

BOARD OF DIRECTORS MEETING

THURSDAY, JANUARY 29, 2015

A~G~E~N~D~A

<p>Call to Order - 4 pm</p> <p>Adoption of Minutes: December 18, 2014</p>	<p>Dr. Boufford</p>
<p><u>Acting Chair's Report</u></p>	<p>Dr. Boufford</p>
<p><u>President's Report</u></p> <p>➤ Information Item: Dietary Services Update – Antonio Martin, Executive Vice President, Chief Operating Officer</p> <p>>> Action Items <<</p>	<p>Dr. Raju</p>
<p><u>Corporate</u></p> <p>2. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract with GSI Health, Inc. to provide a Care Coordination and Management Solution. This solution will serve as the foundational population health management, coordination, communication, collaboration, documentation tracking, and registration system for the Corporation's overall Delivery System Reform Incentive Payment (DSRIP) strategy and several programs operated by the Corporation in conjunction with its DSRIP program. The contract shall be for a period of five years with two, one-year options to renew, exercisable solely by the Corporation, in an amount not to exceed \$35,441,897 (including a contingency of \$1,177,918 for additional software services as needed). <i>(Med & Professional Affairs / IT Committee – 01/15/2015)</i> <i>EEO: Approved / VENDEX: Pending</i></p>	<p>Dr. Calamia</p>
<p>3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a one-year revocable license agreement with SST, Inc. for its use and occupancy of approximately one square foot of exterior space for the operation of acoustical equipment at a single pilot facility of the Corporation with the occupancy fee waived and with the President holding an option to extend the license for up to four additional years to match the length of the Licensee's agreement with the New York City Police Department if such agreement is extended and with the President having the authority to designate the location included in the license. <i>(Capital Committee – 01/15/2015)</i></p>	<p>Ms. Youssouf</p>
<p><u>Central & North Brooklyn Health Network</u></p> <p>4. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a Customer Installation Commitment with the New York City Department of Citywide Administrative Services and the New York Power Authority for an amount not to exceed \$9,462,866 for the planning, pre-construction, design, construction, procurement, construction management and project management services necessary for the Energy Conservation Measures upgrade project at Woodhull Medical and Mental Health Center. <i>(Capital Committee – 01/15/2015)</i></p>	<p>Ms. Youssouf</p>
<p><u>Committee Reports</u></p> <ul style="list-style-type: none"> ➤ Capital ➤ Community Relations ➤ Equal Employment Opportunity ➤ Finance ➤ Medical & Professional Affairs / Information Technology ➤ Strategic Planning 	<p>Ms. Youssouf Mrs. Bolus Mrs. Kril Mr. Rosen Dr. Calamia Mrs. Bolus</p>

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BOARD OF DIRECTORS MEETING
THURSDAY, JANUARY 29, 2015
A~G~E~N~D~A – Page Two

<u>Subsidiary Board Reports</u>	Dr. Raju Dr. Raju
<ul style="list-style-type: none">➤ HHC Insurance Company, Inc. / HHC Physicians Purchasing Group, Inc.➤ HHC Accountable Care Organization (ACO) Annual Membership	
<u>Executive Session / Facility Governing Body</u>	
<ul style="list-style-type: none">➤ Kings County Hospital Center➤ Dr. Susan Smith McKinney Nursing & Rehabilitation Center	
<u>Semi-Annual Report (Written Submission Only)</u>	
<ul style="list-style-type: none">➤ Elmhurst Hospital Center	
>>Old Business<<	
>>New Business<<	
Adjournment	Dr. Boufford

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 18th of December 2014 at 4:00 P.M. 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. Jo Ivey Boufford
Dr. Ramanathan Raju
Mr. Steven Banks
Josephine Bolus, R.N.
Dr. Vincent Calamia
Dr. Herbert F. Gretz, III
Ms. Anna Kril
Mr. Robert Nolan
Mr. Mark Page
Mr. Bernard Rosen
Ms. Emily A. Youssouf

Patricia Yang was in attendance representing Deputy Mayor Lilliam Barrios-Paoli, and Dr. Oxiris Barbot was in attendance representing Commissioner Mary T. Bassett, both in a voting capacity. Dr. Boufford 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 November 20, 2014 were presented to the Board. Then on motion made by Dr. Boufford and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on November 20, 2014, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON' S REPORT

Dr. Boufford received the Board's approval to convene in Executive Session to discuss matters of quality assurance.

Dr. Boufford received the Board's approval to accept the committee assignments.

Dr. Boufford informed the Board that the annual membership meeting of HHC's Accountable Care Organization would convene following the conclusion of the Board meeting.

Finally, Dr. Boufford updated the Board on approved and pending Vendex.

PRESIDENT' S REPORT

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

Joe Schick, Executive Director/Senior Advisor to the President provided the Board with an overview of the work of the Fund for HHC, including the Guns Down, Life Up violence prevention initiative.

Finally, Dr. Raju honored Lillian Roberts as HHC's Person of the Year. As Executive Director of District Council 37, New York City's largest public employee union, Ms. Roberts has ably represented many HHC employees and has fought for workers'

rights as well as for social justice. She has always worked to develop positive relationships with management, recognizing the partnership between labor and management ensures that patients receive the very best of care.

Ms. Roberts expressed her gratitude for the recognition and stated that she regarded the honor and appreciation not just for her, but for all the DC 37 people and everyone that she has worked with.

ACTION ITEMS

2. RESOLUTION

DSRIP APPLICATION

Authorizing the New York City Health and Hospitals Corporation the "Corporation") to (i) submit an application to the New York State Department of Health ("DOH") to participate in the Delivery System Reform incentive Payment program ("DSRIP") pursuant to which the Corporation will establish a single Performing Provider System (a "PPS") in collaboration with various health care providers (the "Participants"); and

CONTRACTS WITH PPS PARTNERS

Authorizing the Corporation to (ii) enter into agreements within the PPS structure with those Participants listed on the attached Schedule of Participants designated as "City Wide" and those Participants designated as "Hub-Based" in the attached Schedule of Participants subject to the addition of additional Hub-Based Participants or the removal of some Hub-Based Participants at the discretion of the Corporation President as he determines to be necessary or appropriate to respond to evolving DOH requirements, guidance and regulations, and the Corporation's assessment of the ability of the Hub-Based Participants to perform as required for the DSRIP program; (iii) enter into such other and further ancillary contracts as are necessary or appropriate to carry out the purposes of the DSRIP program

and to ensure the Corporation's successful execution of its DSRIP projects using the structure diagramed in the attached Table of Organization; and

**HHC ASSISTANCE CORP TO FUNCTION AS CENTRALIZED SERVICE
ORGANIZATION**

Authorizing the Corporation to (iv) cause the HHC Assistance Corporation (the "CSO") to provide technical assistance to the PPS in the capacity of a centralized service organization; (v) nominate the among the officers and senior managers of the Corporation the directors of the CSO provided that the Corporation President shall have the authority to nominate one or more directors of the CSO who are not officers or employees of the Corporation provided further that such outside directors never exceed 25% of the total of CSO directors; and

PROCUREMENT, COMPLIANCE AND REPORTING

Directing the Corporation to (vi) subject the activities of the CSO under the DSRIP program to the Corporation's compliance and internal audit programs; (vii) requiring that all procurement contracts of the CSO be subject to the procurement rules applicable to the Corporation; and (viii) make regular, periodic reports to the Corporation's Board of the progress of the DSRIP application and the implementation of the DSRIP projects including an overview of all contracts made by either CSO or the Corporation to carry out the DSRIP program.

Dr. Christina Jenkins, Senior Assistant Vice President, Medical and Professional Affairs provided the Board with an overview of HHC's participation in the DRSIP program.

Dr. Bufford moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTIONS

3. Authorizing the President of the New York City Health and Hospitals Corporation to execute a five-year **lease extension agreement** with **LSS Leasing Limited Liability Company** for 5,120 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the **Women's Medical Center operated by Elmhurst**

Hospital Center at an initial rent of \$225,280 per year or approximately \$44 per square foot to increase at a rate of 2.75% per year for a five-year total of \$1,190,079.

- and -

4. Authorizing the President of the New York City Health and Hospitals Corporation to execute a five-year **sub-lease agreement** with **Pediatric Specialties of Queens** for 2,560 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Subtenant's pediatric program at an initial rent of \$112,640 per year or approximately \$44 per square foot to increase at a rate of 2.75% per year but in no event less than half of all of the Corporation's occupancy costs at the premises.

Ms. Youssouf moved the adoption of the resolutions which were duly seconded and unanimously adopted by the Board.

RESOLUTION

5. **Reappointing Lloyd Williams** as a **member** of the **Board of Directors of MetroPlus Health Plan, Inc.** a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York to serve in such capacity until his successor has been duly elected and qualified, or otherwise provided in the Bylaws.

Mr. Rosen moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

SUBSIDIARY AND BOARD COMMITTEE REPORTS

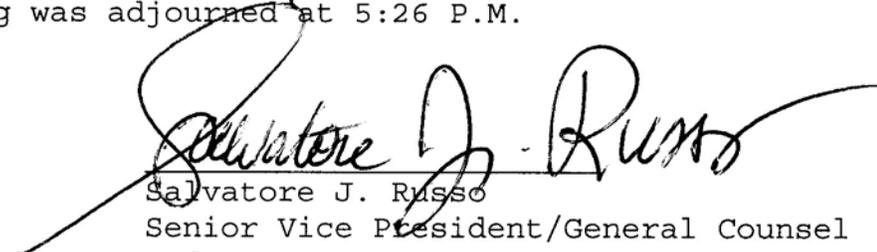
Attached hereto is a compilation of reports of the HHC Board Committees and Subsidiary Boards that have been convened since the last meeting of the Board of Directors. The reports were received by the Acting Chair at the Board meeting.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Boufford reported that, 1) the Board of Directors, as the governing body of Bellevue Hospital Center, received an oral report and written governing body submission and reviewed, discussed and adopted the facility's report presented; and 2) as governing body of Jacobi Medical Center and North Central Bronx Hospital, the Board received and approved their semi-annual written reports.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 5:26 P.M.



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

COMMITTEE REPORTS

Audit Committee – December 4, 2014

As reported by Josephine Bolus, RN on behalf of Ms. Emily Youssouf

KPMG June 2014 Management Letter

Ms. Maria Tiso introduced herself as the Engagement Partner and she introduced Joseph Bukzin, Senior Manager. She stated that they were there to discuss the 2014 management letter; they will go through some of the key highlights rather than going through a 50-page document.

Ms. Tiso began with page one which is the opinion. The opinion talks about the review of internal controls and that there were no material weaknesses or significant deficiencies identified in the comments in the management letter. These comments are more a matter of the internal controls improvements or best practices. There was nothing noted that was a material weakness or a significant deficiency. The letter is broken into five sections, which are broken out in the matrix of observations, which gives a snapshot of where the findings fell under. We also have comments relating to Corporate Office, Information Technology, site visits and also added a section about prior-year comments that were cleared and then lastly the industry comments. These industry comments are comments that we have been including in many healthcare organizations and talks about items and issues that are going on in the healthcare industry globally.

Ms. Tiso continued by stating that page three is the matrix of observations. Many of our comments relate to Corporate Office and then some of the comments do relate to some of the networks. Page four begins with our observations; Ms. Tiso then turned the presentation over to Mr. Bukzin.

Mr. Bukzin saluted everyone and said picking up on page four, starting with some of the corporate observations. The first one relates to the External Financial Reporting Package Review. As part of the bond obligations, the organization is required to file their financial statement publicly online on a quarterly basis, and the recommendation is to make sure that the financial statement gets published quarterly; it is also reviewed and compared against what was approved during the Finance Committee and Board-level meetings. Management agrees to implement the control around that process. The next one is Accrued Expenses – with tight regulatory requirements and in the spirit of quarterly reporting, it makes sense as a best practice to make sure that the accruals are adjusted more frequently than annually, perhaps on a quarterly basis. Management has agreed to revisit the process for accruals to ensure that they are.

Mr. Page asked if it is realistic to try to do that on quarterly basis.

Mr. Weinman answered stating that currently in Central Office we take care of most of the quarterly adjustments because we must report quarterly expenses coming out of Central Office, but we are talking from the facility standpoint. Most of what they purchase is OTPS, supplies and services; we think it is realistic that we could accomplish this on a quarterly basis.

Mr. Page then asked if they are also reporting on the revenue side. To which Mr. Weinman responded yes.

Mr. Page asked if your accruals on the revenue side were working. Ms. Zurack answered that we do that now quarterly. Mr. Weinman added that a very large part of the audit's concentration is on the revenue, and we do that quarterly and is reviewed extensively by the end of the audit. Part of their opinion is based on the fact that we recorded appropriately.

Ms. Zurack stated that if a facility is following our standard operating procedures, when a good is received, it should be logged into the OTPS system, so that accruals should be almost automatic. It is about services, and there is not much of that going on.

Mr. Bukzin continued to page five and stated that the next comment is a repeat from the prior year regarding affiliation contracts, and there is a whole host of bullets that were carried over from the prior year management letter. Management has continued to work towards and implement policies and procedures to remediate and address these bullets. It is not fully remediated at this point, so we felt it was necessary to continue to carry it forward.

Mrs. Bolus asked about the incomplete human resources files where they do not have the letters from people who are exiting HHC.

Ms. Tiso said that this comment was the same that was in last year's management letter – it is identical.

Mrs. Bolus asked if they had been more diligent in getting this letters.

Ms. Tiso answered that there have been some improvements, but not enough for it to be taken out of the management letter. The Corporation is working towards it, but it is taking a bit longer to get the comment remediated.

Mr. Bukzin added that there is a 2014 observation that falls under the category of “Affiliation Contracts” and we just wanted to highlight that as something new that falls under this heading. This is the internal audit review of the PAGNY corporate expenses that did not occur but it is required to occur. It is our understanding that management is in the process of working with the PAGNY management team to make sure that the internal audit does occur on a timely basis.

Mr. Page referred back to the documentation of people coming in and out, and asked if we are dependent on the affiliate to produce that information, or is that something we do internally for individuals that we pick up through the affiliation.

Mr. Nelson Conde was asked to approach the table by Mr. Martin. Mr. Conde responded that we are dependent on the affiliate to produce the documentation for us.

Mrs. Bolus stated that she has come across this in two years and asked why it cannot be cleared up and why is it still such a problem that it has to appear in the letter.

Ms. Zurack asked if this is KPMG’s direct finding. To which Ms. Tiso replied no, this is a comment that was issued in last year’s management letter, and it was a sample of affiliates, so it is not just one affiliate. It was a sample that we have taken from last year.

Ms. Zurack then asked what audit work did they do to check to see whether it was cleared.

Mr. Bukzin replied that we work with Mr. Weinman and his team to understand the status of the prior-year comments.

Ms. Zurack asked what that work consisted of. Mr. Weinman answered that generally, in response to a prior year’s audit comments, we give an opportunity for those comments to provide some type of support of remediation for that comment. If we do not get any type of proof of remediation, it still appears on the letter. We still have an opportunity to clear this for next year, but we do not have any support yet.

Ms. Zurack asked in this particular comment, who did we solicit that opportunity to show the remediation, to the affiliates or to ourselves?

Mr. Weinman answered to us. Ms. Zurack then asked to which office? Mr. Weinman responded generally to the Office of Professional Services & Affiliations.

Mr. Martin asked who is responsible. Ms. Zurack stated that she thinks that Mr. Weinman is saying is that probably someone on my team went through all the comments and sent a note to someone on each area of responsibility to say, “If you cleared this up, show us,” and OPSA would have gotten this one, not the facilities themselves. Maybe Mr. Conde has to do some homework and let us know what happened, but whatever you guys provided is not addressed.

Mrs. Bolus said that we have a lot of vacancies, sometimes three to four month vacancies, and what offers are being made, then when people resign; we need to know why they are resigning.

Ms. Zurack suggested that we should come back to this, because it is such a long comment that probably Mr. Conde and his team had so much to answer that this one item may be on memory. We are still talking a lot about the recalcs and everything else and maybe this one had not been highlighted as important.

Mr. Bukzin continued with the next comment on page eight entitled Capitalization of Software Costs. This is an accounting treatment relating to computer software upgrades, major electronic medical records systems and costs incurred that may or may not meet the definition of expense versus capitalization. There were about \$5 million of expenses that were reported as expense that should have been capitalized. Since the electronic medical records system is a significant ongoing project with a lot of expenses attached to it, we felt it was appropriate to recommend review of this area as well as working with the IT Department to capture payroll-related expenses as well.

Mr. Bukzin stated that the next comment titled Centralization also falls under the category of a best practice of revisiting certain functions that currently are not centralized. We do acknowledge that management has started centralizing certain functions, such as the procurement function, but perhaps there are also other areas for opportunity, and that opportunity could enhance controls, reduce costs to the organization, and promote cross-functionalization amongst employees.

Mr. Bukzin moved on to page nine, Vendor Listings – this is a new audit procedure that we did just to basically compare who was on the vendor master listing file to a listing of active employees, and we did identify some employees that were on the vendor master file. Our recommendation is for management to enhance controls of policies and procedures to ensure that when

someone is hired that they are removed from that vendor master list on file. On page ten, Account Analysis Received from Other Departments, this is actually the subset from what we detailed when we presented the results of the financial statements. We only highlight a number of post-closing adjustments; one is related to the double accounting of an accrual for asbestos, pollution remediation liability. Then there was also a cut-off issue related to pool rather than for net patient services by account \$100 million. This comment gets to the point of making sure there is a default review of analysis received from other departments that falls into the lap of the finance team. Page eleven has one of our IT-related findings around timely removal of terminated users. There were two findings under the subcategory related to access perhaps after the employee was no longer employed by the organization. There should be tightened controls and processes between HR and IT process to make sure that the removal of employee occurs on a timely basis. This is a comment we see at many organizations, making sure there is not a huge issue related to these particular findings. We do look to see if terminated employees did access the system after their termination date, and there were no instances of that.

Mr. Bukzin continued with page twelve stating that it covers some of the site-visit findings or findings relevant to a specific entity. The first one relates to a finding at the Coney Island Hospital where there was a fixed asset that was marked as received and accrued for when in fact the facility did not have possession of it. This was somewhat of an isolated instance around Super Storm Sandy, and they did actually have possession of it, but the vendor took it back for safeguarding and safekeeping during the process. Ongoing communications enhancing policies and procedures around vendor payment and when assets are returned or perhaps not been received yet. Bottom of page twelve, Goldwater Movable Equipment Disposal – not material to the financial statements, but there were some assets that were transferred as part of that closure transaction that were not accounted for. This is an opportunity for enhancing policies and procedures and communication in that area.

Mr. Bukzin stated that page fourteen covers the prior-year comments that were addressed by management. These are comments that appeared in last year's management letter that were considered remediated or addressed by management. The first one falls under the heading Construction Management. There were several observations around construction progress, monitoring budgets, over-runs, making sure that items that are construction in progress (CIP) are properly accounted for and captured in a general ledger system. Management has gone through a process of implementing tools to track it. They mentioned a Scorecard Tool, which helps to identify scope issues and if there is going to be over-runs issues with the initial budget that was established for that project and they did provide to us to review as part of the remediation of this comment.

Mr. Bukzin continued with page fifteen, Material Management and stated that again, there were a handful of observations related to segregation of duties, related to receiving, paying and ordering goods. Management has implemented and adopted new procedures to ensure that there is segregation of duty between receiving and payments, approval process, and also the Office of Internal Audits plans to do a more detailed review of this area in connection with the centralized procurement function. The other observation relates to cut off of expenses and reporting of grants. We did not identify any similar issues related to that area in the current year, and management has offered a process of training its employees, making sure there is a verification review process in place to ensure those expenses are reported in the proper period in accordance with the grant management. On page seventeen, there are some prior-year site-visit findings around payroll and material management. These policies and procedures have been adopted and enhanced and we did not have any similar findings in the current year related to these.

Mr. Bukzin asked if there were any further comments at that point. He turned the presentation over to Ms. Tiso.

Ms. Tiso continued with page nineteen through thirty-one and stated that these are industry comments. These comments are specifically included in HHC's letter as information only and we do not include them in other health organizations. The first is Internal Audit Reporting – the best practice is that the Chief Internal Auditor should report to the Chief Executive Officer or the Chief Financial Officer. He currently reports to the Chief Operating Officer, so best practice is to change the reporting structure. The organization is currently looking into that. Page nineteen also talks about the DISRIP Program and page twenty talks about Convergence in Healthcare. To me they are similar comments, right now healthcare is transforming, the organization needs to merge and affiliate with other organizations and converge going forward.

Mrs. Bolus asked if DISRIP pays for any IT systems? To which Ms. Zurack responded that DISRIP does not pay capital. However, New York State in tandem with DSRIP has appropriated \$1.2 billion for capital, but it is possible there could be some IT. That application is going kind of parallel to DSRIP and it is due the third week of February.

Mr. Martin added that yes, but that \$1.2 billion is over a seven-year period. Ms. Zurack commented that that is for the whole State.

Ms. Tiso moved on to page twenty-four which talks about the ICD-10 extensions approved by the Senate. Obviously, the ICD-10 diagnostic and procedure codes need to be implemented over the next several years. The effective date was supposed to be October 1, 2014, but that has been extended. Our comment here is just to make sure that the organization is currently on track to implement the ICD-10 when the date gets approved. Page twenty-four and twenty-five and the top of page 26 talk about HIPAA compliance. There is a lot of discussion about protecting patient health information and making sure that your corporate compliance program addresses that, looking at subcontractor agreements and vendor agreements, making sure that those parties

are also protecting the patient information. I know that HHC does a good job with that because KPMG gets forms to complete. Page 26 talks about data analytics – this is top-of-mind on all governance committee meetings now. A lot of people do not understand how to use them at this point, but going forward, this really needs to be looked at by the organization to figure out how to decrease expenses and increase quality. Page twenty-seven is social media. Our comment is to make sure that the organization has a plan in place to address any social media risk. Page 28, Use of Cloud Computing in Healthcare – healthcare in general is lagging behind on the use of cloud computing. Our comment is that healthcare organizations could really reduce costs as it relates to data storage. Page 29 talks about Oversight – there is a lot of oversight, the SEC obviously is involved in not only public companies but also government entities, bond offerings, municipal examinations. This comment is about the fact that the SEC is not only monitoring public accounts but also private and governmental accounts as well. Page thirty, the Sunshine Act, CMS requires any manufacturing or group purchasing organizations to have a list of any physicians that gets any type of payments or gifts. There needs to be a listing and Corporate Compliance probably needs to make sure physicians, or they are looking at conflict-of-interest statements, making sure those are completed accurately, making sure there are no surprises from the Corporation's perspective.

Mr. Page asked in terms of this latter section of the letter, is this something generic to your healthcare clients? Ms. Tiso responded yes.

Mr. Page then asked if they include this section in your management letters to all of your audit healthcare clients. Ms. Tiso answered yes, we typically do. Our management letters are broken out into the actual facility observations and the industry. The reason we do that is because the management letter is supposed to go to your governing body, and it is to keep them aware of what is going on.

Mr. Page then commented that it seems off as a vehicle because it strikes me as quite different in its substance from your client-specific comments. I am surprised that it is in the management letter, it is valuable and it is good that you give it to us.

Ms. Tiso added that historically it has been; we have had one-offs where the organization does not want it and we will issue a separate letter. It depends upon what you like. I prefer to put it in there, it gives everybody one place to look at the comments.

Ms. Zurack added that in other years you have told us how we are doing relative to others on some of those areas and it is helpful.

Mrs. Bolus asked for a motion to approve the management letter, it was seconded and approved by the Committee.

Internal Audits Update

Mr. Telano saluted everyone and stated that page three of the briefing summarizes the status of the audits being conducted by government agencies. The first one is the audit of the Lincoln Affiliation Agreement conducted by the New York City Comptroller's Office. It began last July 2013, and it is still ongoing. They are currently conducting interviews and obtaining information from the PAGNY side of the audit. The second audit is related to the Patient Revenue and Accounts Receivable. At this point in time they are attempting to request information that we consider protected health information, Mr. Russo and Mr. McNulty have been involved in the discussions with them because we do not want to provide this confidential information. This is an ongoing matter and we will keep you updated. On page four is the Bellevue Hospital's Emergency Operations Plan. The City Comptroller's Office has decided to close that audit at this time, but they reserve the right to reopen it at a later date. The next audit listed is one being done by the State Comptroller's Office, a follow-up of overtime and that is ongoing. We have sent them additional information this week and we hope to receive some status of the findings shortly.

