the establishment of a Managed Long Term Care Plan and to better enable MetroPlus to conduct its business;

NOW THEREFORE, be it

RESOLVED that the Certificate of Incorporation of MetroPlus be amended as follows: (1) changing the principal office of MetroPlus to 160 Water Street, 3rd floor, New York, New York 10038; (2) amending the powers and purposes of MetroPlus to allow the establishment and operation of a Managed Long Term Care Plan, a Behavioral Health Managed Care Plan, and other plans, programs and lines of business; and (3) raising the threshold of HHC’s reservation of contracting authority found in the seventh paragraph of section SIXTH from One Million Dollars (\$1,000,000) to Three Million Dollars (\$3,000,000).

Executive Summary

In an effort to curb the approximate 13.6 billion dollar annual cost for long term care services, the New York State Department of Health (SDOH) is mandating enrollment into Managed Long Term Care (MLTC) plans as of July 1, 2012 for persons 21 and older in need of 120 days or more of service. An MLTC coordinates coverage with a patient's primary medical insurance. The MLTC will cover nursing home care, home care, personal care, meals and other ancillary services. The goal will be to keep members stable at home to avoid unnecessary nursing home stays.

MetroPlus has submitted an application to SDOH to establish and operate a MLTC. In reviewing the application, SDOH identified certain changes necessary to MetroPlus's Certificate of Incorporation and Bylaws. Specifically, the Certificate of Incorporation needs an expanded definition of the purposes and powers of MetroPlus to include the operation of an MLTC. The Bylaws need to articulate the requirement that the MetroPlus Board of Directors meet at least four times annually, once in each quarter (which has, in fact, been the practice of MetroPlus).

In addition, two other changes to the Certificate of Incorporation are appropriate at this time. One is simply to change the address of MetroPlus to its current location at Water Street. The other change concerns contracting authority. The current Certificate of Incorporation reserves to HHC the power to authorize MetroPlus to enter into contracts (other than with HHC or other health care service providers) when the annual value is in excess of one million dollars. To better enable MetroPlus to conduct its business and to be consistent with the new procurement guidelines issued by the HHC Board for HHC's procurement, MetroPlus seeks to raise the threshold of HHC's reservation of contracting from one million dollars to three million dollars.

**CERTIFICATE OF AMENDMENT
OF THE
CERTIFICATE OF INCORPORATION
OF
METROPLUS HEALTH PLAN, INC.**

UNDER SECTION 7385(20) OF THE UNCONSOLIDATED LAWS

The undersigned, being the Chairman of the Board of Directors of MetroPlus Health Plan, Inc., does hereby certify:

- (1) The name of the corporation is MetroPlus Health Plan, Inc.
- (2) The certificate of incorporation of MetroPlus Health Plan, Inc. was filed by the Department of State on the 13th day of April, 2000. The said corporation was formed as a public benefit corporation under Section 7385(20) of the Unconsolidated Laws of the State of New York.
- (3) Paragraph Fourth of the certificate of incorporation of MetroPlus Health Plan, Inc., which sets forth the address of the principal office of the Corporation, is hereby amended pursuant to Section 7385(20) of the Unconsolidated Laws of the State of New York to read as follows:

FOURTH: The principal office of the Corporation shall be located at 160 Water Street, 3rd Floor, New York, New York 10038.

- (4) Paragraph Fifth of the certificate of incorporation of MetroPlus Health Plan, Inc., which sets forth the purposes of the corporation, is hereby amended pursuant to Section 7385(20) of the Unconsolidated Laws of the State of New York to read as follows:

FIFTH: This Corporation is formed to engage in any lawful act or activity for which a public benefit corporation may be organized under Section 7385(20) of the Unconsolidated Laws of the State of New York, including, without limitation: (a) to perform studies, feasibility surveys and planning with respect to the development and formation of a health maintenance organization; in conjunction therewith, to accumulate compile and analyze statistics and such other data as will promote the health, safety and welfare of the general public; and (b) upon obtaining a certificate of authority from the Commissioner of the New York State Department of Health, to own, operate and manage a health maintenance organization, including providing or arranging for the provision of comprehensive health services, to an enrolled population, and to have and exercise all powers necessary and convenient to effect any or all of the foregoing purposes for which the entity is formed, together with all the powers now or hereafter granted to it by the State of New York. Notwithstanding any other provision of this certificate of incorporation to the contrary, nothing contained herein shall authorize the Corporation to establish, operate, construct, lease or maintain a hospital or to provide hospital services or health-related services or to operate a drug maintenance program, a certified home health agency, or a hospice as defined and covered by Articles 28, 33, 36 and 40, respectively, of the Public Health Law, or to solicit, collect or otherwise raise or obtain funds, contributions, or grants from any source for the establishment or operation of any hospital.

(5) Paragraph Sixth of the certificate of incorporation of MetroPlus Health Plan, Inc., which sets forth the authority, responsibilities and powers of the Board of Directors and the Member, is hereby amended pursuant to Section 7385(20) of the Unconsolidated Laws of the State of New York to read as follows:

SIXTH: The Board of Directors of the Corporation shall have the authority and responsibility for the general management, control and supervision of the Corporation's affairs, business, activities and assets, provided, however, the Member shall have the sole power with respect to:

- (1) electing and removing the members of the Board of Directors;
- (2) amending this Certificate of Incorporation;
- (3) adopting, amending and repealing the Bylaws of the Corporation;
- (4) selling, transferring or otherwise disposing of all or substantially all of the assets of the Corporation;
- (5) dissolving the Corporation, or the filing of a petition for bankruptcy (or similar state process for receivership, liquidation or rehabilitation);
- (6) acquiring, merging with or otherwise combining with another corporation, partnership, joint venture or other entity;
- (7) entering into a contract, other than with the Member or a health care service provider, with an annual value in excess of **Three Million Dollars (\$3,000,000)**;
- (8) entering into a management or administrative services agreement with a third party, other than in the ordinary course of business;
- (9) mortgaging, pledging, granting a security interest in, or otherwise encumbering any of the property or assets of the Corporation, with the exception of a purchase money security interest granted in the ordinary course of business;
- (10) terminating, modifying or developing additional employee benefit plans and pension plans; and
- (11) selecting outside legal counsel.

(6) The Secretary of State of New York is hereby designated as agent of MetroPlus Health Plan, Inc. upon whom process against it may be served. The post office address to which the Secretary of State shall mail a copy of any process against the corporation which is served upon him is:

**160 Water Street
3rd Floor
New York, New York 10038**

(7) This amendment to the certificate of incorporation of MetroPlus Health Plan, Inc. was authorized by an affirmative vote of the members entitled to vote thereon, at a meeting of the Board of Directors of the New York City Health and Hospitals Corporation, the sole member of MetroPlus Health Plan, Inc., duly called and held on the ____ day of May, 2012, the affirmative vote being at least equal to the quorum.

IN WITNESS WHEREOF, the undersigned has subscribed this certificate and affirms the statements herein as true under the penalties of perjury this ____ day of May, 2012.

Bernard Rosen
Chairman
MetroPlus Health Plan, Inc. Board of Directors

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