Mr. Telano continued on with page five which lists the audits that the Office of Internal Audits has completed since the last meeting. Coincidentally, all of the audits for this meeting are of the South Manhattan Network. The first audit is of Hospital Police at Bellevue. Mr. Telano asked the representatives to approach the table and introduce themselves. They did as follows: Joseph Sweeney, Director of Hospital Police at Bellevue; Kirk Leon, Director of Corporate Security; Mr. Steven Alexander, Executive Director of Bellevue.

Mr. Telano stated that during the course of the audit, we evaluated the payroll and use of resources. We noted that security posts were not always regularly manned. On two specific dates, we found that 6 of the 27 posts were vacant. We also noted that extensive amounts of overtime were being earned by the Hospital Police, and additionally we found that the Bellevue Police was borrowing personnel from other sites and this expense was not always charged back.

Mr. Sweeney said that we have some posts assignments that are mandatory 24 hours a day, 7 days a week; there is no reason that the person assigned to that post should leave the post. However, we have many posts that may be covered all day except when that person is called to an emergency situation and some are left for meal or breaks. The people on the post are responsible to escort somebody out of the building or to our CPEP. There are variety of reasons why somebody might not be on the post that they assigned to.

Mr. Alexander added that on some posts there might be two people assigned, and that would be considered two posts for two individuals, so one person who had to respond to an emergency did not leave that particular post totally uncovered. It was basically reduced from two one person on that site at that time.

Mrs. Bolus asked how often you actually walk through the actual stations.

Mr. Sweeney responded not as often as I probably should. We do rounds maybe once every two weeks or so, but I will visit each post in the different course of my business a couple times a week.

Mrs. Bolus asked if there is any way that they may know what your schedule is. To which Mr. Sweeney responded no. I have many other supervisors that their job is to randomly go to these posts and the uniformed supervisors are mandated to go to the post at least twice a shift and they are supposed to sign their books, so we have a process to make sure that these folks are on the posts.

Mr. Martin added that we need to make a differentiation between the mandatory posts and the sort of posts that are good to have. Twenty-seven is a tremendous amount of posts to have any facility. They are operating at an overabundance of caution when they have 27 posts. I want the Board to feel comfortable that the mandatory posts, the ones that really protect the security of the facility are being manned on a consistent basis.

Mr. Page added that obviously the underlying point is you hope that the personnel you are paying for to man the posts are actually doing that as opposed to doing something else.

Mr. Sweeney stated that that is the concern, but I can assure you that it is busy enough that everybody is doing something at one point or another. I am confident that nobody is disappearing from the post and sleeping somewhere or off somewhere doing something they are not supposed to. If they are off the post, it is for a specific reason and we are on top of it.

Mr. Telano then asked about the overtime and the use of personnel from other facilities?

Mr. Sweeney responded that one of the issues we are consistently trying to address is mandatory overtime for my staff. I want people to want to stay at the hospital. The difference between somebody who wants to stay and somebody who is told they have to stay is quite stark. In an effort to reduce mandatory overtime, we had to set up a system that we can get folks from other facilities who are interested in working overtime to cover these posts. It has been an effective program – it helps, especially on weekends, fill some slots that would normally have to keep somebody from going home. The way the process was being set up, I worked with Payroll and Finance to figure out how we can do these charge backs and we keep separate time sheets. We keep overtime sheets and we send all the documentation to the facility where the person comes from and that facility then pays that person and is supposed to charge us back. One of the findings in the audit was that Bellevue did not always know what needed to be collected because the burden is supposed to be on the facility that pays that employee. We are now going to give copies of what we collect as far as overtime hours and pay that directly to our client so that they know what bill is coming. The part of getting the people paid from their facility was working. It is that facility charging Bellevue back for that overtime was the lag in how long they let that slide.

Mrs. Bolus asked if they would rather have 17 full time employees as opposed to paying overtime equivalent to 17 full time employees.

Mr. Sweeney responded yes, absolutely. That is a complicated answer because the process of hiring a special officer is a cumbersome one. It is a civil service position and they have to take a test. We have to have hiring pools and there is a lengthy process to vet those who are on the list that would eventually be candidates in the approval for the facility to actually choose their candidate that they want to hire and some point they have to do to the academy.

Mrs. Bolus asked how many vacancies are there at this point.

Mr. Alexander answered that we opened ten positions for hire about year ago and in the course of vetting individuals to bring them on board, some of the people leave, so we are trying to stay ahead of that. We opened another ten positions recently, anticipating that it is a bit of a protracted process to get people through to make sure we have the right qualified hospital police that can perform appropriately; we are basically going with an understanding that this is going to take nine months. I need to float the positions well in advance so that I always have a flow of people coming in. In order to get ahead of it, we had to advance that process a little more than we had in the past. For example, this last year those ten positions that we were successful in getting, they just finished the academy a couple of weeks ago and since then we lost an additional six. This is the kind of attrition we are dealing with. I guarantee that those few people that just came out of the academy who will for a variety of reasons will not be here in six months.

Mrs. Bolus asked if he knew why? Mr. Sweeney said that some of it is they go to other City agencies, Corrections, NYPD or they are interested in law enforcement. Most of them leave for greener pastures or something.

Mrs. Bolus asked if you ask them to exit. Mr. Sweeney responded yes, that some of them do not work out. There is a probationary period and we want to weed that out at the front end rather than call in sick and have a problem on your hands.

Mrs. Bolus pointed out that this should be on our list of vacancies. It is very important, we should ask about the police department too.

Mr. Martin stated that he thinks that is a great point. When they talk about the protracted time it takes to bring somebody on. The academy only operates three times a year, so if you select somebody, you have to wait for the next academy session to put them in. It is not just HHC, it is other agencies, and you need a full list of a certain number of people for the academy to actually occur. It is difficult, but we will put it on the QA.

Mr. Page stated that it is a test, but it is a training period that you provide. Mr. Sweeney explained that after you go through the test process and you are selected as a candidate and Bellevue hires you, and so do the other facilities, they go through the same process. Then at some point, when there is enough vacancies filled, they go into an academy class, which is six weeks, plus an additional week for specific HHC training.

Mr. Page added that the training has a certain value to other employers. Mr. Sweeney said yes.

Mr. Page asked if you can get some kind of commitment from candidates for whom you provide training that they continue working for you for a year or something? Mr. Sweeney said that they all say they will.

Mr. Page asked if you can make it stick? Mr. Russo responded that they are collectively bargained, and any additional requirements we have to pose, we have to bargain with the unions.

Mr. Leon said that it should be noted that we have our own specific test for HHC, and there is also a citywide exam as well so we prefer those who are taking our test remain with us, but unfortunately, as Mr. Sweeney said that does not always happen, so we have to bargain, deal with other agencies.

Mr. Bolus asked how much does academy cost? To which Mr. Leon answered that prices varies depending on the number of candidates that we have. They do a per-person per number of days and then a proposal is sent. The proposal is looked at very carefully based on a number we have, it is anywhere from \$50,000 to \$80,000 per class.

Mr. Page asked what the cost of one of those positions is. Mr. Sweeney said that is somewhere in the high \$30s, after a few years it goes up to \$42.

Mr. Martin said that we have found is that the training they receive at the academy is very generic because they want to make it really applicable to all City agencies so Mr. Leon has added HHC-specific training because we have some unique situations within HHC that our hospital police have to refer to.

Mrs. Bolus asked if they are on salary from day one. To which Mr. Sweeney responded that as soon as they step into the academy, Bellevue folks are paid by Bellevue. Some of the directors and I have talked about perhaps maybe doing more of our own type of academy so we could have that HHC influence from the very beginning.

Mrs. Bolus asked if they would be certified and will this education then go from whatever hospital to hospital? Mr. Sweeney responded yes. Then Mr. Bolus asked if they would be paid a different salary at some places or the same salary? Mr. Sweeney said that within HHC it is all the same. People do transfer from different facilities.

Mr. Page asked if they would see value in trying to run this resource more broadly than just hospital to hospital. Mr. Sweeney responded yes.

Mrs. Bolus asked if there is any value in centralizing it. Mr. Alexander answered that there are some differences from facility to facility, there are some cultural things. Some of the basics of how you approach a patient and things like that would be the same, but there is a little bit of a learning going from Kings to Bellevue to Elmhurst.

Mr. Telano stated that he had additional comments related to Bellevue. There was licenses and certifications that we could not locate, and as a result we could not confirm that the security officers, the special officers and the watch persons, were properly trained or that they were authorized to perform the job that they were in.

Mr. Sweeney stated that they used to have a notification process and is not sure where that fell off. Locally it was not part of our responsibility to keep track of that, but the issue came up when the auditors were there and frankly I did not know the answer, so we started looking into it. The special officers are 100% compliant. It took us a while to track down the certification for about 11

of them, we verified they had certification. The watch persons' licensing, we had one person who was not up to date and they were previously relieved of duty until they get their certification back, so that is 99% personnel compliance. I think it was more of a bookkeeping error than actually certification.

Mr. Telano moved on to page six. We found confiscated patient items that are deemed harmful to patients or others that were not being properly disposed of in a proper period of time. There were no guns, but there were knives and screwdrivers.

Mr. Sweeney said that that is a challenge for us. We have had some historical issues with what is valuable to me might be different to you. The patients come in with items that we do not want them to have, and typically it is when they enter our CPEP. We do not want to give it back to them because it is something that they can hurt themselves with or somebody else regardless of whether they have been treated and released. In doing that they ended up with a collection, we revamped that process; we have a couple of things to iron out as well with the sharp objects. A lot of the stuff we will discard if it is obvious it is just garbage and dangerous, but the stuff that is dangerous and may not be garbage maybe somebody's personal property we hang on to. We are going to transfer that stuff over to our property office for disposal so that it is all documented. Some of the stuff we had around is because we do use it for training purposes to show new coming officers what they might see out there as far as taking stuff off, but we sort of cleaned that up as well.

Mr. Telano continued by stating that during the course of the audit there was the lack of use of the HHC custom-built Hospital Police Incident Reporting system and asked them if they were now utilizing it.

Mr. Sweeney responded yes, that that was bad timing. We had just gotten it and there was a bit of a learning curve. A lot of folks were not used to using the Group-wise, so we have been training them and it is working much better.

Mr. Telano moved on to the next audit regarding nursing employment agencies at Coler and Bellevue and stated that it should be noted that this was not an audit as much as it was a request by the Chief Financial Officers at both sites. He asked the representatives to approach the table and introduce themselves. They introduced themselves as follows: Aaron Cohen, Chief Financial Officer of the South Manhattan Network; Robert Hughes, Senior Executive Director of Coler and Henry J. Carter; Manuela Brito, Chief Financial Officer of Coler and Carter; Leah Matias, Chief Nurse of Coler and Carter.

Mr. Telano stated that the objective of this audit was to ascertain if nurses who work for both HHC and employment agencies, they are called recycled nurses, were not being paid by both parties for the same hours worked. At Coler we tested 12 recycled nurses and we found that 10 were paid for overlapping hours, and at Bellevue we reviewed about 50% of the sample. There were over 80 recycled nurses, we reviewed 43 and there were only 6 in which they were double paid. We also found some issues in which log sheets were missing and one or two instances in which people were overpaid for a certain number of hours.

Mr. Cohen said that we became aware that there problems and we called Mr. Telano and his folks to come in and they did a very thorough review. Some of the problems that we had discovered they obviously agreed with, and they made a series of recommendations and we agreed with all of the recommendations that they made and we are in the process of implementing all the recommendations. We are very pleased, if one can be pleased about something like this, in terms of them coming in and sort of reinforcing what we saw was happening and coming up with a very useful, helpful report, and we also appreciate the comment at the very end of the audit that the Nursing Director has been very helpful in making changes to make sure that this does not happen. We should mention that this is a consolidated function. Payroll is a consolidated function in the South Manhattan Network. We are physically located at Bellevue for all of the facilities in the network. The timekeepers are at the individual facilities.

Mr. Hughes commented that Mr. Cohen summed it up as far as how this unfolded and Mr. Telano's office had been requested to come in. We have locally at Coler and Carter put a moratorium on using recycled nurses to do overtime. They are not able to do agency, as a way to prevent this from recurring again until we can take the time and put into place a process, a system that will give us the safeguards to prevent this type of abuse from happening again.

Mrs. Bolus said that the one I have the most problem with was the Bellevue nurse who was suspended without pay and yet actually worked that day – could not understand that one.

Mr. Cohen said that it is a significant problem, and we have put things in place with Nursing so that it cannot happen again.

Mr. Telano continued with the last audit which is at Coler, Employee Salary Changes. Overall the findings have to do with record-keeping deficiencies and a lack of a verification process, and as a result, employees were sometimes overpaid or underpaid and sometimes when they were doubled paid, it was not reversed on a timely basis. We also found some inefficiencies in the manner in which they enter items into PeopleSoft, and we also noted that personnel requisition forms were not always fully approved by the required individuals.

Mr. Cohen stated that the first finding has to do with duplicate payments of employees and it is a little bit misleading. When an employee first comes on to the payroll system, sometimes it takes a few payroll cycles, and as a result, we issue advanced checks. What is supposed to happen is once a person gets on payroll, you are supposed to eventually deduct what they have already been paid. In this case that was not happening as timely as it should have been happening. Eventually it was, it is not that it does not get done. It just should be done sooner as opposed to later. The other issue relates to the fact that there were some errors made, and the recommendation by Internal Audits is that we use a scanner; we have a scanner at Bellevue, but not at Coler. Three years ago we requested from the Contract Review Committee that we wanted additional scanners and we were turned down twice. We will bring Mr. Telano to the next meeting of the Contract Review Committee. The scanner is important because there are too many manual things happening in this process. Once you have a scanner, then the manual things that you have to do are much more limited. In the interim we are now bringing the Coler time sheets to Bellevue to be scanned to make this work better. Our network has the most employees, which is why we need additional scanners.

Mr. Page asked how many scanners are you talking about? Mr. Cohen responded that we have one right now. We asked for two more and we were turned down.

Mr. Page asked if this kind of thing you buy from your local store on Broadway. Mr. Cohen answered that it is a bigger deal than that. It is one for HHC's payroll system and probably each network has one.

Mr. Page asked if it is literally wired into the payroll system? Mr. Cohen answered that that is correct.

Mr. Martin stated that he was not aware that they had come and he will speak to the Senior Vice President of the network to make sure that happens.

Mr. Telano then continued and stated that on page nine of my briefing is the audits we are currently working, and on page ten is the status of our follow-up audits and if there are no further comments or questions, I conclude my presentation.

Corporate Compliance Update

Mr. McNulty greeted everyone and began his update on page three, Compliance Program Certification. Under the Social Services Law and its implemented regulations, HHC is required to annually certify, establish and maintain an effective corporate compliance program aimed at detecting fraud, waste and abuse and to put in place a system of controls to deter and detect fraudulent and criminal conduct. To be an effective compliance program, there are seven key core areas that the compliance program must cover and those are billings, payments, medical necessity and quality of care, corporate governance, mandatory reporting, such as overpayments, credentialing and other risk areas that are or should be with due diligence identified by HHC.

The effective compliance program also has eight elements, and they are the development of written policies and procedures on corporate compliance issues that include a code of conduct and a code of ethics, the designation of a chief corporate compliance officer, the development of a training and education program on compliance issues, the establishment of direct communication lines between the corporate compliance officer and the workforce members throughout the organizations including the establishment of a toll-free hotline, the implementation of a system designated to routinely identify risks, the establishment of a system to respond to compliance issues as they are identified, and the creation of a policy that prohibits the intimidation or retaliation of individuals who participate in the compliance program in good faith.

What is a certification program? Every year the Office of Corporate Compliance has to certify through the Office of the Medicaid Inspector General's website that there is an effective corporate compliance program. That certification is actually done by the President and Chief Executive of the Corporation, Dr. Raju, and at the end of this month, we will be performing that certification. We have to keep documentation that we meet the eight elements, and those eight elements have to be certified specifically as part of the certification, and we may be audited within the Office of the Medicaid Inspector General. They generally audit a handful of hospitals throughout the state every year, so we keep documentation that we satisfy all the elements.

Mr. McNulty continued to page four, this is a follow-up and an update. At the last Audit Committee meeting we reported that there was a data breach at the East New York Diagnostic Treatment Center. This occurred when medical records were stored in an employee garage in East New York and these records came from five previously closed clinics. We provided breach notification to the 10, 058 affected patients. We also notified the Office of Civil Rights of the United States Department of Health and Human services. We provided notice of the breach on our website, and we also provided notice to major media outlets throughout New York State. The cost of the breach to provide patient notification and credit monitoring and identity theft services to all affected patients is \$53, 376.

Mrs. Bolus asked who that is charged to? Mr. McNulty responded that it comes from Office of Corporate Compliance budget.

Mrs. Bolus asked that if the breach occurred at East New York, why is it then you have to pay for it. Mr. McNulty answered that historically we handle the data-breach vendors, and therefore we respond to data breach and we make the evaluation of the types

of services that have to be provided to the patient because it is not every HIPAA incident that results in actual breach that we would have to provide these notifications, so historically it is budgeted every year that we have a certain amount of money allocated to respond to data breaches.

Mr. Page asked what is our obligation to maintain records when we close? Mr. McNulty said that when you close a clinic, you have to establish a facility closure plan with the Department of Health, and the Department of Health outlines where those records should go and how they should be stored. In this particular process, that was not followed when this facility closed. We have to store depending on the type of records. If a record is related to a minor, we have to keep them until the minor is 21 years old. If it is a record pertaining to any other patient, we have to keep it six years. If it is a record that was dealing with the billing of Medicaid or Medicare, we have to keep it for ten years.

Mr. Russo that generally, the closure plan focuses on two things: one, transition of patients to another setting and two, the maintenance of records.

Mr. McNulty continued by stating that what we are doing in addition to the closure plan is we have developed a procedure that the facility executive directors must now follow. That procedure should be coming out by the end of the month, and it designates a specific person who is going to be responsible to make sure the records get from point A to point B. It either goes through the facility medical records department or it goes to our offsite vendor, City Storage. I am personally visiting all of the diagnostic treatment centers, in the past month I have already visited Gouverneur, Renaissance and Belvis and did a walkthrough of the medical records departments along with our outside vendor Tekmark Global Solutions to make sure there are not records of this nature that are valid.

Mr. McNulty moved on to the next item Compliance Reporting Index for the Third Quarter of Calendar Year 2014. For the third quarter, July 1 to September 30, 2014, there were 110 compliance-based reports. One was classified as a Priority A report, 51 were Priority B reports and 58 were Priority C reports. Of the 110 reports, 55 were received by my office through an anonymous toll-free compliance hotline. We also received 19 through e-mails, and 11 were through face to face and 11 were received directly through telephone call to the Office of Corporate Compliance. The difference categories of complaints that we received, the majority, 36 or 32% pertain to policy and process integrity, mainly violation of corporate Ops or violations of statutes and regulations.

Mr. McNulty continued on to section IV, the Privacy Reporting Index for the Third Quarter, we received 29 incidents reported through the HIPAA Complaint Tracking System. Out of those, 12 were found to be actual violations of the HHC HIPAA Privacy Operating Procedures and 13 were found not to be in violation. Out of the 12 that were found to be violations, 3 were determined to be breaches of protected health information which I will go into detail in the executive session. One of those breaches was the East New York breach that we discussed earlier.

Mr. McNulty said that on page six we have no reports of excluded providers since the last time the Audit Committee convened on October 2, 2014. He then stated that that concludes his report.

Executive Session

Mrs. Bolus stated that they are back from the Executive Session; they discussed matters that were confidential and related to patient care and quality assurance as well as ongoing investigations.

Capital Committee – December 4, 2014

As reported by Josephine Bolus, RN on behalf of Ms. Emily Youssouf

Senior Assistant Vice President's Report

Roslyn Weinstein, Senior Assistant Vice President, Office of the President, stated that the meeting agenda included two (2) lease agreements for the Queens Health Network and a power point presentation about the Corporation's energy program. She advised that expectation would be to have the energy team present to the Committee twice a year.

Ms. Weinstein noted that it was the last Capital Committee meeting of the year and therefore reviewed some accomplishments over the course of 2014. The Capital Committee oversaw the purchase of 70 ambulances for the City, approved space for legal services at various Corporation facilities, extended primary care throughout Network communities by approving a number of leases, built out 241,000 square-feet of space, moved into emergency rooms at Lincoln and Harlem, provided optometry space at Kings County Hospital, approved two (2) 99 year leases for housing via CAMBA at Draper Hall, and began construction on the Ida Israel project. Ms. Weinstein thanked Ms. Youssouf, Mrs. Bolus and Mr. Page for helping to provide a framework for Corporate construction projects, ensuring that HHC continue to thoroughly review construction projects to ensure they are in scope, on budget and on time. She stated that there would be \$1.6 billion of FEMA funding coming to the Corporation and a request for \$350

million in capital for the Delivery System Reform Incentive Payment (DSRIP) process, and she was confident that the Corporation would be successful in utilizing those funds.

That concluded Ms. Weinstein's report.

Action Items:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year lease extension agreement with LSS Leasing Limited Liability Company (the "Landlord") for 5,120 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Women's Medical Center (the "Center"), operated by Elmhurst Hospital Center (the "Facility") at an initial rent of \$225,280 per year or approximately \$44 per square foot to increase at a rate of 2.75% per year for a five year total of \$1,190,079.

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Overtenant") to execute a five year sublease agreement with Pediatric Specialties of Queens (the "Subtenant") for 2,560 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Subtenant's pediatric program at an initial rent of \$112,640 per year or approximately \$44 per square foot to increase at a rate of 2.75% per year for a five year total of \$595,040.

Chris Constantino, Senior Vice President, Queens Health Network, read the resolutions into the record.

Mr. Constantino explained that the program began operations approximately 16 years ago with Elmhurst Hospital handling the Women's Health portion of service and Pediatric Specialties handling pediatric services. He noted that most patients were risk-plan patient, so benefits were seen from that as well as from deliveries. He added that patients from the clinic site frequently visit Elmhurst Hospital when needing specialty services.

There being no further questions or comments, the Committee Chair offered the matters for a Committee vote.

On motion by the Chair, the Committee approved the resolutions for the full Board's consideration.

Information Items:

Project Status Reports

South Manhattan Health Network

- Bellevue Hospital Center: Day Care Center Playground
- Bellevue Hospital Center: C&D Bldg. Elevator Controls Upgrade

Ms. Weinstein advised that the Day Care Center playground project was substantially complete, and the elevator upgrade projects were on schedule for completion in the first quarter of 2015.

Energy Projects Update

Cyril Toussaint, Director, Office of Facilities Development, narrated a Power Point presentation outlining progress and future plans for reaching the Corporation's energy benchmarks and the City's initiatives. Mr. Toussaint was joined by Ruby Cruz, Energy Manager, and Marcus Lewis, Energy Analyst.

Mr. Toussaint explained that this status update would inform of the goals of the energy master plan and the next steps outlined.

He noted that in September of 2013, New York City committed to reduce citywide Greenhouse Gas (GHG) emissions 80% below 2005 levels by the year 2050, and to put New York City on that path, a comprehensive, 10-year plan to address energy used in NYC was released. The plan, called "One City: Built to Last – Transforming New York City's Buildings for a Low Carbon Future", set interim targets to reduce emissions by 35% by the year 2025. Another 45% reduction would be expected in the following 25 years.

Mr. Toussaint advised that in 2007 the City had released "PlaNYC", a comprehensive set of strategies for a sustainable future that included a goal to reduce emissions by 30% by the year 2030. "One City: Built to Last" does not replace that plan, it extends on it.

As of the end of 2014, the Corporation has shown a decrease of 9.34% in emissions over 2006 levels. While that may be a ways from the 35% reduction by 2025 there are projects underway at Elmhurst and Metropolitan Hospitals, and projects in design at Harlem, Woodhull and Kings County Hospitals. The completion of these projects is anticipated to bring the Corporation much closer to targets.

Mr. Toussaint explained that a dip shown on a graph of progress was the result of the temporary closure of two facilities (Coney Island and Bellevue Hospitals) as a result of Super-storm Sandy.

Several items to be completed Corporate wide by 2019 include lighting upgrades, and upgrades to heating and cooling systems.

Mr. Toussaint outlined completed accomplishments. At Coney Island Hospital new dual fuel boilers were in operation and windows were replaced, which resulted in annual savings of \$1.5 million dollars, commencing in FY 2013. Additionally, the facility reduced its GHG emissions by more than 7,000 tons CO₂ per year, representing a 36% reduction over 2006 levels for that facility.

Mark Page asked what level the boilers were at. Mr. Toussaint said they met the 100 year flood plan levels, installed on a 13 foot above sea level platform. Mr. Page asked if the savings that were reached at Coney Island Hospital were comparable to improvement effects that would be seen at other facilities undergoing energy projects or whether that facility had a particularly poor starting point. Mr. Toussaint explained that the transition to number six (6) fuel oil, and use of the new, more efficient boilers, were part of what made such an impact at Coney and that type of work would be performed at some other facilities, so improvements should be somewhat comparable.

Mrs. Bolus asked if old equipment operated with the new oil. Mr. Toussaint explained that some equipment would need to be upgraded or replaced. Burner replacement would allow for the switch to take place and it would provide the same level of service. Mr. Page noted that money was being spent to make some of these upgrades.

At Metropolitan Hospital the Comprehensive Energy Efficiency Upgrade project was 40% complete. At Elmhurst Hospital Center, construction was in progress, approximately 45% complete. Completion of both projects was anticipated for completion in December of 2015. Changing boilers at both facilities will allow for dual fuel use, enabling a switch from natural gas to fuel.

Mr. Page asked if it cost a lot of money to maintain the ability to burn oil even though the majority of the time a facility may run on natural gas. Louis Iglhaut, Acting Assistant Vice President, Office of Facilities Development said that dual fuel boilers are very common place now and they do allow for a greater chance of meeting goals and lowering energy usage costs. Mr. Page asked if the costs would be less if allowing for interruption when needed or what the balance is versus the savings. Mr. Iglhaut explained that when facilities had completed boiler commission and upgrade projects, then participation in the demand response program would be an option, which allows for switching to generators during summer months to lower costs. Jeremy Berman, Deputy General Counsel, Legal Affairs, added that there were some costs associated with the projects and with additional equipment but dual fuel is the industry standard.

Mr. Page asked if the facilities lease the temporary boilers. Mr. Toussaint said yes, that was part of the package with NYPA.

Mr. Page asked if a new building were being constructed, what would be the preferred method of heating, steam or hot water. Mr. Iglhaut said he would recommend using a medium pressure steam because hospitals need steam for various uses.

Mr. Toussaint noted that the Office of Facilities Development (OFD) had applied for an approximately \$28 million grant of PlaNYC funding for specific projects under the Accelerated Conservation and Efficiency (ACE) program. The facilities that received funds from that grant were: Woodhull, which received \$7.9 million; Harlem Hospital center, which received \$10 million; and Kings County Hospital Center, which also received \$10 million. Although the projects will cost slightly more than the funds received the Corporation has worked with the Office of Management and Budget (OMB) to secure additional funds; \$1.5 million for Woodhull; \$2.7 million for Kings; and, \$600,000 for Harlem. The New York Power Authority (NYPA) and OFD were in process of reviewing bids for the Woodhull projects, and design phase work has begun at Harlem and Kings. Once design is completed and projects are bid then they will be brought before the Capital Committee for approval.

Mr. Page asked if NYPA were related to these projects and whether they provided funding. Mr. Toussaint said yes, they are involved in all the projects and are providing funding for the two projects under construction.

Next steps for energy management plan included establishing a Corporate Energy Committee, which will report to the Capital Committee every six (6) months, implementation of energy conservation measures [such as sub-metering, lighting sensors, an upgraded Building Management System (BMS)], conducting energy audits at each major facility (7 have been completed with NYPA, and grant money has been received to perform one at Bellevue), providing energy efficiency training to facility personnel, annual update of benchmark and emissions inventory, and promotion of Demand Response Program Participation throughout the Corporation.

Finance Committee – December 9, 2014
As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Marlene Zurack stated that FY 15 began with an open cash balance of approximately 18 days of cash on hand (COH) compared to the current level of 13 days. However, based on the projected receipt of DSH and UPL payments before the end of the current FY 15, HHC is expected to end the year with 35 days of COH. The expected payments include \$200 million in DSH funding by February 2015 and \$1.3 billion in outpatient and inpatient UPL payments by April 2015. It is important to note that these payments are pending the review and approval of CMS that is currently underway.

In response to questions raised by Mr. Rosen and Mr. Page regarding the approval of those payments by CMS and the month those payments are expected, Ms. Zurack stated that the State has requested approval from CMS of the \$200 million expected in February 2015 and the April 2015 date is based on the required change in the State law which is expected to come as part of the State budget at that time.

Mr. Rosen asked if the change in State law has to happen in the legislative session beginning in January 2015 to which Ms. Zurack stated that the pre-work is now underway but that it is expected in January 2015.

Mrs. Bolus asked if any opposition was expected. Ms. Zurack stated that as of now there is none.

Ms. Zurack moving to the next item which addressed the NYC Budget in which the November Plan was issued by the City that included significant funding for HHC relative to collective bargaining (CB) as follows: \$127 million in FY 15; \$68 million in FY 16; \$112 million in FY 17; \$127 million in FY 18 and \$132 million in FY 19. These allocations will fund the full cost of the CB COLA adjustments net of the health insurance savings. In addition, HHC was allocated \$20 million for EBOLA costs and \$5 million for Hands-Up Guns Down. As part of the January 2015 Plan, agencies are required to submit their administrative savings program. HHC Finance has prepared a narrative for Dr. Raju's review and submission to the Mayor's office. The narrative was shared with NYC OMB reflecting those savings as part of the financial plan which includes \$72 million for revenue cycle improvements; \$75 million for supply chain savings; \$53 million in staff reductions; \$20 million in laboratory savings; \$30 million in FQHC enhanced revenues; \$7 million in 340B savings. These savings were included in HHC financial plan and when the January Plan is release next year a full presentation will be made to this Committee shortly thereafter.

Ms. Zurack stated that the next item on the agenda related to the retirement of a very prominent CFO who has been a part of the HHC finance family for thirty one years and acknowledging the enormous contributions made by Aaron Cohen was particularly noteworthy. Mr. Cohen served as CFO at two facilities but most notably as the CFO at Bellevue Hospital since 1996 and on two occasions as the Acting Senior Vice President for Finance and deputy director of the South Manhattan Network. Mr. Cohen has been a scholar at HHC and lead many efforts in transforming some of the key finance methodologies used by HHC today.

Mr. Cohen thanked Ms. Zurack and the Committee for their acknowledgements adding that as Tom Paxton said in one of his songs "the pleasure was all mine" but as it relates to his tenure the pleasure was mostly his and that it has been a privilege to work at HHC for the last thirty one years. Most endearing was to have been a part of the leadership team at Bellevue for the last eighteen years when the world changed around us with 911 and Bellevue played a major role in some of those changes.

Mr. Rosen on behalf of the Committee congratulated Mr. Cohen on his retirement.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS

Ms. Krista Olson reported that utilization as of October 2014 continued to decline; however, there appeared to be a decrease that might be an indication that the trend is leveling out. Discharges were down by 3.5% since last year for the first time it appeared that the reduction was due to a decline in one-day stays and readmissions. Visits were down by 1.9%; D&TC visits were down by 2.4% compared to last year at 6.5%. Nursing home days remained fairly consistent with last year which is an improvement over the declines last year. Specifically, Henry J. Carter had a decline of 17.6% compared to 25% earlier this fiscal year. This is due to the reduction in beds at the new facility and a slower phase-in of the long term care beds. This is countered by a significant increase at Gouverneur, whereby several new floors were opened with a 64% increase in workload. The ALOS all of the facilities with the exception of Coney Island were below the corporate average. Coney Island's patient population is a contributing factor to its higher LOS. The CMI was up by 2.6% over last year which is consistent with the decline in one-day stays and readmissions.

Mr. Fred Covino continuing with the reporting stated that FTEs were up by 240 since the end of last fiscal year. The details of the increase would be covered in the PS Key Indicators quarterly report later on the agenda. Receipts were \$57 million worse than budget and disbursements were \$21 million over budget for a net year-to-date deficit of \$78 million. A comparison of receipts and disbursements against last year for the same period, receipts were \$29 million less due to the receipt of a \$100 million "risk pool" payments from MetroPlus in October FY 14 that was received this FY 15 in November 2014 which will balance out going forward. That reduction was offset by an increase in Medicare and Medicare managed care over last year due to an increase in the DSH that began last year in October and November; an additional \$26 million due to the City's prepayment of tax levy for the fiscal year. Expenses were \$145 million more than last year for the same period due to an increase in PS by \$100 million for collective bargaining payments for various unionized contract settlements; an increase of \$13 million due to allowances and an increase of 60 FTEs compared to last year. Fringe benefits were \$22 million less than last year due to a retroactive health payment for equalization to the City which is a timing issue compared to payments made last year during this period. This payment will be made at the end of the current fiscal year. OTPS expenses were up by \$35 million due to an increase in pharmaceuticals of \$9

million; utilities up by \$4 million; other purchased services up by \$3 million for new cost associated with hospital medical home, DSRIP and Meaningful use and consulting costs associated with the labs IT related to Cerner and QuadraMed were up by \$13 million. Affiliation expenses were up by \$29 million due to a change in the payment methodology from one payment per month to biweekly payments. There was a \$12 million offset payment for physician UPL which was funneled back and counted as a contract expense but for this FY 15 it will be reflected as a receipt. Bond debt was up by \$2.1 million due to the refinancing of the debt to get a lower interest rate. A comparison of actual versus budget, total receipts were down by \$57 million due to a decrease in workload and PS expenses were \$5 million under budget and OTPS expenses were \$28 million over budget. The reporting was concluded.

PS Key Indicators Report as of October 2014 – FY 2015 First Quarter

Mr. Covino reported that disbursements in comparison to budget were \$5 million less than budget which was due to a slight reduction in the projected increase in FTEs budgeted at 280 compared to 240 for the period. Overtime expenses were under budget by \$2.3 million. A comparison of overtime by major categories, nursing, plant maintenance and all other, there was a total decline of 2.5%. Nurse registry was up by \$7.9 million compared to last year for the same period. The bulk of that increase was due to a change in the payment methodology with the vendor whereby payments are now made within 90 days. Several facilities, Harlem, Lincoln and Metropolitan hospitals have significant lags in payments that are now up to-date including prior year payments. Bellevue was up by \$2.8 million due to an increase in usage relative to the hiring of 53 nurses who are in training. Allowances were up by \$13 million due to a reduction in agency and temporary staffing costs and extended hours for weekend and night coverage. The reporting was concluded.

Medical & Professional Affairs / Information Technology Committee **-December 11, 2014 – As reported by Dr. Vincent Calamia**

CHIEF MEDICAL OFFICER REPORT

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

Accountable Care Organization (HHC ACO)

ACO Clinical Leadership Teams at 18 hospitals, D&TCs, and Nursing Facilities gathered earlier this month to review 2014 population management efforts, exchange best practices, and review end-of-year and 2015 strategic priorities and goals. The group is eager to build upon the success of the ACO's strong 2013 performance in this second performance year, by continuing to focus on high-quality primary care, coordination across the system, and keeping our patients healthy and out of the hospital.

Quality Management leads from across HHC convened for the ACO's 2014 Quality Reporting Kickoff. Building upon successful 2013 efforts, each facility is developing their process and staffing plans for chart review, to be integrated with EMR data under the leadership of IT partners, to fully and accurately report our ACO quality performance.

Managed Care Readiness – Behavioral Health

As the transformation of Behavioral Health services is taking shape, in the context of DSRIP and “Managed Behavioral Health”, the therapeutic role for individuals (peers) who have reached a point in their own recovery to help other consumers through their lived experience is increasingly recognized as important and effective.

As part of HHC further expanding its cadre of these peer counsellors, the Office of Behavioral Health held an event to provide education on opportunities in peer counseling and recovery coaching in Behavioral Health services. Approximately 100 consumers attended the event, which took place at Kings County Hospital Center. The event featured presentations by representatives of DOHMH and Howie the Harp as well as by several HHC Peer Counsellors. Vocational providers, including ACCES-VR, were also on hand, offering materials about specific training and employment programs. Attendees participated in breakout groups designed to elicit concepts and strategies for attaining educational and vocational goals. Consumers expressed tremendous interest and enthusiasm in opportunities to work.

Office of Population Health

Through the Teen Health Improvement Program, we are planning a conference in April of 2015 focusing on models for integrating behavioral health care into pediatric/adolescent primary care. We plan to launch a "YouthHealth" marketing campaign and website in the spring, to raise awareness about the comprehensive services we offer for adolescents.

Other activities include: Partnering with Health Leads, a program which enables physicians to refer patients to help for social needs, i.e. housing, food. We will be relaunching the program in 3 facilities and evaluating the impact. The Fruit and Vegetable Prescription program was featured in a New York Times story by Jane Brody on December 1; to reduce barriers to smoking cessation, we are distributing nicotine replacement therapy to provide at the point of care, and are working with IT to create automated referral to the New York State Quitline thru Quadramed. HHC is partnering with NYU in the re-application for a

Clinical Translational Science Award from NIH. If awarded, the grant will provide funds to support a few research personnel at HHC.

FLU

There is ongoing vaccination of HHC's health care workforce, so far without the declaration of the flu season by NYS DOH. This declaration will trigger the use of masks by all staff who are not able to demonstrate their vaccination status as positive. The committee should also be aware of the recent CDC comments on the number of H3N2 (Infl A) strains that have been pathogenic so far this year, which may not be covered by the current vaccine. These comments in no way reduce the clinical and social imperative for all healthcare workers to be vaccinated against the flu.

DSRIP

HHC is on course to complete its DSRIP application by the December deadline. This will be a robust application with many community partners for our single PPS and its 4 borough hubs. There is an action item on today's agenda, which seeks ratification by the Board for management's actions in undertaking this application, as well as authorization for the use of an existing subsidiary company to undertake a central services role to support the operation of the PPS.

MetroPlus Health Plan, Inc.

Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of November 1, 2014 was 469,070. Breakdown of plan enrollment by line of business is as follows:

Medicaid	395,407
Child Health Plus	12,231
Family Health Plus	5,820
MetroPlus Gold	3,401
Partnership in Care (HIV/SNP)	4,954
Medicare	8,477
MLTC	774
QHP	37,318
SHOP	688

Attached are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans. As FHP membership is rolling into Medicaid, we will continue to see increases in the latter. However, the Medicaid membership increase experienced in the month of November was greater than the transfer (rollover) from FHP (same as in October). We have also seen a slight increase in the Exchange membership.

As you know, the Open Enrollment Period (OEP) started on November 15th. In addition to strategically pricing our products, we have taken numerous important steps in an effort to grow membership. We have been collaborating with HHC facilities in targeting 190,000 HHC self-pay patients who are potentially eligible for insurance, embarked on aggressive advertising and marketing campaigns emphasizing our relationship with HHC, as well as initiated an extensive member retention campaign.

One of the barriers we faced with the new Exchange line of business during last year's open enrollment period and thereafter, was that the State had no mechanism in place to allow us to assign PCPs to members. This led to major customer dissatisfaction and extremely high call volume to our Customer Services department. For the current open enrollment, we have worked on a homegrown solution for MetroPlus staff and HHC HCs whereby they can assign the PCP of the member's choice using the MetroPlus website.

We have also learned from the previous year's experience that our members were looking for easier ways to pay their premiums, select their PCP, view their account information online, etc. We listened to the voice of our members and have therefore adapted our website, improving its functionality, thereby offering all those solutions at the click of a button.

Our Brooklyn community office opened on the first day of Open Enrollment. We have experienced a tremendous volume of walk-ins on the very first day, resulting in over 200 applications.

We have seen a high number of Exchange applicants during the first week of Open Enrollment. There was a total of 2,672 submitted applications, and 96 applications in progress for the period 11/15 thru 11/21/14.

During this first week of Open Enrollment, there were a total of 41,000 transactions and a total of 23,000 membership renewals. As of the date of this report, we cannot tell how many of the above referenced transactions are new members, changes to existing member information, cancellations, etc. I will have more accurate information to report at the next meeting.

As we look back at the first year operating under the new ACA Exchange product, I would like to summarize the year in numbers for this committee. The previous Open Enrollment Period (OEP) started on October 1, 2013, and ended on March 31, 2014. Anyone who enrolled before December 23, 2013, was effectuated as of January 1, 2014. The Exchange membership on January 1, 2014, was 13,025 (3% of total membership) and 27,978 as of April 1, 2014 (215% increase during Open Enrollment) and it represented 6.3% of total membership as of that date. The highest Exchange membership was in May 2014, at 44,311 members. Over the following few months, there have been slight decreases due to member non-payment.

The total membership as of January 1, 2014 was 432,791, representing an increase of almost 12,000 members from December 1, 2013 (an increase of 3% in one month). As of April 1, 2014, our total membership was 444,748 – the majority of members enrolled as follows: 362,939 or 82% in Medicaid and 27,978 or 7% in Exchange. As of this month, Medicaid increased to 84%, and Exchange to 8% of the total of 469,070 (a net increase of approximately 25,000 members – or 6% from December 2013).

As far as the MetroPlus Gold line of business, we have only seen a very small increase in membership over the course of this year (from 3,322 as of YE13 to 3,401 as of November 1, 2014 – an increase of 2%).

On a positive note, I concluded my last report by thanking and congratulating the MetroPlus Communications team for their innovative work that led to MetroPlus' award-winning performance in the 2014 American Health and Wellness Design Awards. I have obtained the award winning materials to share with this committee.

Action Items:

Ratifying the action taken by the New York City Health and Hospitals Corporation (the "Corporation") to (i) submit an application to the New York State Department of Health ("DOH") to participate in the Delivery System Reform Incentive Payment program ("DSRIP") pursuant to which the Corporation will establish a single Performing Provider System (a "PPS") in collaboration with various health care providers (the "Participants"); and

Authorizing the Corporation to (ii) enter into agreements within the PPS structure with those Participants listed on the attached Schedule of Participants designated as "City Wide" and those Participants designated as "Hub-Based" in the attached Schedule of Participants subject to the addition of additional Hub-Based Participants or the removal of some Hub-Based Participants at the discretion of the Corporation President as he determines to be necessary or appropriate to respond to evolving DOH requirements, guidance and regulations, and the Corporation's assessment of the ability of the Hub-Based Participants to perform as required for the DSRIP program; (iii) cause the HHC Assistance Corporation (the "CSO") to provide technical assistance to the PPS in the capacity of a centralized service organization; (iv) nominate from among the officers and senior managers of the Corporation the directors of the CSO provided that the Corporation President shall have the authority to nominate one or more directors of the CSO who are not officers or employees of the Corporation provided further that such outside directors never exceed 25% of the total of CSO directors; (v) enter into such other and further ancillary contracts as are necessary or appropriate to carry out the purposes of the DSRIP program and to ensure the Corporation's successful execution of its DSRIP projects using the structure diagramed in the attached Table of Organization; and

Directing the Corporation to (vi) subject the activities of the CSO under the DSRIP program to the Corporation's compliance and internal audit programs; (vii) requiring that all procurement contracts of the CSO be subject to the procurement rules applicable to the Corporation; and (viii) make regular, periodic reports to the Corporation's Board of the progress of the DSRIP application and the implementation of the DSRIP projects including an overview of all contracts made by either CSO or the Corporation to carry out the DSRIP program.

The resolution was approved for the full Board's consideration.

INFORMATION ITEMS

Michael Keil – Assistant Vice President, IT Service Management Office

EITS Business Continuity Program (ITDR/BCM)

Review (Established 2011). The foundation for a Business Continuity Management program is comprised of several components: Understanding the Operationally Critical Business processes and the IT resources required. Business Impact Analysis (BIA) completed (2011) with 35 critical apps identified. Engaged the ITPMC with Methodology documented and used moving forward in the EPIC implementation. Establishing a DR recovery prioritization chart with Recovery Time Objectives (RTO) & Recovery Point Objectives (RPO). Tiering prioritization for the top 35 clinical applications developed and reviewed/published. Annual review continues as HHC business needs change.

EITS Business Continuity Program (ITDR/BCM)

Establishing a Disaster Recovery (DR) testing methodology to apply repeatable procedures throughout all IT infrastructure.

Standardized DR Guides for QCPR, Application Recovery Plans written for Key applications.

Financial application templates and owner participation, Project Plans written for each exercise event

Conducting periodic tests to ensure the quality of the program meets the needs of the organization.

All eight QCPR domains have been exercised for full Failover and Failback, Financial applications have been exercised on an annual basis. Selected critical ancillary applications have been exercised in preparation for EPIC implementation

All exercises now documented with Project Management Program and Homeland Security Standard forms

Identifying and preparing for the risks and vulnerabilities for recovery at our facilities.

An analysis was done for 2013 and updated to 2014 for Tiers 1 thru Tier 4, the systems are still being tested on worked on.

Target Completion: June 2015

Recovery Plan	Current Status
IT Business Continuity Management Plan	1 / 1
Facility Coordination Plans	7 / 7
Tiered Application Recovery Plans	
2013	28 / 35
Discovered Dependent Plans	110 / 180
2014	
Infrastructure Recovery Plans	5 / 5

Business Continuity Program Next Steps

Develop auditor approved BCM Planning template document

Develop educational strategy for EITS regarding BCM

EITS RISK Management strategy and metrics (Risk and BIA)

Improved Working relationship with HHC OEM on related solutions:

Crisis Management software discovery and deployment (NC4)

SendWordNow Communication software discovery and deployment

Business Continuity Software management (Sustainable Planner – Virtual Corp)

He also touched on the Disaster Recovery Maturity – Self Assessment and Program Time Line.

Strategic Planning Committee – December 9, 2014

As reported by Josephine Bolus, RN

Senior Vice President's Remarks

FEDERAL UPDATE

Lame Duck Session

Members in the House and Senate continue to debate long-term and short-term funding issues for the federal government as the race to the finish line for the Lame Duck session draws to a close on December 12. Members still have to pass a spending measure in order to avoid a government shutdown, slated to begin December 11, if Congress does not act.

Some in Congress seek to pass an Omnibus Bill which would fund the federal government through September 2015. Others, especially some hardline Republicans, want to pass a series of short-term Continuing Resolutions, funding the government for a few months at a time. This strategy is in response to President Obama's recent Immigration Order. Finally there are those Members who wish to combine the best of both worlds and fund most federal agencies through 2015 with the exception of those aspects of the federal government like the Department of Homeland Security (DHS) that deal with immigration and providing visas to the undocumented population described in the President 's recent Executive Order. Thus in Washington speak, they favor a "Cromnibus."

House appropriators have been working for weeks on an omnibus bill that would fund all government agencies for one year, and have stated their preference for going that route and relying on a bipartisan vote to pass the bill. Assembling and ultimately moving a broad year-end spending package will likely need some Democratic support to pass the House and require trade-offs

among appropriators in both parties. Given growing opposition from conservatives, House GOP leaders may need Democratic support to pass the pending “Cromnibus” package as they have on several fiscal deals in recent years.

Senate Appropriations Chairwoman Barbara A. Mikulski said that it’s her intention to be done with the omnibus spending package at the Appropriations Committee level by Friday, December 5, with remaining decisions to be made by leadership. But some conservatives in Congress insist they will not back any deal unless it contains a rider barring the President’s actions. As a result, GOP leaders may need to count on Democratic votes if hard-liners continue their efforts.

Schumer Presses the Fight for Ebola Funds

Senator Charles Schumer held a press conference at Bellevue Hospital on November 16th in an effort to raise awareness and secure federal reimbursement for the City and HHC’s Ebola-related expenses. The Senator called for the creation of an “Ebola Trust Fund” “to reimburse New York City for the \$20+ million spent, of which, \$14+ million was accounted for by HHC. Schumer’s efforts to cast a spotlight on this important issue have begun to pay off because House Republicans have recently agreed to allow some emergency Ebola funding. Now the Senator and his staff are pushing for additional federal monies for hospitals like Bellevue that have incurred expenses by treating Ebola patients. Other hospital associations and national medical groups have rallied around the Ebola funding effort. For example, the American Hospital Association wrote to the Senate appropriators requesting \$500 million for Ebola preparedness funding.

Federally Qualified Health Centers Look Alike (FQHC-LAL)

In mid-November, HHC began to lobby and engage NYC Members of Congress in support of the HHC-Gotham application to become a Federally Qualified Health Center Look Alike. The East New York, Cumberland, Gouverneur, Renaissance, Segundo Belvis-Ruiz and Morrisania Diagnostic and Treatment centers are located in the Congressional Districts of Reps. Rangel, Jeffries, Serrano and Velazquez. HHC has also enlisted New York Senators Schumer and Gillibrand to weigh in with HHS Secretary Sylvia Burwell and HRSA Administrator Mary Wakefield. Beginning in December 2012, HRSA staff has twice denied HHC-Gotham’s application for unwarranted and questionable elements.

President Obama’s Executive Actions on Immigration

On November 20, the President Obama’s Immigration Accountability Executive Actions were released during a national television address. They were designed to will help secure the border and hold nearly 5 million undocumented immigrants accountable. President Obama indicated that he was acting within his legal authority. Republicans in Congress immediately disagreed with that assessment and vowed to struggle with the Obama Administration over other issues like funding the federal budget.

The President’s executive actions will crack down on illegal immigration at the border, prioritize deporting felons not families, and require certain undocumented immigrants to pass a criminal background check and pay their fair share of taxes as they register to temporarily stay in the U.S. without fear of deportation. For HHC, the President’s executive order will lead to tens of thousands of New York residents becoming eligible for Medicaid coverage in New York. New York’s Medicaid program is required under the 2001 *Aliessa v. Novello* decision to grant Medicaid to any immigrant residing legally in the state. Federal regulations require immigrants to generally be in the United States for 5 years. The result is that those immigrants that will be allowed to register under the President’s actions and stay would be considered Persons Residing under the Color of Law (PRUCAL) and Medicaid eligible in New York. However, the federal government will not contribute its normative 50% match as the eligibility is only through state law. It is unclear how many HHC patients would gain insurance coverage as a result but it will be significant.

STATE UPDATE

Start of the Legislative Session

The 2015 State Legislative Session will kick-off on January 7th when the Governor delivers his annual State of the State Message to a joint session of the Senate and Assembly. Work on the 2015-16 State Budget is already underway with much attention focused on how to spend the projected \$5.1 billion surplus. Because the surplus is derived from one-time settlement payments, State Comptroller Tom DiNapoli and others have urged that it be spent on non-reoccurring expenses. Healthcare associations are advocating for \$1 billion of the surplus to be added to the healthcare Capital Restructuring Financing Program. The Governor must release his Executive Budget proposal by February 1st.

Gottfried to Hold Hearings on Single-Payer Healthcare Legislation

Assembly Health Committee Chair Richard Gottfried is holding a series of six public hearings across the state on his legislation to create a single-payer healthcare system. This bill, known as the New York Health Act, would implement a system of comprehensive, universal health insurance paid for by payroll taxes. The Medicaid program would be subsumed into the New York Health program. Gottfried has carried the legislation for more than twenty years. Senator Bill Perkins co-sponsors the legislation.

CITY UPDATE

Council Approves Leasing of Draper Hall for Development of Low-Income Housing

On December 8, 2014, the City Council voted to approve HHC's proposal to enter into a long term lease for the development of 203 units of housing for low-income elderly and/or disabled individuals in Draper Hall, which is part of the campus of Metropolitan Hospital Center. HHC has worked closely with several City agencies, local elected officials, community representatives and the developer, SKA Marin, on this project. Through the efforts of Speaker Melissa Mark-Viverito, the U.S. Department of Housing and Urban Development (HUD) agreed to a 25% community preference requirement for the units that will be developed. This will ensure that at least (50) apartments that will be developed will be set aside for eligible residents of the community. HUD also agreed to perform a demographic analysis to determine if a higher community preference would be feasible for this project. Additional conditions negotiated by the Speaker include a requirement for NYCHA to conduct targeted outreach to all seniors on the Section 8 waiting list from Community Board 11 in Manhattan and the section of the Speakers District that extends into the Bronx. Lastly, the developer of the project will be required to conduct a coordinated marketing campaign with the assistance of local community based organizations. HHC would like to thank the Speaker and Members of their City Council for approving this project and providing \$2 million in Capital funding as part of the budget agreement adopted in June for Fiscal Year 2015.

Information Item

Presentation: Federal and State Healthcare Trends and Challenges

Dennis Whalen, President, Healthcare Association of New York State

Val Grey, Executive Vice President, Healthcare Association of New York State

Ms. Brown respectively introduced Dennis Whalen, and Val Grey, President and Executive Vice President of the Healthcare Association of New York State (HANYS). Ms. Brown informed the Committee that Ms. Grey had been extremely helpful with HHC's negotiations with North General Hospital to build a new nursing home, the Henry J. Carter Specialty Hospital and Nursing Facility. Ms. Brown invited Mr. Whalen and Ms. Grey to provide an overview of the healthcare trends at the federal and state levels; the potential challenges resulting from the transitioning of leadership post the mid-term elections; and the policy directions and their implications for HHC and the rest of the healthcare community in New York State.

Mr. Whalen thanked Ram Raju, MD, HHC's President, Board members and members of the Strategic Planning Committee for the opportunity to provide a presentation on federal and state level healthcare trends and challenges. Mr. Whalen stated that there was a blizzard of initiatives underway. He explained that there was a dynamic of elemental changes which were not only driven by government reforms at both the state (i.e., DSRIP, SHIP) and federal (value based purchasing) levels, but also changes that were driven by societal behavior such as technology and the demand for convenience. These changes will drive changes in the way payment is going to be made in healthcare and how services will be organized. Moreover, these changes are breaking new grounds in terms of partnerships and relationships among different sectors of the healthcare arena. Mr. Whalen informed the Committee that these issues would be discussed in his presentation and that he would also provide a snapshot of HANYS' perspective on these changes. Mr. Whalen further stated that his presentation would also cover the predicted dynamics in the coming year as well as the ensuing reactions of the hospitals and health systems in New York. Because it is a national trend, as these changes are happening all over the country, it is important to understand how systems are behaving and what it might mean in terms of impact on a system like HHC.

Ms. Grey began her presentation by highlighting the outcomes of the recent elections. She stated that, at the national level, the Republicans swept the Senate as well as Congress. She noted that, as a result of Louisiana run-off results, there were 53 seats in the Senate. She informed the Committee that to get anything done at the federal level 60 seats were needed. Ms. Grey stated that, as we move forward, it was important to remember that Senator Schumer will continue to be a formidable advocate on behalf of the hospitals in New York State that as we move forward. She also reminded the Committee that Senator Schumer had already endorsed the Ebola issue.

Ms. Grey stated that, at the state level, Governor Cuomo was unsurprisingly re-elected. However, she noted that there had been some shifts in terms of his standing. She added that, looking at the map and the counties that the Governor carried, there were big differences across the entire state. The Governor has favorability ratings right now that are the lowest in his term to date. Ms. Grey commented that these factors were worth mentioning because, as we move to another session, the willingness of the legislators to take on certain issues and debate with the Governor oftentimes depended upon his popularity. Ms. Grey stated that there was an opportunity as we move forward for further legislative engagement. Ms. Grey informed the Committee that all eyes are on the State Senate. She added that, although the Republicans had gained the majority, it was a very thin majority. She informed the Committee that Senator Skelos would continue to seek out an arrangement with Senator Klein, who was the head of the Independent Democratic Coalition, to figure out a power sharing agreement. Ms. Grey stated that, while they got a little bit

more leverage than they did the last go round, it was hopeful that something would get worked out. Ms. Grey noted that, as the Republicans do not have that cushion, this arrangement was smart on their part. She noted that, with the Senate being a different party, this provided an opportunity to make changes to proposals that are advanced by the Governor or the Assembly.

Ms. Grey reported on some upcoming events at the federal level as follows:

December 11th

Ms. Grey reported that the first big event would be occurring this week with the need for a Continuing Resolution to keep the government operating. She informed the Committee that, unlike other precedents, the expectation was that there would not be any government shut down. She added that one relied on this vehicle to ensure that there was Ebola funding for designated Ebola hospitals and for the rest of the hospitals across the state that have been preparing to treat, isolate, identify and transfer lots of activities. Ms. Grey commented that she would be remiss not to commend HHC, who stood out as a beacon of that extraordinary and phenomenal work. Ms. Grey added that this was also the season to ensure that legislators' actions do not cause additional harm to the hospital and health care industry.

March

Ms. Grey reported that, at the end of March 2015, the Medicare "Doc Fix" and Medicare extenders would expire. Ms. Grey informed the Committee that if nothing is done, the Medicare doctor rate would decline by 25%. She added that, while it was not the right thing to let happen, "the pay for" (as it called in DC) should not be through reduced funding for the healthcare industry. Ms. Grey also reported that March 31st was also important because the delay of the enforcement of the Two-Midnight Rule was set to expire on that date. Ms. Grey stated that valuable resources were being wasted by the healthcare industry to fight the audits. She commented that, because these audits were neither helpful nor meaningful, especially looking at the appeals, HANYS together with the Greater New York Hospital Association had filed a lawsuit. She informed the Committee that HANYS would continue to fight at the federal level while at the same time advocating at the state level.

Ms. Grey reported that the top federal issues were the following:

- Protecting Medicare and Medicaid payments
- Medicare Recovery Audit Contractors
- SES Risk Adjustment for Medicare Readmissions
- Disproportionate Share Hospital (DSH)
- 2-Midnight Rule Relief
- Extend Key Expiring Programs/Payments like MDH and LVH
- Improving Meaningful Use Program

Ms. Brown asked Ms. Grey to explain the socio-economic (SES) Risk Adjustment for Medicare Readmissions and Medicare Dependent Hospital (MDH) and Low Volume Hospital (LVH).

Ms. Grey stated that, for Medicare readmissions, it has long been argued that it was not enough to just adjust for acuity for health conditions. She stated that there was so much more that goes into the ability of hospitals and health systems to help patients and prevent readmissions. As such, consideration is given to the socio-economic factors while trying to put them into the equation to reflect the impact that poverty and other issues have on health outcomes. Ms. Grey explained that the MDH and LVH were programs to provide payments to offset some of the small volumes that rural or small hospitals have when they are very dependent on Medicare. She informed the Committee that these expiring programs were more of an upstate rather than a downstate/borough issue.

Ms. Grey stated that the major state issues were the following:

- American Health Planning Association/CON Web Sites
- Medical Malpractice
- Mandatory Nurse Staffing Ratios
- State Budget

Ms. Grey informed the Committee that the Health Planning issue was expected to resurface next session. She stated that the Governor's Office had proposed fairly rigorous but yet not well defined regional health improvement collaboratives. Ms. Grey

added that a major concern with the prior proposals was the potential of allowing regional planning entities to have a role in the Certificate of Need (CON) process. She explained that the collaboratives caused a lot of concern because the CON process was already a lengthy and tough process and hospitals and health systems have difficulty competing with other providers as they do not have to go through a similar process.

Ms. Grey reported that there were several damaging medical malpractice proposals out there. She stated that HANYS would be fighting against them. However, if these proposals move forward they would have significant impacts on HHC.

Ms. Grey reported that Mandatory Nurse Staffing Ratios was another hot topic that would be at the center of the discussions moving forward. Ms. Grey invited Committee members to take a look at California and stressed that the workforce was a key component of the care delivered. However, Ms. Grey stated that there was no evidence that indicated that quality improved with ratios, arbitrary ratios was not the way to go.

Ms. Grey stated that the State Budget would provide a huge opportunity. She reported that the budget included a \$5.1 billion surplus going forward into next year. The Independent Democrat Conference (IDC) released their ideas on December 8, 2014, and they were all about infrastructure. Ms. Grey repeated a common statement used by elected officials, which states, "a onetime surplus should be used for one time needs." Ms. Grey stated that HANYS had recognized that there was an urgency to talk about the necessity to invest more in healthcare. Ms. Grey explained that, upon looking at the State's capital needs and the reforms that are being implemented, the available resources are far from sufficient. As an example, Ms. Grey referred to the Delivery System Reform Incentive Payment Program (DSRIP) which would disburse \$1.2 billion in capital over five years. Ms. Grey commented that, while this amount appeared to be a lot of money, once it is duly allocated, it would not be adequate to support the expected reforms that were afoot. Ms. Grey stated that legislators need to be reminded that DSRIP funds are not guaranteed and that they would be collected over time based on providers' performance. Ms. Grey informed the Committee that there had been some discussions for additional capital funding because the current funding is not enough. She stated that additional transition funding was needed in that and other areas. Ms. Grey referred to the Vital Access Provider (VAP) Program through which the State of New York would assist financially challenged providers that are vitally needed in their communities as they seek to attain stability. Additionally, Ms. Grey stated that there were a number of other priorities.

Ms. Brown commented that the State Budget included a cap on Medicaid spending. She stated that she would like to know more about the cap as the next session draws near. Ms. Grey responded that one of the priorities was first and foremost, "keep your promises." Ms. Grey added that this past year, HANYS and other healthcare advocacy institutions had worked hard to restore the across board two percent (2%) Medicaid rate cut. Ms. Grey also noted that the Global Cap was a big concern and was also another promise the State needs to keep. Ms. Grey explained that oftentimes there are movements of monies outside of that cap to fund other things while they should have been really retained in healthcare. She added that one of those risks is the Office for People with Developmental Disabilities' (OPWDD) audit. Ms. Grey stated that significant funding is at risk to fight the audit at the federal level; however, if not successful, OPWDD may try to come back to the Global Cap.

Ms. Grey informed the Committee that there were some concerns about what form of Medicaid funding would evolve from the Immigration Order that the President issued and that HANYS was working hard on that risky issue. Moreover, Ms. Grey stated that, as the Affordable Care Act (ACA) moved through the process, there would be more savings that should be put back into the healthcare industry. Ms. Grey reminded the Committee of the Shared Saving agreement which basically means that, if spending levels remained under the expected spending limit, (i.e., the cap) that delta would get shared with everyone. She commented that HANYS was working to ensure that happens.

Ms. Grey stated that, in addition to Mr. Whalen's blizzard statement the issues highlighted above, were only a sampling of the current. She added that there were other state policy initiatives. Other policy issues include the waiver, the exchange, the all payer database and the continuation of the Medicaid Redesign Team (MRT) initiatives. Ms. Grey added that there were some really important transitions from fee-for-service to managed care, for some of the most vulnerable populations. These transitions are major and happening now including SHIP and the big data portal that the state has created.

Ms. Grey stated that DSRIP is new and is constantly evolving. Each DSRIP is unique. Therefore, New York State has its own special version of DSRIP. Ms. Grey added that, while we are grateful for the waiver, it was important to identify some of the major DSRIP issues and continue to work with the state on them.

These issues include:

- *Governance*

DSRIP applications are due in less than two weeks. Governance remains a big issue as there are some tough elements to sort through especially as dance partners are changing every day. Ms. Grey added that HANYS had worked very hard to ensure that the state has allowed for some flexibility.

- *The Bridge*

DSRIP is about reducing avoidable hospitalizations, collaborations and doing all of the right things, while at the same time ensuring that safety net hospitals are stabilized as all these major changes happen. Ms. Grey explained that, the idea is that if everything works out as planned, on April 1, 2015, DSRIP funds would flow and these bridge funds will be made available for safety net hospitals. Ms. Grey commented that not much would happen on April 1st. Therefore, HANYS remains concerned in seeking additional transitional funds. Ms. Brown clarified that, as hospitals are making those required DSRIP transformations, such as reducing admissions and readmissions, there would be a revenue stream that diminishes for those very same hospitals that are now in financial distress. The issues are how those performance-based payments would be reconciled with a significant reduction in some of the foundational reimbursements for those hospitals; and how DSRIP funding would help to bridge that transformation. Ms. Grey added that PPSs are having a difficult conversation right now because the stabilization of safety net hospitals and lost revenue are important factors for DSRIP. Mr. Whalen added that there was a math challenge here.

Mr. Whalen explained that the DSRIP dollars that flow to a PPS are to:

1. Provide some cushion - as readmissions and admissions drop, the pathway is smoothed
2. Support other distressed facility members of the PPS
3. Get some revenue for the services they provide

Mr. Whalen explained that there is a governance challenge and a front end challenge. As such, front end dollars will be needed to set up the systems and mount the services to build the coordinating steps. HANYS' comments to the state on the bridge issue were that there is not enough money to do all these things and that it does not flow that way. Whether or not the system is performance-based, there should be some front infusion of dollars, and then the focus should be hitting the benchmark. Mr. Whalen emphasized that facility members were expecting to obtain some revenue as part of the DSRIP process. Thus, there is a need to make more investments. Mr. Whalen stated that in addition to the federal dollars, bridge and gap filling dollars were also needed to make this work.

Mrs. Bolus asked Mr. Whalen what is being done to help those hospitals that are providing the bulk of the uncompensated care for uninsured New Yorkers to get the lion share of DSRIP funding and to ensure that there would be sufficient funds to help them. Mr. Whalen answered that this was a major portion of the challenge because DSRIP has made, in some ways, Medicaid more attractive. He added that there are health care systems now that are getting into the game of population health and focusing on Medicaid beneficiaries; specifically, to provide services in various ways such as through partnerships. However, there are a lot more institutions and systems where Medicaid is higher on their priority list or radar screen. Mr. Whalen stressed that, for HANYS, the challenge is to make sure that the state understands that this is a long term commitment. It just cannot be about getting through DSRIP and realizing a revenue stream. In addition, some of the issues are about geography. So, while PPSs may form through partnerships, it does not necessarily mean that well-off institutions or institutions that prior to DSRIP that did not have a significant role in delivering services to the Medicaid population, can replace the long term commitment and mission of those who have served these populations as part of their core set of services and commitment. Mr. Whalen affirmed that the state gets that. He added that the problem to some degree was that this waiver is a combination of a couple of bad things including:

1. The state's anxiety in getting the dollars – the application occurred at a point and time when the Governor had just closed a \$10 billion deficit and there were not dollars to invest in healthcare. Therefore, the waiver was viewed as an avenue to bring federal dollars to the state.
2. The Federal Government mistrusts New York when it comes to Medicaid. New York is aggressive about making use of these dollars because there is a substantial need for those dollars to serve the Medicaid beneficiaries. However, Mr. Whalen noted that the result of that has been intractability on the part of the federal government. He explained that, when the state goes and makes reasonable requests for flexibility, the federal answer is always no because it is thought that the state is trying to pull something. Mr. Whalen commented that we need to make sure that as these PPSs get put together with multiple facilities and systems, that we preserve, recognize and support the role of the safety net institutions because that's who has served Medicaid for so long and so superbly. Ms. Whalen reiterated that some of it is about geography and access where other institutions would not normally decide to go, preserve, and provide services. That is a key part of HANYS' message.

3. MMC Role and Value-Based Program

Ms. Grey stated that for strategic planning, it is important to think about the multi-year effect and questions such as what is the Medicaid Managed Care Role going forward. Ms. Grey stated that DSRIP has a goal of reaching 90% of payments being value-based. She clarified for the Committee members that value-based is not traditional fee-for-service. She noted that value-based purchasing is a common theme not only just in DSRIP, but also in the Medicaid side of the world but also on the non-Medicaid side of the State Health Innovation Plan (SHIP). Ms. Grey noted that a lot are already happening on the commercial world on this.

4. Meaningful Regulatory Reform

Ms. Grey stated that while everything seems to be positive and the Feds are working on allowing for meaningful DSRIP waivers, HANYS is pushing for a much more robust and long term waiver.

5. Anti-Trust

There is a lot of debate about anti-trust. She added that despite the certificate of public advantage, (COPA), the Accountable Care Organization (ACO) regulations, and the exchanges between the State and the State Agency, the bottom line is the Feds can tromp the State. Therefore, HANYS is urging the state to talk to the Feds. She explained that the last thing that could happen is to have that great system unraveled before the Federal Justice Department when the plans feel uncomfortable. Ms. Grey warned Committee members that there is already a 13-page document written outlining some concerns.

Mr. Whalen added that other key DSRIP issues included timing, intersection with other Initiatives, end view, government consistency and shared agenda, adjustment coordination and the federal view.

Ms. Grey reported on the New York State Health Innovation Plan (SHIP). She described the SHIP program as follows:

- State entry into commercial market
- Mirror image of DSRIP for non-Medicaid
- Same goals for avoidable hospitalizations
- CMMI & DOH concept – actions will reduce healthcare spending in commercial market that can be re-invested via health plans for primary care. Ms. Brown asked who would make the decision for reinvestment and how these reinvestments would occur. Ms. Grey's stated that, like DSRIP, it will be figured out along the way. It is believed that the Department of Financial Services (DFS), the rate setting authority, has a lever to push the plans to pay for advanced primary care. Since HHC has a lot of clinics and provides a lot of primary care services, it would be extremely helpful to HHC if those plans indeed agree to share it. Ms. Grey stated that, thinking through the next few years for HHC, the magnitude of the change that is occurring across the entire spectrum, all at the same time, is also part of the challenge.
- Decision on grant expected soon -- Ms. Grey reported that the state had applied for a grant to CMMI for the SHIP program. Ms. Grey noted that grant amount is for \$100 million, which is almost immaterial in the big world of New York State spending.
- DOH may pursue elements regardless -- Ms. Grey informed the Committee that it was the state's vision and that the state would try to pursue the elements regardless of whether or not a grant is awarded
- No transition funding for hospital inpatient decline

Ms. Grey shared with the Committee a graphic from the New York State Health Innovation plan showing how SHIP and Medicaid had different constituencies, different funding, but share the same goals, which are described as the following:

1. Reduce preventable hospitalizations by 25% in 5 years
2. Transform 80% of provider payment to value based (not fee-for-service)
3. Investment in HIT: APD & SHIN-NY
4. Population Health Improvement Projects (PHIPs) to:
 - a. Align with Prevention Agenda
 - b. Promote and Advanced Primary Care Model
5. Evolve the Health care workforce

Ms. Grey stated that some of the Key SHIP issues were very similar to those related to DSRIP. They include:

- Commercial market intrusion
- Need reinvestment and "bridge"
- Governance
- Meaningful regulatory reform
- Value-based purchasing
- Ensure flexibility
- Don't stifle innovation
- Intersection with other initiatives
- PHIP scope creep

Mr. Whalen continued the presentation and informed the Committee that he would focus on what institutions and systems are doing in reaction to these changes, and would provide a more global way to think about all these changes. Mr. Whalen stated that these changes were not unique to New York State. Many other states are doing similar initiatives. He also informed the Committee that New York's waiver has been highlighted by the National Governor's Association as the template for future waivers around the country because it brought together the necessary elements of federal Medicaid waivers. Mr. Whalen explained that this is about increasing the value of the health system for healthcare investments. Mr. Whalen described some of the major areas as provided below:

1. Cost

A big set of innovations that are underway to make the system more efficient, some of that is about the theory that, if providers to take on risks through capitated payments or some other mechanism, that would drive efficiency in the system.

2. Payment

Payment should be tied to outcome and incentives should be provided for the right kind of outcome. Health care services should be paid partly on the basis of how well the service is provided. There is a need to be more transparent as people do not understand enough how much a test costs, how much an MRI costs and how they might be responsible for paying some portion of that out of pocket in some ways.

3. Incentivize the way services are organized and provided

People are using their phones to do various things, they want to be able to use their phones to make an appointment with their physicians that same way, they want to go on the phone and find out the best knee replacement at the cheapest cost in their area. Mr. Whalen stated that technology is making the data available to do that. The state and the Federal Government are increasingly interested in collecting this information to say why there is a variation in cost for the same service and to identify if there is a quality difference. Are we getting a better outcome for paying more? The state's all-payer database will collect all the information on the cost side and cross-tab it with quality.

4. Transparency

Mr. Whalen stated that every health system and every provider should simply assume that over the next several years, quality scores and costs are going to be available for anybody and everybody to see. He added that the state is moving in that direction in different ways as everything is getting measured. Mr. Whalen commented that HANYS' concern is that this is an inexact science. Mr. Whalen reported that, originally the state had planned to use the information from the hospital charge master. He noted, however, that there is no relation to reality largely from the hospital charge master with what a patient actually pays. HANYS' concern is that even at its best, the chargemaster could be misleading.

5. Cost Control

Mr. Whalen stated that cost control was a consistent factor with continued downward pressure on reimbursement. The assumption is that providers are not going to get paid more for their services. In fact, the pressure would be the other way around, how do they become more efficient.

6. Quality

Mr. Whalen stated that quality will be a benchmark. There will be an intense focus on quality and outcome.

Mr. Whalen stated that all these issues were swirling now and behind many of them is the theory that hospitals and health systems should be at risk for the payment, which could be through capitation. Mr. Whalen explained that capitation is a payment arrangement for health care service providers. Capitation pays a physician or group of physicians a set amount for each enrolled person who is assigned to them, per period of time. If the physician or group of physicians is able to manage within that set amount and use fewer dollars to achieve the outcome, they are entitled to incentives for delivering quality and well-managed services to their patients. On the hand, when the cost of the services goes above the statistical value assigned to them, they will not receive extra dollars. Mr. Whalen informed the Committee that capitation is happening in various ways in many areas.

Mr. Whalen reported that there has been an emergence of retail medicine in our communities. Convenience stores such as Walgreens and Duane Reade are hosting clinics that are offering services that are highly convenient and fairly inexpensive. Furthermore, Walmart is advertising a \$40 same day appointment for a primary care visit. The question for providers around the country is whether to compete or partner with them.

Mr. Whalen summarized some of the common trends that were highlighted earlier as the following:

- Downward pressure on costs
- Quality and cost measurement
- Transparency
- Payment Reform – Mr. Whalen stated that there has been a lot of talk about population risk. While everybody has their own definition of population risk, Mr. Whalen stated that some of that is being responsible for a community defined by geography in some way, which is a very traditional role for HHC. Some other places are saying that they would be responsible for a population of a specific disease stake such as Type II diabetics in a particular region. Some of it is about employers deciding to go out into the market in new ways and find somebody to contract with for care to their set of individuals. Mr. Whalen explained that the usual way health insurance happened is for employers to go through that process of working with a broker and designing a plan and offering that plan to their employees. He noted that this process is changing for a couple of reasons:
 - Mr. Whalen referred to the North Shore LIJ affiliation with the Cleveland Clinic for cardiac surgery. He explained that the reason that happened was because Walmart decided a year or two ago that any Walmart employee who needed a cardiac by-pass surgery was going to get it at the Cleveland Clinic. A deal was struck with the Cleveland

Clinic for a price and a guarantee on the outcome. North Shore LIJ, realizing the impact of that deal on their system, decided that they could not afford to lose those surgeries. They sought this arrangement with the Cleveland Clinic to partner.

- National employers could segment services by going to the market to find a best price and guarantee (ex. on joint replacements etc.,) or conceivably anything.

Mr. Whalen stated that, considering these changes and the development of the exchanges, including the possibility that private exchanges would come forward as employers worry about getting hit with the Cadillac Tax in 2018; these factors could provide a major changing dynamic for the way patients get connected to healthcare systems. Mr. Whalen shared with the Committee that HANYS was facing a double digit increase for healthcare benefits. He added that this year for the first time HANYS, in a transparent way, had started the high deductible plan with the health savings account as part of their benefit offering. In terms of the exchange, Mr. Whalen noted that consumers are totally price sensitive. He added that individuals are choosing plans that have high co-pays and high deductibles. Mr. Whalen explained that, taking into consideration average family incomes it appears to be almost unaffordable in terms of individuals being able to make those co-pays or meet those deductibles. As such, there are a lot of concerns on the provider side. Mr. Whalen reminded the Committee that the promise of the Affordable Care Act (ACA) was that it was feasible because all patients now come with insurance. Mr. Whalen cautioned that this could create a situation where there is a need to chase the co-pay and the deductible payment and some of the bad debt charity care would likely increase.

Mr. Whalen discussed how to decide to share risks. The question should be, “is it bundling, is it ACO, or is it sharing some upside risks only and not downside risks? Mr. Whalen informed the Committee that he had participated in a Chief Financial Officer (CFO) retreat last August. In attendance were CFOs from Kaiser in California, Presbyterian in New Mexico and two for-profit hospital chains. A member from the audience asked the CFOs what was the plan of their choice and what should the payment model look like. Mr. Whalen stated that interestingly enough, they all answered that they do not know but they were playing in all of them to build their competency for the right skills set to be ready when one plan is chosen. Mr. Whalen stated that another truism is that it is no longer easy to tell who is doing what in health care. He noted that systems, such as North Shore and Montefiore, that are also insurers and that they are also some insurers that are trying to get into the clinical game. In addition, some unions have decided to open primary care operations. Moreover, in Hudson Valley, there is a whole string of private physicians’ specialty practices that have become Accountable Care Organizations (ACOs) and have gotten insurance licenses. Mr. Whalen noted that these lines about whether you are an insurer or a provider of care are getting blurred.

Mr. Whalen informed the Committee that HANYS had spoken to hospitals that have decided to become insurers. North Shore is being the most aggressive with branching into Connecticut and New Jersey. Others are at risk but yet do not want to become an insurer as it is not consistent with their mission. Mr. Whalen added that this will lead to the pathway of cost management decisions rather than care management decisions. Mr. Whalen noted that some places like Montefiore, for example, have invested heavily in care managers. Just like social workers, these managers build a file on each patient. This practice has drastically impacted readmissions and other services that they provide. There are a lot of activities in consolidations and partnerships happening across the City and across the state notably in the Hudson Valley, with lots of New York City providers reaching up into areas that are largely densely populated with good payer-mix.

Mr. Whalen shared with the Committee that, Mike Owen from Citi Group, who specialized in healthcare guilds, had made presentations to HANYS on two occasions. Mr. Whalen asked Mr. Owen what were the characteristics shared by their most successful arrangements. Mr. Owen responded that it was found that the emerging successful models had:

- *Scale and integration* – Consolidation and partnership is about building a population of patients that you are responsible for in certain geographies.
- *Aligned Physicians* – The alignment of physicians with clinical and other staff is important for the transformation of the organization. Everybody needs to participate in the design of this new organization and its goal setting in order to operate as a closely integrated enterprise to succeed.
- *Market essentiality*
- *Leading quality and patient safety*
- *Sophisticated IT with high adoption rates*
- *Highly Efficient cost Structures*
- *Post-Acute Linkages*
- *Progressive Governance and Leadership*

Mr. Whalen concluded his presentation with the following key reminders:

- *Know when to jump . . . but be prepared.* Mr. Whalen stated that the healthcare industry’s existence is a fee-for service environment because a substantial portion of our services is fee-for-service. Therefore, to get ready, providers must ensure that skills set are organized and practiced to be able to move at the appropriate time. Mr. Whalen cautioned that providers must be careful about when the indicators are right to make the move.

- *Every market is unique* – Mr. Whalen reiterated what he always shared with HANYS' members: “do not think just because system X has done something that this is what you should do.” He praised HHC for having a very long history of service to its community and to its patients. His recommendation is to be true to oneself and to really study the numbers for one's market and make the decision on that basis, not on what somebody else has decided to do because it might not be the right answer for you.
- *Most important ingredient is intellectual capacity to manage* – Mr. Whalen stated that, while pieces can be moved around, having the intellectual capacity to manage the enterprise is critical. He noted that this means an investment in talent and training that should be cultivated and supported. He also encouraged the Board to think about the great team at HHC and to protect and support them.
- *“Build, buy, or partner?”* – Mr. Whalen stated for any major undertaking nowadays, the following questions will always come to mind: Do we build that ourselves because our system has those unique aspects – or do we just go out and buy it? Is it available on the market some place or do we get it through a partnership? Does it make sense to partner in some way to bring in the services, or to increase the system's capacity?
- *Grand experiment; change is constant and dynamic* - Mr. Whalen reminded the Committee that no one is certain that all is going to change in the rise of the healthcare costs. He also re-stated that the theory is about controlling that growth line. He shared with the Committee his most common response to individuals about stability: “things will not stabilize and that this challenge will persist overtime.” He added that the change switch is frozen in the “ON” position. Mr. Whalen stated that the right metaphor in order to conceptualize this challenge is that, “these changes are just like ocean waves, they change intensity and speed, lose power and other things; they may sometimes be a little slower than other times, but they do not stop.”
- *Maintain organizational objectivity* – Mr. Whalen stated that the most valuable attribute for an organization to have is objectivity, which is a willingness to examine and re-examine decisions as circumstances change. The environment is so dynamic that, not only will there be a need to worry about changes occurring from the government side but also from every one of the providers as they are also changing the way they do business. Mr. Whalen commented that, often times, organizations do not like the new idea or the idea that may challenge what is being viewed as their deeply held mission. However, he cautioned that the environment is so dynamic that one really has to value this objectivity and willingness to re-examine and keep testing decisions against the new issues and the new circumstances, because things are also changing.

Mrs. Bolus asked Mr. Whalen to clarify the Cadillac Tax rule. Mr. Whalen responded that, in 2018, health plans that cost above a certain threshold would be taxed at 40% of their costs in excess of the limit. Mr. Whalen added that there was a lot to worry about because it does not take much to bump against these thresholds.

Ms. Brown asked about HANYS' work on the expiration of the Charity Care Law. She further inquired about HANYS' plans to ensure that organizations like HHC get a fair outcome. Mr. Whalen responded that talks were ongoing with the state regarding this issue. He added that, not only is it a general concern, it was also federally related. It is a lurking view wiring all of hospitals on a level playing field. He explained that at the federal level this has been playing out for critical hospitals. Mr. Whalen informed the Committee that there are about 12 critical access hospitals in New York and they receive added reimbursement to continue to provide services. However, in some areas of the country, some members of Congress feel that we should get rid of that designation. The idea is, if a hospital is needed in a community, it will get supported by the community. Mr. Whalen pointed out that there were some similar strands of that idea in the Bad Debt/Charity Care argument and it was unclear as to where the Senate was going to land on this question. He reminded the Committee that Senator Kemp Hannon was reasonable and has, in the past, supported the idea that this issue should be re-examined continually and move the percentages. Mr. Whalen stated that HANYS has a traditional position to support the idea of a level playing field. Moreover, HANYS continue to be concerned about the role for safety net institutions and their long term commitment to those communities. He noted that there are just some places where other providers are not going to undertake the necessary set of services to deal with those populations.

Mr. Rosen, Committee Member, asked Mr. Whalen if Concierge Medicine was a new term used in the healthcare industry. Mr. Whalen responded that Concierge Medicine is linked to physicians' practices, although some institutions around the country are also practicing Concierge Medicine. Mr. Whalen defined Concierge Medicine as a customized plan for money that a patient can buy to get special services. He added that it is essentially a premium plan that the patient can buy into and get house calls and other types of services. Mr. Whalen informed the Committee that Presbyterian Health Systems in New Mexico had a service called ICU at home. He explained that, if the patient resides 30 miles away from the hospital and have a certain diagnosis such as Congestive Heart Failure, instead of bringing the patient to the hospital, the bed, telemetry and home care visits are sent to the patient's home along with the services. Mr. Whalen commented that, while Concierge Medicine may not be practical in New York, it shows that there is a willingness to examine the traditional way services are provided. Mr. Whalen added that New York is also behind the times in its willingness to experiment with telemedicine. He explained that telemedicine is only used in New York with psych services, where psychiatrists may go back to their institutions and conduct an interview with the patient with the help of an iPad.

Mr. Whalen noted that the general traditional bureaucratic worry is, considering the number of services included, would Medicaid pay for it instead of thinking about the resulting cost saving opportunities that telemedicine provides.

Mr. Mark Page, Board Member, referred to Mr. Whalen's example of the use of Concierge Medicine for Congestive Heart Failure patients in New Mexico and asked if it was more expensive to move the bed to the patient's home rather than treating the patient in a hospital's ICU. Mr. Whalen answered that the claim was that it is extraordinarily less expensive. Ms. Anna Kril, Committee Member, commented that the outcomes would likely improve because the patient would not be exposed to hospital acquired infections. Mrs. Bolus also added that family care would also be included.

Mrs. Bolus thanked Mr. Whalen and Val Grey for their presentation. She commented that the presentation was one of the best presentations that she had seen in a long time. She also added that the presentation was very thoughtful. Ms. Brown promised to invite Mr. Whalen and Ms. Grey again to present to the Strategic Planning Committee.

SUBSIDIARY BOARD REPORTS

HHC Capital Corporation – November 20, 2014 **As reported by Dr. Jo Ivey Boufford**

HHC Debt Structure

Ms. Dehart provided an update on HHC's outstanding debt. \$164 million or 18.6% of the total portfolio is variable rate while \$716 million or 81.4% is fixed rate. The variable rate demand bonds ("vrdb") continue to be supported by letters of credit ("loc") issued by TD Bank and JP Morgan Chase bank. TD Bank's loc expires on September 3, 2019 and JP Morgan Chase's loc expires July 1, 2017. Both banks receive high ratings from the three major rating agencies.

According to Ms. Dehart, HHC Debt Finance researched the Community Reinvestment Activity ("CRA") of both loc providers. The ratings are based on three components or areas: lending, investing and services/branch activities. The latest report which is dated December 2010, rated JP Morgan Chase as "satisfactory" overall based on the following ratings – lending: high satisfactory; investing: outstanding; services: high satisfactory. TD Bank's overall rating is "outstanding" based on the following: lending: outstanding; investing: outstanding; services: high satisfactory.

Dr. Boufford asked if HHC can benefit from the Community Reinvestment Act ("CRA"). Ms. Youssouf stated that banks can get CRA credits but how it works is a bit of a "black box". If banks back an un-rated bond deal, or fund an equipment lease, HHC can make the argument that it should be counted as a CRA credit. Ms. Youssouf added that CRA is traditionally used for housing projects whereby banks buy low income housing credits as opposed to making loans in those neighborhoods and get CRA credits for the activity. Ms. Youssouf agreed that it could not hurt to raise the CRA topic with the banks.

Dr. Boufford recalled that the CRA issue came up at a recent San Francisco Federal Reserve meeting. The Fed was encouraging community reinvestment on the part of banks and discussed ways to expand the program into areas other than housing.

Ms. Zurack replied that under the "new business" part of this meeting, she will comment on a topic that will relate to the CRA.

TD Bank Letter of Credit Extension

According to Ms. Dehart, HHC negotiated an extension of the TD Bank loc that was set to expire on September 3, 2015. As part of the loc extension to the new expiration date of September 3, 2019, the bank reduced its fees by 10 basis points to reflect current market pricing which saves approximately \$100,000 a year in fees. Finance conferred with its financial advisory firm PFM who confirmed that the rate is competitive.

Responding to Ms. Youssouf who was asking if there is a finite term on the variable rate bonds, Paulene Lok stated that there are two series that expire in 2026 and two series that expire in 2031.

Construction Fund Balance on the 2010 Bonds

According to Ms. Lok, HHC borrowed \$200 million in 2010. As of September 30, 2014, \$15.7 million is still available for drawdowns reflecting capital expenditures through to August 31, 2014.

Ms. Youssouf asked if the money was used to fund specific projects. Ms. Zurack said that the \$200 million was intended to fund routine capital spending over an 18-month period, major modernizations were excluded from the project list. The spend-down of those funds is exceeding 4 years.

Ms. Youssouf then asked if the remaining \$15.7 million is targeted for specific purposes. Ms. Lok's answer was that all the funds are allocated and that some construction projects take longer to complete and spend down.

Mr. Page asked about the earnings rate on the balance. Ms. Zurack replied that the earnings rate is 50 basis points while the average interest paid to bondholders is 4.50%. In the past, if HHC earned money on the construction fund balance, any excess was rebated to the IRS. In the current market, there are no investment vehicles available which would provide such favorable returns.

Ms. Youssouf asked if the \$15.7 million is for a long list of projects or one project. Ms. Zurack responded that the balance will be used to fund the close-out of several projects.

New Business

Ms. Zurack reported that Finance had gotten authorization from the HHC Board of Directors to borrow up to \$40 million from banks for equipment purchases. Only two banks submitted proposals in response to the RFP – Santander and JP Morgan Chase Bank. Both institutions requested the lockbox guaranty that bondholders are entitled to. The lockbox is a complex arrangement whereby all of HHC's Medicaid and Medicare revenues must first flow through the HHC Capital Corporation Account to pay bondholders before paying for operational expenses. When the banks were told that it was impossible to give them the lockbox guaranty, the interested parties wanted a guaranty from the City of New York. The City explained that it could not provide this type of guaranty. Both banks withdrew their proposals.

Finance is reviewing an alternative solution which is to offer a "subordinate lockbox" or "subordinate lien/pledge of HHC's healthcare revenues" after the funds flow through the lockbox to pay bondholders. This additional security might persuade potential lenders to respond more favorably to the next RFP. In addition, HHC can try to convince the banks to treat the loan as a CRA credit as the HHC Cap Corp board members have suggested.

Ms. Youssouf asked how the subordinate lockbox would work in the case of the \$40 million loan - is it applied to the principal only, or both principal and interest; will the payments be made monthly or semi-annually? Ms. Zurack said that the lockbox would cover both principal and interest.

Ms. Youssouf then commented that \$40 million does not seem to be a large sum of money for HHC. Ms. Zurack replied that the loan amount will probably increase.

Ms. Zurack said that Finance is pursuing a "private placement/direct loan with a subordinate pledge" as opposed to issuing bonds which is expensive, time consuming and requires a lot of effort.

Mr. Page asked if HHC "can embody a bond obligation in our relationship with a bank that can step up as we have draw downs". Ms. Zurack answered that if HHC can establish the subordinate obligation structure, we would be able to do as Mr. Page suggests. Mr. Page then asked why the pledge has to be subordinate. Ms. Dehart's reply was that after consultations with our bond counsel firm, Hawkins Delafield & Wood ("HDW"), granting the lenders direct access to the lockbox requires a change in the bond resolution because it changes the obligation relationship for existing bondholders.

Mr. Page asked three questions: if HHC has a cap on the amount of bonds outstanding, if HHC has reached its ceiling, if HHC can issue more bonds. Ms. Zurack stated that HHC can issue more debt but then it would have the same problem of paying interest on a construction fund that takes time to spend down.

Mr. Page said that he did not "understand why HHC cannot categorize its obligation to a bank as a bond". Ms. Zurack replied that conceivably HHC could do so by giving the lenders direct access to the lockbox but that is not allowed under the bond resolution. Ms. Zurack recommends convening a call with Finance, PFM, HDW, Mr. Russo and interested members of the Board to discuss this further. Ms. Zurack added that the ultimate goal is for the Corporation to find a flexible means of financing its capital needs.

Dr. Boufford mentioned that there is a social investing precedent in New York City. Goldman Sachs provided funds to the NYC Department of Corrections ("DOC") to reduce recidivism. Ms. Youssouf stated that if the DOC programs are not successful, the City has to repay the money to Goldman Sachs. Ms. Youssouf also explained that the Goldman DOC example is not relevant to HHC's situation.

As a follow-up to Mr. Page's earlier question, Ms. Dehart said that another consideration with characterizing the loan as a bond obligation is that HHC has to fund and increase its capital reserve which is an added expense. Ms. Youssouf noted that the increase in the capital reserve fund should not be very high on a \$40 million loan.

Mr. Page wanted to know if HHC could "get a bank to give a LOC on variable rate debt so that the Corporation is not carrying so much negative arbitrage". Ms. Zurack said it was possible, but then HHC would have to go to market to issue new bonds. Ms. Zurack added that before the idea of private placements and 'lockbox light" were conceived, HHC had considered issuing bonds every 4-6 months for smaller amounts but it required a lot of expense and effort. Mr. Page said that HHC can "do successive closings on variable rate debt with a lot less elaboration than closings on fixed rate bonds". Ms. Youssouf agreed that the process is easier if a revolving facility is in place.

Dr. Boufford announced that the next step is that Ms. Zurack's office will set up a call to further discuss the subordinate lien and other related matters with Mr. Russo and interested members of the Board.

MetroPlus Health Plan, Inc. – December 9, 2014
As reported by Mr. Bernard Rosen

Chairperson's Remarks

Chair Rosen welcomed everyone to the final MetroPlus Board of Directors meeting of 2014. Mr. Rosen stated that immediately following the meeting, MetroPlus would hold its annual public meeting. Dr. Saperstein would present the Executive Director's report and Dr. Dunn would report on Medical Management issues. Mr. Rosen stated that there would be two resolutions presented at the meeting including one to adopt the annual operating budget for fiscal year 2015. Mr. Rosen wished everyone a happy and healthy holiday season.

Executive Director's Report

Dr. Saperstein reported that the total Plan enrollment as of November 1, 2014 was 469,070. Breakdown of Plan enrollment by line of business was as follows:

Medicaid	395,407
Child Health Plus	12,231
Family Health Plus	5,820
MetroPlus Gold	3,401
Partnership in Care (HIV/SNP)	4,954
Medicare	8,477
MLTC	774
QHP	37,318
SHOP	688

Attached to Dr. Saperstein's report were 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. As Family Health Plus (FHP) membership is rolling into Medicaid, MetroPlus will continue to see increases in the latter. However, the Medicaid membership increase experienced in the month of November was greater than the transfer (rollover) from FHP (same as in October). MetroPlus has also seen a slight increase in the Exchange membership.

Dr. Saperstein reported that MetroPlus' Open Enrollment Period (OEP) started on November 15th. In addition to strategically pricing its products, the Plan has taken numerous important steps in an effort to grow membership. MetroPlus have been collaborating with HHC facilities in targeting 190,000 HHC self-pay patients who are potentially eligible for insurance, embarked on aggressive advertising and marketing campaigns emphasizing our relationship with HHC, as well as initiated an extensive member retention campaign.

Dr. Saperstein stated that one of the barriers that MetroPlus faced with the new Exchange line of business during last year's OEP and thereafter was that the State had no mechanism in place to allow MetroPlus to assign PCPs to members. This led to major customer dissatisfaction and extremely high call volume to the Plan's Customer Services department. For the current OEP, the Plan has worked on a homegrown solution for MetroPlus staff and HHC Hospital Care Investigators whereby they can assign the PCP of the member's choice using the MetroPlus website.

The Plan has learned from the previous year's experience that its members were looking for easier ways to pay their premiums, select their PCP, view their account information online, etc. The Plan has listened to the voice of its members, therefore adapting its website, improving its functionality, thereby offering all those solutions at the click of a button.

Dr. Saperstein reported that MetroPlus' Brooklyn community office opened on the first day of the OEP. The Plan has experienced a tremendous volume of walk-ins on the very first day, resulting in over 200 applications.

MetroPlus has seen a high number of Exchange applicants during the first week of the OEP. There were a total of 2,672 submitted applications, and 96 applications in progress for the period November 15th thru November 21st.

During this first week of the OEP, there were a total of 41,000 transactions and a total of 23,000 membership renewals. As of the date of this report, the Plan cannot tell how many of the above referenced transactions are new members, changes to existing member information, cancellations, etc. More accurate information will be provided to the report at the next meeting.

Dr. Saperstein stated that, looking back at the first year operating under the new ACA Exchange product, the year in numbers have been summarized for the Committee. The previous OEP started on October 1, 2013, and ended on March 31, 2014. Anyone who enrolled before December 23, 2013, was effectuated as of January 1, 2014. The Exchange membership on January 1, 2014, was 13,025 (3% of total membership) and 27,978 as of April 1, 2014 (215% increase during the OEP) and it represented 6.3% of total membership as of that date. The highest Exchange membership was in May 2014, at 44,311 members. Over the following few months, there has been slight decreases due to member non-payment.

The total membership as of January 1, 2014 was 432,791, representing an increase of almost 12,000 members from December 1, 2013 (an increase of 3% in one month). As of April 1, 2014, MetroPlus' total membership was 444,748 – the majority of members enrolled as follows: 362,939 or 82% in Medicaid and 27,978 or 7% in Exchange. As of this month, Medicaid increased to 84%, and Exchange to 8% of the total of 469,070 (a net increase of approximately 25,000 members – or 6% from December 2013).

As far as the MetroPlus Gold line of business, the Plan has only seen a very small increase in membership over the course of this year (from 3,322 as of year-end 2013 to 3,401 as of November 1, 2014 – an increase of 2%).

Dr. Saperstein reported that MetroPlus continues to move forward with implementing the delegation of all Behavioral Health and Substance Abuse Disorder services to Beacon Health Strategies. Due to a delay in obtaining New York State Department of Health (NYSDOH) approval for the Beacon contracts with its provider network, MetroPlus' implementation will need to be delayed. Contingency plans are in full force so that MetroPlus meets its contractual obligations to go-live with FIDA despite the Beacon delay. Beacon is still in the process of contracting for Behavioral Health and Substance Abuse services with the HHC system. It is the Plan's expectation that it will be able to fully implement the Beacon contract within 60 days.

MetroPlus is currently in discussion with multiple State agencies on a decision point whether the Health and Recovery Plans (HARP) product will require one license or possibly a second separate license for the HIV SNP HARP members. The issue is the fact that MetroPlus would be the only plan to be awarded two separate licenses as MetroPlus is the only plan that manages a Mainstream Medicaid population as well as a HIV SNP. A decision on the license issue is expected by December 1st. MetroPlus is continuing ongoing meetings with two State liaisons to help achieve all readiness initiatives required. At this time the NYSDOH is advising that the SSI Carve-In and HARP line of business will be implemented April 1, 2015. Internally, MetroPlus continues its work on the infrastructure to make both the carve-out to Beacon and the new HARP line of business fully operational.

Medical Director's Report

Dr. Dunn stated that as a part of MetroPlus' continuing efforts to provide health education and valuable information to its members, the Plan completed several mailings. Some of these mailings included: prenatal lead testing of pregnant women and children for lead exposure, flu and pneumonia postcard mailings to all members who are considered high risk and need to get the flu shot or pneumonia vaccine, Chlamydia mailing sent to all females between the ages of 16 and 24 informing them of the importance of Chlamydia and a men's health postcard mailing to all males between the age of 50 and 65 highlighting important screening and preventative test for heart disease, diabetes, colon cancer, high blood pressure, HIV and prostate cancer.

Dr. Dunn provided the Committee with a chart that showed the percentage of measures that were above average compared to New York State (NYS) between the following Plans: MetroPlus, Affinity, Fidelis, HealthFirst and HIP/Emblem. The New York State Department of Health (NYSDOH) released the preliminary results of the 2013 HEDIS/QARR season. MetroPlus increased the number of measures that were above NYS Average compared to 2012. MetroPlus had 39 versus 35 from 2012. HealthFirst was the winner with 43.

Dr. Dunn also provided a Consumer Assessment of Healthcare Providers and Systems (CAHPS) CAHPS chart that measured the rating of the health plan, getting the care needed and customer service and information for the following plans: MetroPlus, HIP/Emblem, Fidelis, Affinity and HealthFirst. MetroPlus did not do well in CAHPS scores. The Plan was below the NYS average for getting needed care of 72% versus 78%, which was the NYS average. MetroPlus showed significant improvement in the following areas: Under Medicaid/FHP, adolescent immunizations went from 70% to 81%, adult Body Mass Index went from 75% to 89% and Breast Cancer Screening went from 69% to 74%. Under Medicare, diabetes eye exams went from 70% to 75%, disease-modifying antirheumatic drugs for Rheumatoid Arthritis went from 75% to 84% and glaucoma screening went from 42% to 77%. Under

HIV/SNP, adolescent Well Care went from 48% to 65%, antidepressant Medicine Management-Acute Phase went from 39% to 53%, antidepressant Medicine Management-Continuation Phase went from 26% to 41% and Breast Cancer screening went from 68% to 79%. MetroPlus showed a significant decline in the following areas: Under Medicaid/FHP, Pharmacotherapy Management-Bronchodilator went from 93% down to 71%. Under Medicare, Diabetes – Blood Pressure (BP) of 140/80 went from 63% down to 49%, and Diabetes – BP 140/90 went from 71% down to 59%. Under HIV/SNP, appropriate testing for Pharyngitis went from 82% down to 44%.

On November 21, 2014, the NYSDOH released the preliminary 2014 Regional Consumer Guides for Managed Care. The major change from the 2013 Consumer Guide was moving to a 5-star scale for the domains and overall ratings rather than a numerical scale. A 5-star plan is rated excellent where a 1-star plan is rated poor. MetroPlus received a 4-star rating. In the Plan's region, there was only one 5-star plan (HealthFirst) and 2 other 4-star plans (HealthPlus and Fidelis) in the New York City region.

Dr. Dunn provided the CMS report scores and compared plans based on performance. There were four categories that CMS uses to measure quality: operational measures (reviewing appeals and call center performance), Part D measures (access to PCP and Part D medication adherence), Healthcare Effectiveness Data and Information Set (HEDIS), and customer service. CMS also uses Star Rating to determine reimbursement. The ratings are used to compare Medicare Advantage and Prescription Drug Plans. The ratings emphasize patient care and satisfaction, using national clinical and service-quality measures, health outcomes and patient feedback. Health outcomes are weighted three times more than health plan operations. Patient satisfaction is weighted 1.5 times more than health plan operations. The number of Stars earned by a health directly relates to percentage of HEDIS measures met. There is a penalty assessment for plans performing poorly 3+ years (administrative holds, plan shut down). The 2015 overall MetroPlus Star Rating was 3.5 for Medicare Advantage and Part D.

Action Items:

The first resolution was introduced by Mr. Rosen.

Approving Lloyd Williams for nomination to serve as a member of the Board of Directors of MetroPlus Health Plan, Inc. ("MetroPlus"), a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York, to serve in such capacity until his successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

The adoption of this resolution was duly seconded and unanimously adopted by the MetroPlus Health Plan Board of Directors.

The second resolution was introduced by Mr. Dan Still, Chairman of MetroPlus' Finance Committee.

Adopting the Annual Operating Budget and Expense Authority of the MetroPlus Health Plan, Inc. (the "Plan"), for Fiscal Year 2014, Amended and Fiscal Year 2015.

Mr. Still advised that this budget was discussed in great detail at the Finance Committee that was held in November. Mr. Still commended Mr. Cuda and his staff on their hard work supporting the Health and Hospitals Corporation with benefits both programmatically and financially. Mr. Cuda reviewed in detail the highlights of the budget. Mr. Cuda provided the Board of Directors with a spreadsheet showing proposed calendar year 2015 revenue and expense budget. Mr. Cuda also provided a spreadsheet comparing the 2015 final budget to the 2014 forecast.

The adoption of this resolution was duly seconded and unanimously adopted by the MetroPlus Health Plan Board of Directors.

***** *End of Reports* *****

RAMANATHAN RAJU, MD
HHC PRESIDENT AND CHIEF EXECUTIVE OFFICER
REPORT TO THE BOARD OF DIRECTORS
DECEMBER 18, 2014

Good afternoon. As customary, I will highlight just a few items from the full version of my report to the board. The full version is available to all here and will be posted on our website.

DSRIP UPDATE

Next week, HHC will submit the final application to participate in the Delivery System Reform Incentive Payment (DSRIP) program, a \$6.42B Medicaid Waiver program intended to achieve sustainable health care system transformation and significantly decrease avoidable hospitalizations. HHC is leading a Performing Provider System (PPS) which is organized into local, borough-based hubs to best meet community needs. Each PPS hub is comprised of Medicaid providers, community-based organizations and other stakeholders who will undertake the eleven selected DSRIP projects over the next five years.

As I reported last month, we secured agreements with four other emergent PPS's to work together to implement health care projects in the Bronx, Brooklyn and Queens. This month, SUNY Downstate Medical Center officially joined the HHC-led PPS and will be a key partner to help transform the health care delivery system in the borough of Brooklyn. We continue to engage in discussions with many other community-based and city-wide organizations, labor and affiliate partners, our Community Advisory Board members and others about the community needs assessment (CNA) process and results and the creation of guiding principles for successful partnership over the five-year program period and beyond.

We believe that by working together, all our institutions have greater opportunity to lead in improving the health of the communities we serve in every borough. We look forward to the approval of our application, which will officially set in motion a major change in the way the entire industry delivers care to New Yorkers and will accelerate HHC's goals to create a sustainable health care system focused on providing high quality, person-centered care in a population health management model.

CURE VIOLENCE AGREEMENTS WITH HHC PARTNERS

In August 2014, the de Blasio Administration and the New York City Council announced a \$12.7 million investment to support and expand Cure Violence (CV) programs and other comprehensive, community-based strategies to prevent gun violence. The CV programs operate in conjunction with HHC's Guns Down, Life Up programs.

Of the allocated grant monies, HHC and The Fund for HHC serve as the fiscal conduit for approximately \$5 million for Fiscal Year 2015, which will support Cure Violence organizations and other hospital-based work aligned with Guns Down, Life Up. As of today, HHC has entered into 24 contracts with provider organizations selected by the City Council and the de Blasio Administration for their respective locations within high-violence areas and for their capability to undertake and execute violence reduction work. The Fund for HHC will oversee these fully grant-funded contracts.

FLU SEASON BEGINS

Last week we received notice that Acting NYS Health Commissioner Dr. Howard Zucker had declared that influenza is now prevalent in New York. At HHC, this means that all personnel must either be vaccinated against flu or wear a mask whenever they are in HHC facilities, including a home health care setting for home health personnel.

This is the policy of the NYS Department of Health and it will be the HHC policy for the duration of flu season, but it is so much more. It represents our ongoing commitment to our patients and our families, to do whatever we can to keep them healthy. It is particularly urgent for health care providers to get a flu shot to protect their own health and the health of our patients, whose health is already fragile.

Our employee vaccination rate is presently 63%, well short of the 92% target that we've set to achieve what is called "herd immunity" -- the state of the community in which there is unlikely to be any new infections.

HHC offers vaccination that is readily available and free of charge, at vaccination tables in lobbies, at many facility events, and at Employee Health Service. Nurses also make rounds in all divisions, so employees can be vaccinated right where they work. Until employees are vaccinated, they must mask. Masks will be provided by all supervisors, and are free of charge. They must be used without exception until Dr. Zucker declares that flu season is officially ended.

HHC LEADERS SHARE EXPERTISE AT BREAKTHROUGH CONFERENCE

Last month more than 200 HHC leaders and staff had the unique opportunity to attend the 6th Annual Breakthrough Conference. The audience learned about Lean Leadership and Management Systems from two guest lecturers and panels composed of HHC leaders. Many HHC facilities and individuals were recognized for their contributions to advance Breakthrough's implementation and improvements. One example is Elmhurst Hospital, which reduced the Average Length of Stay for Behavioral Health inpatients from 26 to 16 days.

FEDERAL UPDATE

On December 13th, the Senate passed what the House of Representatives had already approved on December 11th -- a \$1.1 trillion spending plan to fund most government agency operations through September 2015. The spending bill includes \$5.4 billion in emergency funding to support domestic and international efforts to combat Ebola.

Hospitals across the country will have access to funding to support Ebola preparedness, and treatment efforts through several different funding streams. The bill provides \$1.77 billion for the Centers for Disease Control and Prevention (CDC). The CDC will have funding to support public health emergency preparedness, state and local response, worker training and migration and quarantine efforts. In addition, the bill includes \$733 million for HHS to prevent, prepare for, and respond to Ebola. HHS will also have funds to implement a regional strategy for designating treatment Centers. Bellevue is on track to becoming recognized by HHS.

Within 30 days, HHS Secretary Burwell has a mandate from Congress to release details about the various Ebola funding streams and the process to apply for such funds. HHC will be prepared to apply to all CDC and HHS programs for which we might possibly be able to draw down support for funding as soon as details from HHS are available.

The Corporation held meetings last week in Washington with staffers from the NYC Congressional delegation to brief them on our two-year effort to achieve Federally Qualified Health Center (FQHC) status for HHC's six diagnostic and treatment centers from HRSA. We will keep you up to date on further developments.

Near the end of last month, President Obama announced Immigration Accountability Executive Actions which challenge illegal immigration at the border, prioritize deporting felons rather than families, and require certain undocumented immigrants to pass a criminal background check and pay their fair share of taxes as they register to temporarily stay in the U.S. without fear of deportation. Most Immigrants who have children who were either born in the United States or came when minors will benefit from the Executive Action, which will allow them some leeway to stay in the United States.

The President's Executive Action will also lead to tens of thousands of New York residents becoming eligible for Medicaid coverage in New York, since New York State is required to grant Medicaid to any immigrant residing legally in the state. However, the federal government will not contribute its normative 50% match as the eligibility is only through state law. It is unclear how many uninsured HHC patients will gain insurance coverage as a result, but some should.

START OF STATE LEGISLATIVE SESSION

The 2015 state legislative session will kick-off on January 7th when the Governor delivers his annual State of the State Message to a joint session of the Senate and Assembly. Work on the 2015-16 State Budget is already

underway, with much attention focused on how to spend the projected \$5.1 billion surplus that has resulted from payments for legal settlements negotiated by State regulators. Because these are one-time payments, State Comptroller Tom DiNapoli and others have urged that it be spent on non-reoccurring expenses. Health care associations are advocating for \$1 billion of the surplus to be added to the health care Capital Restructuring Financing Program. The Governor must release his Executive Budget proposal by February 1st.

CITY COUNCIL APPROVES LEASING OF DRAPER HALL FOR DEVELOPMENT OF LOW-INCOME HOUSING

This month, the City Council voted to approve HHC's proposal to enter into a long term lease for the development of 203 units of housing for low-income elderly and/or disabled individuals in Draper Hall, which is part of the campus of Metropolitan Hospital Center. HHC has worked closely with several City agencies, local elected officials, community representatives and the developer, SKA Marin, on this project. Through the efforts of Speaker Melissa Mark-Viverito, the U.S. Department of Housing and Urban Development (HUD) agreed to a 25% community preference requirement for the units that will be developed. This will ensure that at least 50 apartments will be set aside for eligible residents of the community. HUD also agreed to perform a demographic analysis to determine if an increase in the community preference requirement would be feasible for this project.

I want to thank the Speaker and the City Council for approving this project and providing \$2 million in capital funding as part of the budget agreement adopted in June for Fiscal Year 2015.

HHC FEATURED PROGRAM: THE FUND FOR HHC/GUNS DOWN, LIFE UP VIOLENCE INTERRUPTION

As I do at every Board meeting, I'd like to highlight an important HHC program that is making a real difference in our communities far beyond the work inside the walls of our health care facilities.

As you all know, in addition to its many quality contributions internal to the Corporation, The Fund for HHC connects our corporation with highly significant and productive external undertakings across our city's communities. A remarkable anti-violence program -- Guns Down/Life Up -- is one of these. I ask your forbearance as I invite Senior Advisor to the President and Executive Director of the Fund for HHC, Mr. Joe Schick, to briefly sketch the latest news of the Fund, and to highlight this very special program....

[Mr. Schick - - - 10 min presentation]

Thank you, Joe. I salute and congratulate the staff of all our Guns Down, Life Up programs for their courage and their message of positive change.

HHC FEATURED PERSON OF THE YEAR: LILLIAN ROBERTS, LABOR LEADER

In my monthly report to the Board of Directors, I've begun a new tradition to highlight an HHC employee who has made an outstanding contribution to the communities we serve. I hope you have enjoyed meeting these wonderful and deserving members of our staff. For the month of December, I want to expand that tradition to feature a Person of the Year -- someone who has made a substantial contribution to our organization, to our patients and to our employees.

For the inaugural Person of the Year, I have chosen Ms. Lillian Roberts, the outstanding labor leader whose career in union activism, and advocacy in the pursuit of fairness and justice, spans half a century.

Ms. Roberts plans to retire at the end of this year and I could not end 2014 without a special thank you on behalf of the HHC employees she has so ably represented and on behalf of our patients who have benefitted from her compassionate leadership.

During the last 13 years, she has been the Executive Director of District Council 37, New York City's largest public employee union of 120,000 members. In our hospitals, more than 15,000 workers are members of DC 37, including social workers, psychologists, housekeepers, engineers, hospital technicians, and even chaplains.

But the long, proud history of Ms. Roberts as a unionist fighting for worker's rights goes back many more decades. She grew up in the tenements of Chicago's South Side and became a nurse's aide. In 1959, she joined the hospital local of District Council 34, and was eventually hired as a union rep by District Council 19 in Chicago. She spearheaded the creation of five locals, and led an organizing drive in four Chicago mental health hospitals. She moved to New York to build up DC 37's Hospitals Division, leading the union's campaign to organize thousands of city hospital workers. She has led DC 37 since 2002 when she was elected as its first female executive director.

Time and again Lillian Roberts led negotiations for fair wages and expanded services for union members that range from improved access to affordable housing, to legal advice and educational programs. She's dedicated her career to giving a voice to her members, helping to provide better opportunities and improve the quality of life of working men and women.

At the same time, she has always worked to develop strong, positive relationships with the representatives of management with whom she negotiated, recognizing the solid partnership between labor and management that insures our patients receive the very best health care.

Essence Magazine called her one of the most powerful persons in American labor and the New York Post included her in the list of 30 Most Influential Black New Yorkers in 2007. She has won much praise and respect from municipal leaders and hospital workers across our city. Today, I'm happy to join that throng of admirers as I name her: the Health and Hospitals Corporation 2014 Person of the Year.

Thank you, Lillian, for everything you've done for our employees and for our patients.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

Hospital sexual assault program gets global attention, NCBH: Brigitte Alexander, MD, Medical Director of the Bronx Sexual Assault Treatment Program, News12 Bronx, 12/8/14

Expert offers tips on flu season protection, Dr. Elizabeth Jenny-Avital, Infectious Disease Specialist, Jacobi, News12 Bronx, 12/16/14

Brooklyn man who traveled to Mali tests negative for Ebola at Bellevue, WABC, 11/20/14

Patient at Bellevue Hospital tests negative for Ebola, WPIX, 11/20/14

Print

U.S. designates 35 hospitals as Ebola centers, USA Today, 12/3/14

Monitoring for Those Exposed to New York Ebola Patient Ends, The New York Times, 12/3/14

U.S. hospitals wary of caring for Ebola patients because of cost and stigma, Bellevue, The Washington Post, 12/1/14

Costs of responding to Ebola adding up, HHC, Bellevue, USA Today, 11/26/14

GNHYHA presses Obama for more Ebola aid, Bellevue, Crain's New York, 12/3/14 Bellevue

Ebola: Who Bears The Cost of Keeping Us Safe? Bellevue, Roll Call, 12/10/14

Feds to reimburse Bellevue for Ebola treatment, Bellevue, AM New York, 12/12/14

Bronx health-care workers will fight spread of Ebola in Liberia, Dr. Julie Hoffman, Infectious Disease Specialist, Jacobi, Sara Back, Family Nurse Practitioner and HIV/AIDS Specialist, NCBH, New York Daily News, 12/15/14

Treating Ebola May Be Cheaper in Texas Than in New York, Dr. Raju, HHC President; Bellevue, Bloomberg News, 12/5/14

H.H.C. receives boost from de Blasio's budget, Marlene Zurack, HHC Chief Financial Officer, Bellevue, Capital NY, 12/12/14

Controller Thomas DiNapoli: NYC's financial outlook getting rosier, HHC, New York Daily News, 12/17/14

FEMA Grants \$1.6 Billion in Assistance for Hospitals Hit by Superstorm Sandy, Terry Mancher, RN, CNO, Coney Island Hospital, HHC, Bellevue, Metropolitan, Coler, Nurse.com, 12/12/14

Insurers prepare for Obamacare, round two, MetroPlus, Crain's 12/3/14

City hospital ranked as top performers by country's leading accreditor of health care organizations, Lincoln, NCBH, Bellevue, The Daily News, 12/2/14

HHC Lincoln Medical Center named "Top Performer", Denise Soares, Sr. Vice President of the Gen+/Northern Manhattan Health Network, Amsterdam News, 12/16/14

Bellevue Hospital recognized as "top performer", Steven R. Alexander, Executive Director, Bellevue, Town & Village, 12/15/14

Prescribing Vegetables, Not Pills, HHC, Harlem, Lincoln, Elmhurst, Bellevue, Dr. Sundari Periasamy, Harlem, The New York Times, 12/2/14

A Prescription for Produce?, Lincoln, Harlem, Yahoo.com, 11/26/14

Surgeon as Comfortable With a Paintbrush as She Is With a Scalpel, Dr. Kathryn Ko, Neurosurgeon, Kings County, The New York Times, 12/12/14

City to Lease Site to Affordable Developer for \$100K per Year, HHC, Metropolitan, NY Observer, 11/26/14

City seeks to lease former nurses' dorm to affordable housing firm, build units for seniors, HHC, New York Daily News, 12/1/14

Health care is a civil right, says Dr Ramanathan Raju, HHC President Dr. Raju, Coney Island, MetroPlus, Asian Tribune, 12/16/14

East Harlem Nurses Welcome Patients to New LGBT Clinic, Metropolitan: Clifettia Grissett, RN, clinic staff nurse; Lillian Diaz, RN, CNO and Deputy Executive Director Nurse.com, 11/24/14

New York City's HHC honors nurses, film director, Nurse.com, 11/19/14

Cash Money Records founders return to Harlem for annual turkey giveaway, Harlem, New York Daily News, 11/24/14

Changed Life for Brooklyn Boy Hit by Crossfire, Kings County, The New York Times, 11/28/14

Teen boy who survived East Harlem explosion has world of thanks to give, Harlem, New York Daily News, 11/28/14

Cheery Playroom Unveiled at Elmhurst Hospital's Pediatric Department, Chris Constantino, Senior Vice President of the Queens Health Network, Executive Director, Elmhurst, DNAinfo, 12/15/14

New foreign visit to hospital unit, NCHB, NY Daily News, 12/4/14

Plans resume to turn historic T Building into affordable housing, Queens, Queens Courier, 12/17/14

Audit finds city misspent \$183 million in Sandy hospital funds, HHC, Bellevue, Coney Island, Capital New York, 11/28/14

RESOLUTION

DSRIP APPLICATION

Authorizing the New York City Health and Hospitals Corporation (the “Corporation”) to (i) submit an application to the New York State Department of Health (“DOH”) to participate in the Delivery System Reform Incentive Payment program (“DSRIP”) pursuant to which the Corporation will establish a single Performing Provider System (a “PPS”) in collaboration with various health care providers (the “Participants”); and

CONTRACTS WITH PPS PARTNERS

Authorizing the Corporation to (ii) enter into agreements within the PPS structure with those Participants listed on the attached Schedule of Participants designated as “City Wide” and those Participants designated as “Hub-Based” in the attached Schedule of Participants subject to the addition of additional Hub-Based Participants or the removal of some Hub-Based Participants at the discretion of the Corporation President as he determines to be necessary or appropriate to respond to evolving DOH requirements, guidance and regulations, and the Corporation’s assessment of the ability of the Hub-Based Participants to perform as required for the DSRIP program; (iii) enter into such other and further ancillary contracts as are necessary or appropriate to carry out the purposes of the DSRIP program and to ensure the Corporation’s successful execution of its DSRIP projects using the structure diagramed in the attached Table of Organization; and

HHC ASSISTANCE CORP TO FUNCTION AS CENTRALIZED SERVICE ORGANIZATION

Authorizing the Corporation to (iv) cause the HHC Assistance Corporation (the “CSO”) to provide technical assistance to the PPS in the capacity of a centralized service organization; (v) nominate from among the officers and senior managers of the Corporation the directors of the CSO provided that the Corporation President shall have the authority to nominate one or more directors of the CSO who are not officers or employees of the Corporation provided further that such outside directors never exceed 25% of the total of CSO directors;

PROCUREMENT, COMPLIANCE AND REPORTING

Directing the Corporation to (vi) subject the activities of the CSO under the DSRIP program to the Corporation’s compliance and internal audit programs; (vii) requiring that all procurement contracts of the CSO be subject to the procurement rules applicable to the Corporation; and (viii) make regular, periodic reports to the Corporation’s Board of the progress of the DSRIP application and the implementation of the DSRIP projects including an overview of all contracts made by either CSO or the Corporation to carry out the DSRIP program.

WHEREAS, pursuant to a waiver issued by the Centers for Medicaid and Medicare Services, DOH designed the DSRIP program to reduce preventable hospital admissions by 25% over a five-year period by implementing various health care reform projects; and

WHEREAS, DSRIP requires healthcare providers, mostly led by public hospitals and safety-net hospitals, to form PPS's to collaborate in providing coordinated health care within geographic areas; and

WHEREAS, the DSRIP program requires that each PPS choose from among 26 projects or initiatives to implement to achieve the desired health care reform goals with certain projects and a certain required over-all scale of projects being required; and

WHEREAS, the DSRIP program provides for substantial funds to flow: through the PPS's to the PPS Participants based upon their performance of the projects launched measured against various statistical benchmarks; to the PPS's to compensate for certain administrative expenses incurred in their operation, the implementation of the projects and the preparation of the required reports to DOH; and to the PPS's for acute care hospital Participants to offset the loss of revenue attendant to the reduction of hospital admissions to the extent achieved as a result of the DSRIP program; and

WHEREAS, in June 2014, the Corporation filed with DOH a DSRIP Grant Funding Application that outlined in preliminary terms the DSRIP projects the Corporation intends to pursue, the criteria for selection of Participants and the general structure envisioned for the PPS all to form the foundation for the DSRIP Application that was due in December 2014; and

WHEREAS, DOH accepted the Corporation's Grant Funding Application and awarded the Corporation a DSRIP planning grant that the Corporation used to prepare its DSRIP Application; and

WHEREAS, on or about December 19, 2014 the Corporation filed its DSRIP application; and

WHEREAS, the Corporation's DSRIP application indicates that the Corporation will pursue eleven projects under the umbrella of a single PPS but administered by four Hubs each operating within a defined geographic area (each, a "Hub"); and

WHEREAS, to achieve the goals of the projects, it is necessary to create a management and governance structure for the PPS and a structure to provide essential technical services to the PPS; and

NOW, THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation (the "Corporation") be, and it hereby is, authorized to submit an application to the New York State Department of Health ("DOH") to participate in the DOH Delivery System Reform Incentive Payment program ("DSRIP") pursuant to which the Corporation will establish a single Performing Provider System (the "PPS") in collaboration with various health care providers (the "Participants"); and it is further

RESOLVED, that the Corporation be, and it hereby is, authorized to enter into agreements within the PPS structure with those Participants listed on the attached Schedule of Participants designated as “City Wide” and those Participants designated as “Hub-Based” in the attached Schedule of Participants subject to the addition of additional Hub-Based Participants or the removal of some Hub-Based Participants at the discretion of the Corporation President as he determines to be necessary or appropriate to respond to evolving DOH requirements, guidance and regulations, and the Corporation’s assessment of the ability of the Hub-Based Participants to perform as required for the DSRIP program; and it is further,

RESOLVED, that the Corporation be, and it hereby is, authorized to enter into such other and further ancillary contracts as are necessary or appropriate to carry out the purposes of the DSRIP program and to ensure the Corporation’s successful execution of its DSRIP projects using the structure diagramed in the attached Table of Organization; and it is further,

RESOLVED, that the Corporation be, and it hereby is, authorized to cause the HHC Assistance Corporation (the “CSO”) to provide technical assistance to the PPS in the capacity of a centralized service organization; and it is further,

RESOLVED, that the Corporation be, and it hereby is, authorized to nominate from among the officers and senior executives of the Corporation the directors of the CSO, provided that the Corporation President shall have the authority to nominate one or more directors of the CSO who are not officers or employees of the Corporation provided further that such outside directors never exceed 25% of the total of CSO directors.

The Corporation, the CSO and the Participants shall enter into a Master Hub and Services Agreement under which the CSO shall furnish technical services to the PPS including information technology, training, accounting, tracking, reporting, data analysis and health care management consulting services and for the CSO to be compensated for such services performed. Furthermore, the Master Hub and Services Agreement will establish the formulae to distribute: to the Participants DSRIP funds received based on the achievement of the DSRIP reform objectives and to the acute care hospital Participants to offset the loss of revenue attendant to the loss of hospital admissions to the extent achieved as a result of the DSRIP program.

The PPS will be managed by an Executive Committee with the support of a Care Models Sub-Committee, a Business/IT Sub-Committee, a Stakeholder Sub-Committee and such other sub-committees as may be established by the Executive Committee. Each of the Hubs will be governed by a Hub Committee consisting of representatives of Participants in that Hub. The PPS will have a Nominating Committee that is responsible for recommending members of the Executive Committee, the Sub-Committees, and the Hub Committees. The PPS will also establish a PPS Advisory Committee (the “PAC”), as required by DSRIP. The PAC will be comprised of all partners and providers from each borough-based hub, as well as representatives from unions, affiliate representatives, City agencies, Community Advisory Board representatives, and other key stakeholders.

The Corporation will be responsible for entering into a DSRIP project contract with DOH under which it will be the fiduciary. As fiduciary, HHC will be responsible for collecting DSRIP

funding from DOH, and for distributing such funding to CSO and the Participants. And it is further,

RESOLVED, that the President of the Corporation be, and it hereby is, authorized to perform all other acts and to do all other things and to execute and/or attest all such documents for and on behalf of the Corporation as he, in his sole and absolute discretion, from time to time determines to be necessary, desirable, advisable or appropriate and in the best interests of the Corporation to carry out the purposes of these Resolutions; and it is further,

RESOLVED, that any and all actions taken or contracts entered into heretofore by any officer of the Corporation, on behalf of the Corporation in connection with the DSRIP program be and the same are hereby ratified, approved and confirmed, and all such actions and contracts are hereby adopted by the Corporation, as applicable, as if each and every act had been done pursuant to the specific authorization of the Corporation, and it is further,

RESOLVED, that the Corporation be, and it hereby is, directed to subject the activities of the CSO under the DSRIP program to the Corporation's compliance and internal audit programs; and it is further,

RESOLVED, that all procurement contracts of the CSO be subject to the procurement rules applicable to the Corporation; and it is further,

RESOLVED, that the Corporation be, and it hereby is, directed to make regular, periodic reports to the Corporation's Board of the progress of the DSRIP application and the implementation of the DSRIP projects including an overview of all contracts made by either CSO or the Corporation to carry out the DSRIP program.

The provisions of these Resolutions shall be separable and if any section, phrase or provision of these Resolutions shall for any reason be declared invalid, such declaration shall not affect the validity of the remainder of the sections, phrases or provisions of these Resolutions.

Organization Name

Each organization name listed may include the organization's affiliates, sites, members, and operating divisions

Acacia Network, Inc.
AHRC New York City
American Dental Offices
ArchCare
CassenaCare
Coordinated Behavioral Care
CenterLight
Centers Health Care
Community Healthcare Network
FEGS Health & Human Services
Metropolitan Jewish Health System
Office of Mental Health
PAGNY
Rockaway Care Center
Ryan Center
Sentosa Care
The Children's Collaborative
Village Care
Visiting Nurse Service of New York
The New York State Nurses Association (NYSNA)
Allen Healthcare Services (National Healthcare Corp)
Calvary Hospital
Compassionate Care Hospice of New York, LLC
Concern for Independent Living
Doctors on Call
MetroNY Home Health Care PLLC
Hospice of New York, LLC
Jewish Home Lifecare
National Black Leadership Commission on AIDS, Inc. (NBLCA)
People Care Inc.
Progressive Home Health Services, Inc.
St. Mary's Center, Inc
Puerto Rican Family Institute
Bronx Mental Health Clinic
Brooklyn Mental Health Clinic
Manhattan Mental Health Clinic
Fortune Society
Health Leads
Callen-Lorde Community Health Center
TRI Center Inc. (The Recovery Institute)
St. Mary's Community Care Professionals
Extraordinary Home Care (St. Mary's Home Care)
St. Mary's Hospital for Children
The Osborne Association
Able Health Care Service, Inc.

Organization Name

Each organization name listed may include the organization's affiliates, sites, members, and operating divisions

All Metro Health Care
Gotham Per Diem, Inc.
Unlimited Care, Inc.
Xincon Home Health Care Services
CityMD
Premier Healthcare, Inc.
Medicaid Service Coordination NY
Young Adult Institute Inc (YAI)
a.i.r. nyc
START Treatment & Recovery Centers
Americare (Certified Special Services, Inc.)
BestCare, Inc.
Cornerstone Medical Arts Center Hospital
Cornerstone Treatment Facilities Network
EAC, Inc
God's Love We Deliver
Harlem United / Upper Room AIDS Ministry
HELP/PSI Inc.
Independence Care System
Iris House, Inc.
Isabella Geriatric Center
Kings Harbor Multicare Center
LegalHealth (NYLAG)
Lott Assisted Living Operating Corp. / Lott Community Home Health Care, Inc.
Mental Health Providers of Western Queens
Northern Manhattan Rehabilitation and Nursing Center
Odyssey House
Pelham Parkway Nursing Care & Rehab (IHS of New York, Inc.)
SES Operating Corp. (Harlem East Life Plan)
Transitional Services for New York, Inc. (TSINY)
YMCA
NYC DOHMH (Department of Health and Mental Hygiene)
1199SEIU Training and Employment Funds
Department for the Aging
MetroPlus Health Plan
Promoting Specialized Care & Health (PSCH)

Organization Name

Each organization listed may include the organization's affiliates, sites, members, and operating divisions

Shield of David, Inc. (The Shield Institute)
Upper Manhattan Mental Health Center, Inc.
Addicts Rehabilitation Center Fund, Inc.
AIDS Service Center of Lower Manhattan Inc., dba ASCNYC
Gay Men's Health Crisis (GMHC)
Little Sisters of the Assumption Family Health Service (LSA)
Queens Nassau Rehab & Nursing
Union Settlement Association
Lenox Hill Neighborhood House
Center for Comprehensive Health Practice
BOOM!Health
Providence Rest
Terrace Healthcare
Rebekah Certified Home Health Care
Rebekah Certified Home Health Agency
Rebekah Rehab & Extended Care Center
United Odd Fellow & Rebekah Home
Blythedale Children's Hospital
Bronx Park Rehab & Nursing Center
BronxWorks (formerly Citizen Advise Bureau)
Bronxwood Home for the Aged
Ocean Breeze Home Care (Community Surgical Supply)
Dominican Sisters Family Health Service
Family Home Health Care Inc.
Park Gardens Rehabilitation and Nursing Center
Allcare Medical
Grand Manor Nursing Center
Amato Pharmacy, Inc.
Avanti Health Care
Best AID Pharmacy
NORC-Naturally Occurring Retirement Community (Bronx Jewish Community Services)
Morris Park Nursing and Rehab Center
Neighborhood SHOPP
Falak Pharmacy
Fedcap Behavioral Health Services
Hostos Community College
Medical Center Pharmacy, Inc.
Planned Parenthood of New York City, PC (PPNYC)
RAIN, Inc.
Cucina Dolores
Riverdale Mental Health Association
Pilgrim Pharmacy
Specialty Care Pharmacy, Inc.
Total Care Pharmacy BX, Inc.

Organization Name

Each organization listed may include the organization's affiliates, sites, members, and operating divisions

Total Care Pharmacy, Inc.
Gold Crest Care Center
Regeis Care Center
Bronx Community College - CUNY
Grameen PrimaCare
Asthma Coalition of Queens
The PAC Program
Chapin Home
The Child Center of New York, Inc
Hamilton Madison House
Hamilton Park Nursing & Rehab
Cerebral Palsy Associations of New York State
Queens Sickle Cell Advocacy Network
Lakeville Ambulette Transportation, LLC
Queens Long Island Renal Institute
The Abraham & Henrietta Malamut Community Health Center - Adult Day Care Program of Parker Jewish Institute
Parker Jewish Institute for Health Care & Rehabilitation (AgeWell New York, LLC)
Comprehensive Community Hospice of Parker Jewish Institute
Sutphin Drugs (Pills on Wheels)
Queens Community House
Sunnyside Home Care Project, Inc.
Sunnyside Citywide Home Care Services
Sunnyside Community Services, Inc.
Queens Village Committee for Mental Health for J-CAP, Inc.
CABS Home Attendants Service, Inc.
CABS Nursing Home Co, Inc.
Saints Joachim & Anne Nursing Rehabilitation Center
Arms Acres Inpatient
Arms Acres Outpatient - Bronx
Arms Acrss Outpatient - Queens
Conifer Park Inpatient
Bensonhurst Center for Rehabilitation and Healthcare
FOUR SEASONS PHARMACY
SUNRISE ADULT DAY HEALTH CARE CENTER
LAKESIDE ADULT DAY HEALTH CARE CENTER
FOUR SEASONS CERTIFIED HOME HEALTH AGENCY
FOUR SEASONS HOME CARE PROGRAM
GATEWAY DIALYSIS CENTER
Parkshore Health Care LLC (Four Seasons Nursing & Rehab)
First MedCare, Inc.
CAMBA
Caring Hospice Services of New York
Conifer Park, Inc.
Crown Nursing and Rehabilitation Center

Organization Name

Each organization listed may include the organization's affiliates, sites, members, and operating divisions

Damon House
Brooklyn Center for Psychotherapy/New Directions
Marg Pharmacy, Inc. (Katz Drugs)
Moffat Garden Assisted Living Program
NAE Edison LLS (Edison Home Health Care)
Family Services Network of NY
La Nueva Esperanza
Ridgewood Bushwick Senior Citizen Council (RBSCC)
Buena Vida
Pella Care
St. Jude's Pharmacy
Scharome Cares, Inc.
St. Christopher's Inn
Family Care Certified Services (Tri-Borough Certified Health Systems of NY)
PSC Community Services, Inc.
Fort Green Strategic Action Partnership (SNAP)
Bedford Stuyvesant Restoration Corporation
Caribbean Women's Health Association, Inc.

Community Physicians

A T M Yousuf Physician, PC
Afzal Hossain Physician PC
AMB Medical Services, PC
AMERICA MEDICAL GROUP
Be Well Primary Health Care Center, LLC
Bridget Chime DBA Hillside Polymedic DTC
Broadway Internal Medicine, PC
Care For The Homeless
East Harlem Council for Human Services /Boriken Neighborhood Health Center
Henry Sardar, MD
Highland Medical Center
Hillside Pediatrics, PC
Jamaica Family Practice & Osteopathic Medicine
Joseph R. Andrade, MD PC
Karine Mednik, MD
Kathrine A. Gold, MD (AKA Debevoise Health, per HC)
MedCare LLC
MEDICAL CLINIC 721 FLUSHING AVE/ Pala Community Care LLC
New York Medical & Diagnostic Center
North Valley Medical, PC
Park Avenue Pediatrics PC
REST Medical Care, PC
Smart Medical Care, PC
The Joseph P. Addabbo FHC
Uptown Health Care Management Inc.

Organization Name

Each organization listed may include the organization's affiliates, sites, members, and operating divisions

ZWH Medical Care, P.C.

CBOs

Academy of Medical & Public Health Services
African Services Committee
APICHA Community Health Center
Arab-American Family Support Center
Arthur Ashe Institute for Urban Health
Asian Americans for Equality
Brooklyn Perinatal Network
Caribbean Women's Health Association, Inc.
Coalition for Asian American Children & Families
Commission on the Public's Health System
Community Service Society of New York (CSSNY)
Council of Peoples Organization (COPO)
Goddard Riverside Neighborhood Center
Greenwich House
Haitian Centers Council
Health People, Inc.
Hudson Guild
Indochina Sino American Community Center
Make the Road by Walking
Medicaid Matters NY
NADAP
New York Lawyers for the Public Interest
Northern Manhattan Perinatal Partnership
Northwest Bronx Community and Clergy Coalition (NWBCCC)
Project Hospitality
Public Health Solutions
Shorefront Y
Single Stop
South Asian Council for Social Services (SACSS)
Southeast Bronx Neighborhood Center
Stanley Isaacs Neighborhood Center
The Bronx Health Link
The LGBT Community Center
The New York Immigration Coalition
United Neighborhood Houses
University Settlement Society of New York
Women's Housing and Economic Development Corporation (WHEDco)

SUNY Affiliated Providers

SUNY Downstate Medical Center
Abdulla Alwani, M.D.
Abraham Sleem, MD
Advantage Care Physicians

Organization Name

Each organization listed may include the organization's affiliates, sites, members, and operating divisions

Albert A. Anglade, M.D.
Brooklyn Cancer Care Medical, PC
Carl Casimir, D.O.
Clifford Urias Young, M.D.
Cobble Hill Health Center, Inc.
Comprehensive Geriatric Medicine PC; DBA Doctors on Call
Daniel Khodadadian, MD
David E. Biro, M.D.
David Schwartz, M.D.
Dexter A. McKenzie, M.D.
Diaspora Community Services
Dove Pediatric Service
Eastern Pediatrics, PC
EAW Medical Care, PLLC
Elbaz, Tamer
Ernest Afflu, M.D.
First MedCare
Gentle Touch Medical PC
Gerald Valme, M.D.
Gwen P. Gentile, M.D.
Harold Fritz Kerolle, M.D.
Hazel L. Goodwin, M.D.
Hyacinthe, Llewellyn
Interboro Pediatrics
Jerry Uduevbo, M.D.
Kantu, Kanhaiyalal
Kelly Chin
Kevin Bruce Norowitz, M.D.
Kevin T. Custis, M.D.
Leonid Reyfman, M.D.
Lippman, Sheldon
Maria Elena Fodera, M.D.
Marie F. Conde-Wright, M.D.
Mark H. Krotowski, M.D.
Mauro L. Ruffy, M.D.
McMillan, George
Melvin C. Mahoney, M.D.
Ngozi Oji, MD
Ogiste-McBain, Sharon
Oluyemi O. Badero, M.D.
Otis M. Jones, M.D.
Oyenike Kilanko, MD
Park Nursing home
Peiying Xiao, M.D.

Organization Name

Each organization listed may include the organization's affiliates, sites, members, and operating divisions

Renaissance Medical Imaging, PC

Sabu John, MD

Schreiber, David

Scott, Claude

Shelby Kevin Samuel, M.D.

Sherill L. Purcell, M.D.

Sudhakar Bhagavath, M.D.

Tomasine Fodera, M.D.

SUNY UHB / UPB

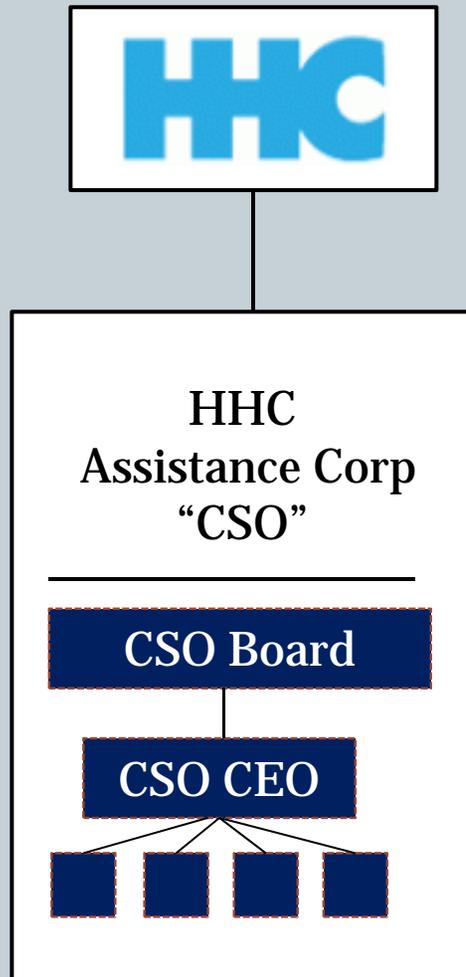
Wellman W. Cheung, M.D.

Yechiel Zagelbaum, D.O.

Yogendra K. Saxena, M.D.

Grace Wong

Organizational Structure: HHC Assistance Corporation



- HHC is lead, or fiduciary, of PPS
- Existing, wholly-owned subsidiary of HHC
- Reports to HHC
- Operations funded by DSRIP Program
- Provides services to PPS partners
- Complies with HHC policies, including audit and procurement
- CSO Board members named by HHC President
- Employees are shared + hired

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year lease extension agreement with LSS Leasing Limited Liability Company (the "Landlord") for 5,120 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Women's Medical Center (the "Center"), operated by Elmhurst Hospital Center (the "Facility") at an initial rent of \$225,280 per year or approximately \$44 per square foot to increase at a rate of 2.75% per year for a five year total of \$1,190,079.

WHEREAS, the Center is a community-based health care center that has been providing primary care services to residents of the Corona section of Queens since 1998; and

WHEREAS, the Center offers a full range of primary care services for women and children including prenatal care and gynecological services; and

WHEREAS, half of the leased premises have been and will continue to be occupied by a subtenant, Pediatrics Specialties of Queens, P.C. which will continue its arrangement of paying one half of all occupancy costs associated with the Center; and

WHEREAS, the proposed sublease with Pediatrics Specialties of Queens, P.C. will be the subject of a separate resolution presented to the Corporation's Capital Committee and Board for authorization; and

WHEREAS, there remains a need for primary care services in this section of Queens and extending the lease for this site will allow the Center to continue to serve the community.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a five year lease extension agreement with LSS Leasing Limited Liability Company for 5,120 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Women's Medical Center, operated by Elmhurst Hospital Center at an initial rent of \$225,280 per year or approximately \$44 per square foot to increase at a rate of 2.75% per year for a five year total of \$1,190,079.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year sublease agreement with Pediatric Specialties of Queens (the "Subtenant") for 2,560 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Subtenant's pediatric program at an initial rent of \$112,640 per year or approximately \$44 per square foot to increase at a rate of 2.75% per year but in no event less than half of all of the Corporation's occupancy costs at the premises.

WHEREAS, the Corporation has been operating a community-based health care center managed by Elmhurst Hospital Center at this location that has been providing primary care services to residents of the Corona section of Queens since 1998; and

WHEREAS, the Subtenant has been providing pediatric services at this site since the late 1990s and the Corporation and the Subtenant maintain separate and distinct medical practices at the site; and

WHEREAS, the Subtenant has subleased half of the space rented by the Corporation and has paid half of the Corporation's occupancy costs; and

WHEREAS, the Corporation proposes, pursuant to separate resolution, to renew and extend its lease for the premises and the Subtenant wishes to continue in occupancy of its half of the premises and to pay half the Corporation's occupancy costs for the entire premises under a sublease with the Corporation.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a to execute a five year sublease agreement with Pediatric Specialties of Queens for 2,560 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Subtenant's pediatric program at an initial rent of \$112,640 per year or approximately \$44 per square foot to increase at a rate of 2.75% per year but in no event less than half of all of the Corporation's occupancy costs at the premises.

RESOLUTION

Reappointing Lloyd Williams as a member of the Board of Directors of MetroPlus Health Plan, Inc. ("MetroPlus"), a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York, to serve in such capacity until his successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

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 from an operating division to a wholly owned subsidiary of HHC; and

WHEREAS, the Certificate of Incorporation of MetroPlus designates HHC as the sole member of MetroPlus and has reserved to HHC the sole power with respect to electing members of the Board of Directors of MetroPlus; and

WHEREAS, the Bylaws of MetroPlus authorize the Chairperson of HHC to select three directors of the MetroPlus Board subject to election by the Board of Directors of HHC; and

WHEREAS, the Chairperson of HHC has selected Mr. Williams to serve an additional term as a member of the Board of Directors of MetroPlus; and

WHEREAS, the Board of Directors of MetroPlus has approved said nomination;

NOW, THEREFORE, be it

RESOLVED, that the HHC Board of Directors hereby reappoint Lloyd Williams to the MetroPlus Board of Directors to serve in such capacity until his successor has been duly elected and qualified, or as otherwise provided in the Bylaws of MetroPlus.



Board of Directors Meeting

Dietary Operations

Process Owner: Antonio Martin, EVP / COO

NYC Health and Hospitals Corporation
January 29, 2015

The Objectives of the Dietary Initiative

- HHC Executed a Contract in 2005 with Sodexo HealthCare Services, US Foods, Inc., and GNYHA Ventures (the Consortium)
- The Contract was fully Implemented in early 2006; the Contract Term is for 10 Years and 3 Five Year Renewals for a total of 25 years
- The Initial Objectives:
 - ❖ Improve patient care, quality of food and increase menu variety options (within first year of the contract)
 - ❖ Increase patient satisfaction (to be monitored by independent survey every year after full implementation)
 - ❖ Improve employee working conditions and safety through modernization of the Cook Chill Plant (CCP) by implementing state of the art equipment and creating more effective workflows for employees
 - ❖ Standardize food policy and procedures throughout the Corporation to comply with regulatory requirements
 - ❖ Optimize facility staffing plan, assure regulatory compliance, create workflows to assure worker safety and increase the cost effectiveness' of the dietary operation
 - ❖ Reduce and contain dietary operating costs throughout the term of the contract

Key Achievements

- Implemented a 21 day menu cycle which increased the variety and ethnic choices for all Acute Care and Long Term Care facilities and improved patient satisfaction
- Improved patient satisfaction scores from baseline and sustained patient satisfaction improvement every year for Acute Care (3.8) and Long Term Care (3.4)
- Instituted Corporate wide Formulary for Nutritional Supplements as established by clinical committee, with a focus on improving the patient experience that resulted in lower costs
- Instituted a Cook Chill model and installed equipment throughout HHC facilities (\$18.2M)
- Modernized the CCP in late 2005, currently producing 17K meals/day, 6.4M meals/yr. and improved employee workplace conditions and safety
- Standardized policies and procedures for food delivery, floor stock, supplements and nourishments that improved the patient experience and worker efficiencies
- Standardized reporting systems for cost controls and financial analysis resulting in real time information that allows for rapid management and corrective action plans
- Assessed staffing levels resulting in identified workflows that improved direct and indirect patient care, patient safety and employee safety
- Established an optimum staffing plan of 934 FTEs, which assures workers safety and productivity
- Average tray cost for Acute Care \$1.88; average tray cost corporate wide \$1.96
- Achieved an aggregate cost savings of over \$57M during the first ten year term of the Contract

Key Contract Service Indicators Under New Contract

In a addition to the previous 10 year achievements, the renewal objectives include the following:

1. Enhance Patient Experience, Quality and Satisfaction

- New Hot Breakfast option to replace continental breakfast and improve the patient experience
 - ❖ Total cost to convert to the hot breakfast in acute care inclusive of one-time equipment cost is \$11M over 10 years
- Developing plan to train staff to achieve dietary certification, provide growth opportunities for workers and improve patient experience through HHC Consortium Union education fund

2. Clinical and Process Excellence

- Enhancement of patient safety and regulatory compliance by deploying CBORD; a clinical software technology that assures patients receive the doctor's dietary order

3. Operational Efficiencies

- Contract guarantees a staffing plan of 947 FTES, inclusive of 13 FTEs required to implement the hot breakfast initiative, and exclusive of an overtime cap to maintain optimal staffing and assure worker safety and productivity
- The consortium will fund \$1.5M with no requirement of the corporation to pay back. In addition, the consortium will loan the corporation \$6.5M to be paid back over the life of the contract at zero interest to allow the corporation to invest as it deems necessary for the capital needs of its dietary operations

Key Contract Service Indicators Under New Contract (continued)

4. Access

- Renovation of the CCP allows for the continued capacity to generate 20% more food in excess of that required by the Facilities thus allowing the Corporation to service more patients, if required
- No layoffs, attrition or outsourcing of unionized dietary workers to operate current services

5. Flexibility

- Standardized reporting systems for cost controls and financial analysis resulting in real time information that allows for rapid management and corrective action plans

6. Expertise

- HHC with the support of Sodexo will continue to comply to the Mayor's Office food guidelines
- Sodexo is able to change menus as needed to meet regulatory compliance

7. Due Diligence

- At the request of the COO, and prior to preceding with a contract renewal, a consultant was asked to assess and review the cost effectiveness of the HHC's current and future expenditures for its dietary operation. The consultant concluded that issuing a solicitation was not a risk worth taking and recommended proceeding with extending the current contract

8. Cost Savings

- In the last two fiscal years of the previous contract term (FY'13 and FY'14), the Corporation accrued a savings of \$15M for each requisite period. These savings are projected to continue to accrue over the renewal term of the Agreement, and we will also achieve a further savings of \$1.4M per year under the renewal Agreement for a total savings in excess of \$16M/yr.

Projected Contract Expenses

	Projected Consortium Contract Expense with Renewal Terms	Projected Consortium Contract Expense	Cost Savings
Jan 2015 – June 2015	\$ 16,796,932	\$ 17,490,680	\$ 693,748
FY 2016	\$ 33,637,443	\$ 35,035,923	\$ 1,398,480
FY 2017	\$ 33,936,883	\$ 35,357,956	\$ 1,421,073
FY 2018	\$ 34,526,085	\$ 35,971,000	\$ 1,444,915
FY 2019	\$ 35,200,748	\$ 36,670,775	\$ 1,470,027
FY 2020	\$ 35,891,576	\$ 37,388,006	\$ 1,496,430
FY 2021	\$ 36,633,427	\$ 38,123,107	\$ 1,489,680
FY 2022	\$ 37,427,223	\$ 38,876,505	\$ 1,449,282
FY 2023	\$ 38,239,437	\$ 39,648,637	\$ 1,409,200
FY 2024	\$ 39,070,512	\$ 40,439,948	\$ 1,369,436
July 2024 – Dec 2024	\$ 19,745,410	\$ 20,420,227	\$ 674,817
Total	\$ 361,105,676	\$ 375,422,764	\$14,317,088

The total cost savings figure above is exclusive of the accrued \$15M savings for each of FY'13 and FY'14 that are projected to continue to accrue over the renewal term of the Agreement.

Thank You

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with GSI Health, Inc. to provide a Care Coordination and Management Solution (CCMS). This solution will serve as the foundational population health management, coordination, communication, collaboration, documentation tracking, and registration system for the Corporation's overall Delivery System Reform Incentive Payment (DSRIP) strategy and several programs operated by the Corporation in conjunction with its DSRIP program. The contract shall be for a period of five years with two, one-year options to renew, exercisable solely by the Corporation, in an amount not to exceed \$35,441,897 (including a contingency of \$1,177,918 for additional software services as needed).

WHEREAS, the Corporation requires a CCMS to allow both internal and network providers and teams to manage and to coordinate the medical and non-medical services and resources patients may require to be successful in reaching their goals, consistent with and in support of the Corporation's DSRIP strategy; and

WHEREAS, the Corporation seeks to enter into a contract to provide a CCMS to support care coordination services for HHC patients throughout the five boroughs of New York City; and

WHEREAS, a Request for Proposals ("RFP") was issued on September 11, 2014; the selection committee, which rated the proposals using criteria specified in the RFP, recommended that GSI Health be awarded the contract; and

WHEREAS, the overall responsibility for monitoring the contract shall be under the Senior Vice President/Corporate Chief Information Officer and the Senior Vice President/Corporate Chief Medical Officer.

Now, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to negotiate and execute a contract with GSI Health, Inc. to provide a Care Coordination and Management Solution (CCMS). This solution will serve as the foundational population health management, coordination, communication, collaboration, documentation tracking, and registration system for the Corporation's overall Delivery System Reform Incentive Payment (DSRIP) strategy and several programs operated by the Corporation in conjunction with its DSRIP program. The contract shall be for a period of five years with two, one-year options to renew, exercisable solely by the Corporation, in an amount not to exceed \$35,441,897 (including a contingency of \$1,177,918 for additional software services as needed).

Executive Summary

Proposed Contract with GSI Health

The Offices of Medical and Professional Affairs and Enterprise Information Technology Services of the New York City Health and Hospitals Corporation (“the Corporation”) are proposing to enter into a contract with GSI Health (“GSI”) to provide a Care Coordination and Management Solution (“CCMS”). This solution will serve as the foundational population health management, coordination, communication, collaboration, documentation tracking, and registration system for the Corporation’s overall Delivery System Reform Incentive Payment (DSRIP) strategy and several programs in conjunction with DSRIP including but not limited to: Health Home, Children’s Health Home, NYCHHC Accountable Care Organization (ACO), and the care of the Uninsured (hereinafter referred to as the Programs).

To this end, the CCMS is a seamless, integrated platform that will enable the Corporation and its community based partners to achieve the goals of improving the health of our patients and reducing the cost of the care.

A Request for Proposal (“RFP”) was issued on September 11, 2014. Eight (8) proposals were submitted and evaluated by a selection committee using criteria specified in the RFP. Four of the proposals did not meet the minimum requirements as specified in the RFP. Each of the remaining qualified vendors demonstrated their solutions for the selection committee. On the basis of its submitted proposal and system performance, GSI’s proposal and system was ranked the highest overall and was deemed to be the most advantageous to the Corporation by the committee.

The contract shall be for a period of five years, with two consecutive one-year options to renew in an amount not to exceed \$35,441,897 (including a contingency of \$1,177,918 for additional software services as needed). The contract shall cover a population scaling up to approximately 2 million patients. The two consecutive one-year options for optional years 6 and 7 will be exercisable solely at the Corporation’s discretion. These funds will be utilized to provide payment to GSI for development, support, maintenance, training, and implementation of the CCMS.

The Corporation and GSI have come to a mutual understanding of GSI’s licensing fees, scope of work and time frames for completion of deliverables.

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

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Care Coordination and Management Solution
Project Title & Number: Collaborative Care Management Solution DCN # 034-0020
Project Location: 125 Worth Street, Suite 418 New York, New York 10003
Requesting Dept.: M&PA/EITS

Successful Respondent:	GSI Health
Contract Amount:	Not to exceed \$35,441,897 for the entire term of seven years (including a contingency of \$1,177,918 for additional software services as needed). In addition, the resolution requests authorization for 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.
Contract Term:	Five years with two (2) one year renewal options, exercisable solely by the Corporation

Number of Respondents: Eight (8)
(If Sole Source, explain in Background section)

Range of Proposals: Monthly SAAS fees ranged from \$150,000 to \$522,540 (based on 1M patients)

Minority Business Enterprise Invited: Yes ___ No if no, please explain: _____

Funding Source: ___ General Care ___ Capital
 Grant: explain Hospital Medical Home – Year 1
 Other: explain DSRIP & Health Home - Subsequent years

Method of Payment: Time and Rate The awarded contract vendor would receive monthly payment for invoiced work.
Other: explain _____

EEO Analysis: Approved November 18, 2014
17% Minority Business Enterprise; 8% Women Business Enterprise

Compliance with HHC's McBride Principles? Yes ___ No

Vendex Clearance ___ Yes ___ No 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.)

CONTRACT FACT SHEET (continued)

Background

In August 2014, NYSDOH informed HHC's Health Home division that its legacy billing program would no longer be acceptable as of Dec 31, 2014 (later postponed by NYSDOH to April 1, 2015). Because the Health Home unit's current vendor was unable to conform to the new standards, the Office of Procurement urgently issued an RFP on September 11, 2014 without prior CRC approval and without obtaining a waiver of Operating Procedure 100-5, which requires such prior approval before issuance of an RFP. On January 2, 2015, the President approved an "after the fact" deviation from only that part of the Corporation's Operating Procedure 100-5 that the Office of Procurement was unable to comply with (i.e., the requirement of obtaining prior CRC approval) given the circumstances. The RFP and selection process otherwise complied fully with Operating Procedure 100-5.

HHC intends to participate in the New York State DSRIP program, a 5-year, \$6.42B waiver to promote care delivery system transformation. DSRIP is the main mechanism by which New York State will restructure the health care delivery system by reinvesting in the Medicaid program, targeting a 25% reduction in avoidable hospital admissions over 5 years.

HHC's DSRIP strategy will include multiple projects that will fall under the auspices of several programs, including but not limited to:

- PPS
- ACO
- FIDA
- Health and Home Care
- Children's Health Home
- Health Home

Despite many enhancements, the current care plan management system meets only some of the initial NYS DOH requirements for Health Home. It can neither provide the needed flexibility for the revised Health Home requirements, nor does it have the capability to serve the complex demands and needs of the above named expanding populations.

CONTRACT FACT SHEET (continued)

Contract Review Committee

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

The proposed contract will be submitted at the January 7, 2015 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:

There are no changes to the contract's scope of work, timetable, budget, and contract deliverables.

Selection Process

Chairperson

Lauren Johnston Office of Patient Centered Care

Members

Ann Frisch	Health and Home Care
Bob Moon	Behavioral Health
Dave Cohen	IT
Deborah Rose	Health Home
Jared Sender	IT
Jennella Joseph	Revenue Management
Maria Arias-Clarke	Finance, Non-voting member
Megan Cunningham	ACO
Paul Albertson	Supply Chain Services
Shelley Cao	DSRIP

List of Firms Responding to the RFP:

1. ACUPERA
2. ADVISORY BOARD COMPANY- CRIMSON
3. BTQ
4. CARADIGM
5. e-CLINICAL WORKS
6. GSI HEALTH
7. NETSMART
8. PHYCARE SOLUTIONS

List of Firms Evaluated:

- THE ADVISORY BOARD COMPANY- CRIMSON
- CARADIGM
- GSI HEALTH
- NETSMART

Firm Selected:

- GSI HEALTH

Describe the process used to select the proposed contractor, the selection criteria, and the justification for the selection:

As a first step in evaluation, proposers provided two current clients for whom they provide a functional Care Coordination and Management Solution ("CCMS") that meets all of the Jan 2014 New York State Health Home Requirements. Only proposers who were able to provide this list were considered by the selection committee in the succeeding evaluation.

A. **Minimum Qualification Criteria (“MQC”)** Pass/Fail – Proposals submitted before the September 19, 2014 deadline were reviewed by the Committee based on the Pass/Fail criterion. The Committee made this determination based on a combination of the proposer’s MQC response document which included reference calls to the proposer’s current lead Health Home client(s).

B. **Preliminary Evaluation** – Only proposals that met the Minimum Qualification Criteria were reviewed by the Committee using the scoring sheet outlined in Section III. The following weighting formula was applied to determine a score for qualified proposals:

1. Care Coordination and Care Management Requirements – 50%
2. Specific Health Home Requirements– 15%
3. Technical Requirements – 15%
4. Billing as a Service – 15%
5. Training and Implementation Plan – 5%

C. **Live Presentations** – The Committee invited up to the top 4 scoring proposers to provide a 1 hour live presentation (including time for questions) to the committee. Presentations were scheduled between September 29 and October 2, 2014.

D. **Secondary Evaluation** – The Committee then re-scored the live presenters and determined the top 2 proposers (The Advisory Board/Crimson and GSI Health) based on the following weighting formula.

1. Care Coordination and Care Management Requirements – 50%
2. Specific Health Home Requirements– 10%
3. Technical Requirements – 15%
4. Billing as a Service – 10%
5. Training and Implementation Plan – 5%
6. Reference Calls – 10%

E. **Negotiations** – The Committee and the Procurement team discussed cost, scope, etc. with the top 2 proposers, The Advisory Board/Crimson and GSI Health.

Selection criteria:

F. **Final Evaluation** – The Committee determined the winner of the RFP based on the following formula:

1. Score from Secondary Evaluation – 50%
2. Total Cost – 50%

The CCMS Evaluation Committee decided to revisit the final scoring for Crimson and GSI for the following reasons:

- 1- During the course of our referral calls with existing clients of our two vendor finalists, there were some negative comments regarding many essential functions of Crimson. These included references to: promised but undelivered functionality such as reporting; significant performance issues (slow application response times) which users referred to as “the black wheel of death”; an unfamiliarity with upcoming NY State Health Home workflows, specifically around Children’s Health Home; inexperience with EMR interfaces; and data ingestion problems.
- 2- The existing RHIO/HIE landscape has changed in the last two weeks. NYeC, who formerly was charged with providing technical resources and support to the downstate RHIOs, has restructured and will no longer be providing those services in order to focus

on its own HISP and the implementation of the SHIN-NY, the Statewide Health Information Network for New York. This potentially puts some of these RHIOs, who were dependent on NYeC resources, at risk. HIE functionality is a major aspect of DSRIP and if RHIOs become unavailable at any time during the 5 year DSRIP period, this would put HHC in a difficult situation. Because the CCMS platform would be receiving most if not all of the same data as the RHIO, the committee has decided to score the vendors with an additional focus as to its suitability for use as a backup HIE platform.

Justification of selection:

- **Robust Care Coordination and Care Management Platform**
 - Facilitates patient care plan development, team collaboration, real-time alerting, documentation and reporting
 - Enhanced risk stratification and analytics capability
- **Knowledge of New York State Programs and Technology Systems**
 - Locally based and well connected to State healthcare administrators
 - Ability to anticipate and respond quickly to evolving regulatory landscape
- **Ease of Integration with Health Home and PPS Partners**
 - Critical mass of NYC Lead Health Homes and downstream providers utilize GSI
 - Reduces training, implementation, and coordination burden
- **Core Technical and HIE Functionality**
 - Meets “Dial Tone Service” requirements
 - Potential alternative for health information exchange if RHIO implementation is delayed
- **Reference Recommendations**
 - Highly positive reviews as compared to competitors, particularly with regard to Health Home support

Other Positives in GSI's Favor

- Has experience in the New York City Health Home ecosystem. Has understanding of connectivity with RHIOs and EMRs.
- Is already a provider for many downstate Health Homes and potential DSRIP PPS partners. This can simplify and speed connectivity with other Health Homes.
- Can support Health Home out of the box.
- Has equivalent Data Center to other vendors.
- Has insight into NY State policy. This will help GSI to anticipate, respond and react to new state technical and reporting requirements before other vendors are aware of changes.
- Supports Direct protocol for secure email. This is a requirement of Meaningful Use.
- Supports CCD clinical data transport. This is also a requirement for Meaningful Use.
- Has out of the box reporting functionality including critical FACT GP and CMART for Health Home.
- Will have risk stratification tool available 1st/2nd Quarter 2015.
- Has a Master Patient Index algorithm that will address patient matching until an Enterprise level solution is available.
- Alerting is available out of the box.

Negatives of Other Bidders

- Crimson: Negative reference call. It was reported that many promised functions are not available and that there are frequent performance issues. Does not support CCD or Direct secure email. Would require some customization.
- Caradigm: Did not display any expertise or knowledge of Health Home or other aspects of Care Plan Management or Care Coordination. CCMS would need to be custom built on their platform by a company that has been late with many deliverables for HHC in the past.
- Netsmart: Did not have many of the necessary features such as Direct secure email, Lab interfaces, document uploads and alerting. Would require significant customization.

CONTRACT FACT SHEET (continued)

The selected vendor is expected to immediately provide an off-the-shelf solution to meet these Health Home detailed requirements, and to go "live" following a 90 day implementation process. As the specifications for the impending Children's Health Home and DSRIP get released, the selected vendor will commit to jointly agreed-to implementation dates, which will also include the Uninsured. The ACO implementation date is flexible, based on the release details/dates for Children's Health Home and DSRIP.

Provide a brief costs/benefits analysis of the services to be purchased.

IT Build	\$ 12,957,097
Program Configuration and Deployment	\$ 1,087,200
PMPM	\$ 21,159,600
Training	\$ 238,000

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

The initial contract for a care plan management system totaled \$16.1 million for 7 years (5 years and 2 - one year renewals), plus work orders for all work deemed outside the initial statement of work (\$830,014 to date). Currently, EITS is paying an annual maintenance fee (\$428,000). Spending will continue for the remainder of the contract by EITS to support the Patient Portal and to achieve Meaningful Use certification.

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

HHC's existing technology does not meet, and is not scalable to the requirements needed for operating and supporting the Health Home, ACO, DSRIP 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 FACT SHEET (continued)

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

- Ross Wilson, MD, SVP, Corporate Chief Medical Officer – M&PA
 - Bert Robles, SVP, Chief Information Officer – EITS
 - Lauren Johnston, Senior AVP, Chief Nurse Executive – M&PA
 - Paul Contino, Chief Technology Officer – EITS
 - Jared Sender, Population Health Management Lead – EITS
 - David Cohen, IT Program Manager – EITS
 - Inger Dobson Slade, Associate Director – M&PA
-

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):

As part of its efforts, the selection committee posted this RFP in The City Record, a long established outreach practice in maximizing inclusive responses to same. Further, it is noted that the selected candidate, GSI Health, has a woman as its principal. Lastly, if approved, GSI Health will be required to submit proof of New York State certification for all subcontractors.

Received By E.E.O. September 16, 2014
Date

Analysis Completed By E.E.O. November 18, 2014
Date

Manassas C. Williams, AVP
Name



Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: Inger A. Dobson Slade, MPA, PMP
Project Director, HIE Initiatives
Central Office – Office of Patient Centered Care

FROM: Manasses C. Williams

DATE: November 18, 2014

SUBJECT: EEO CONTRACT COMPLIANCE

The proposed contractor/consultant GSI Health, LLC, 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): Office of Patient Centered Care

Contract Number: _____

Project: Implementation of Care Coordination and Management Solutions

Submitted by: Office of Patient Centered Care

EEO STATUS:

1. Approved
2. Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3. Not approved
4. Conditionally approved subject to EEO Committee Review

COMMENTS:

c:



HHC Board of Directors: Proposed Care Management Contract with GSI Health Inc.

January 29, 2015

Lauren Johnston, Sr. AVP and Chief Nursing Officer
Ross Wilson MD, SVP & Chief Medical Officer
Paul Contino, Chief Technology Officer

Providing
quality,
affordable care
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Harlem • Health & Home Care • Jacobi • Kings County • Lincoln • Mariner's Harbor • McKinney • MetroPlus
Metropolitan • Morrisania • North Central Bronx • Queens • Renaissance • Sea View • Stapleton • Woodhull



Action Requested

- HHC is seeking Board approval to enter into contract with GSI Health, Inc. for a Care Coordination and Management Software Solution with a Not-To-Exceed Cap of \$35,441,897 (5 year term with 2-one year options)



Care Coordination and Management Solution Operational Imperative

Health Home — HHC is designated as a Health Home by New York state in 4 boroughs. HHC needs an IT platform that not only assists with the care planning process, but facilitates NYS reporting and billing requirements. The current Health Home billing process will become obsolete on *April 1, 2015 and the current care coordination platform is unable to satisfy the requirements. The Health Home patient volume should be up to 50,000, with projected annual revenue of \$15m

*Note: date has slipped, but NYS has not indicated the new date

DSRIP — HHC needs a single platform to support the care coordination of up to *2 million DSRIP patients.

*more likely 1.2-1.5m patients, but exact projection difficult at this time



Care Coordination and Management Solution



Patients may be enrolled in one or more of The Programs that support HHC's integrated healthcare delivery transformation strategy.





Procurement

- Request for Proposal process was utilized
- Advertisement posted in the City Record
- Eight (8) vendors were invited or expressed interest in submitting proposals
- 4 vendors met the minimum qualifications and presented verbal presentations: Caradigm, Crimson, GSI Health, NetSmart
- Evaluation committee:
 - Lauren Johnston, Chair
 - Jared Sender - IT
 - Ann Frisch - Health and Home Care
 - Jennella Joseph – Revenue Management
 - Bob Moon - Behavioral Health
 - Maria Arias-Clarke - Finance
 - Dave Cohen - IT
 - Megan Cunningham – ACO
 - Deborah Rose – Health Home
 - Paul Albertson – Supply Chain Services
 - Shelley Cao - DSRIP





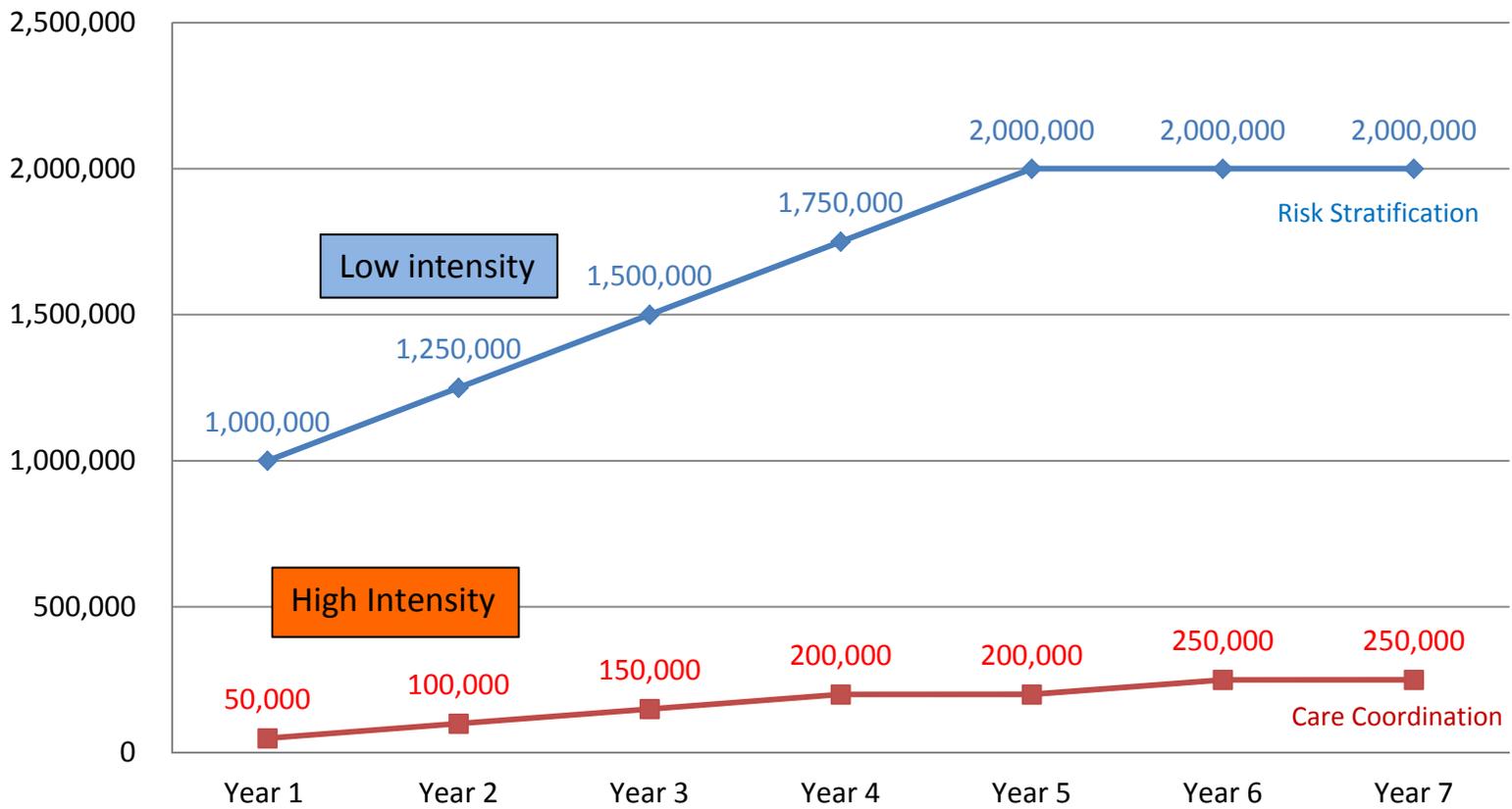
GSI Health Inc. – The Unanimous Choice

- Meets the need of a “functional CCMS that meets all of the Jan 2014 New York State Health Home Requirements”
- Is current platform for 10 Health Homes (5 in NYS including Brooklyn)
- Has been identified by Maimonides PPS as its technology solution for its DSRIP
- Proposes a 60-90 day roll out for immediate use by the Health Home
- Has verbally agreed to contract provisions to minimize HHC risk in the event of poor GSI performance

This Care Coordination and Management Solution can serve as the foundational population health management, coordination, communication, collaboration, documentation tracking, and registration system for HHC’s overall Delivery System Reform Incentive Payment (DSRIP) strategy and several other programs: Health Home, the planned Children’s Health Home and HHC’s Accountable Care Organization (ACO). It is shelf ready and scalable.



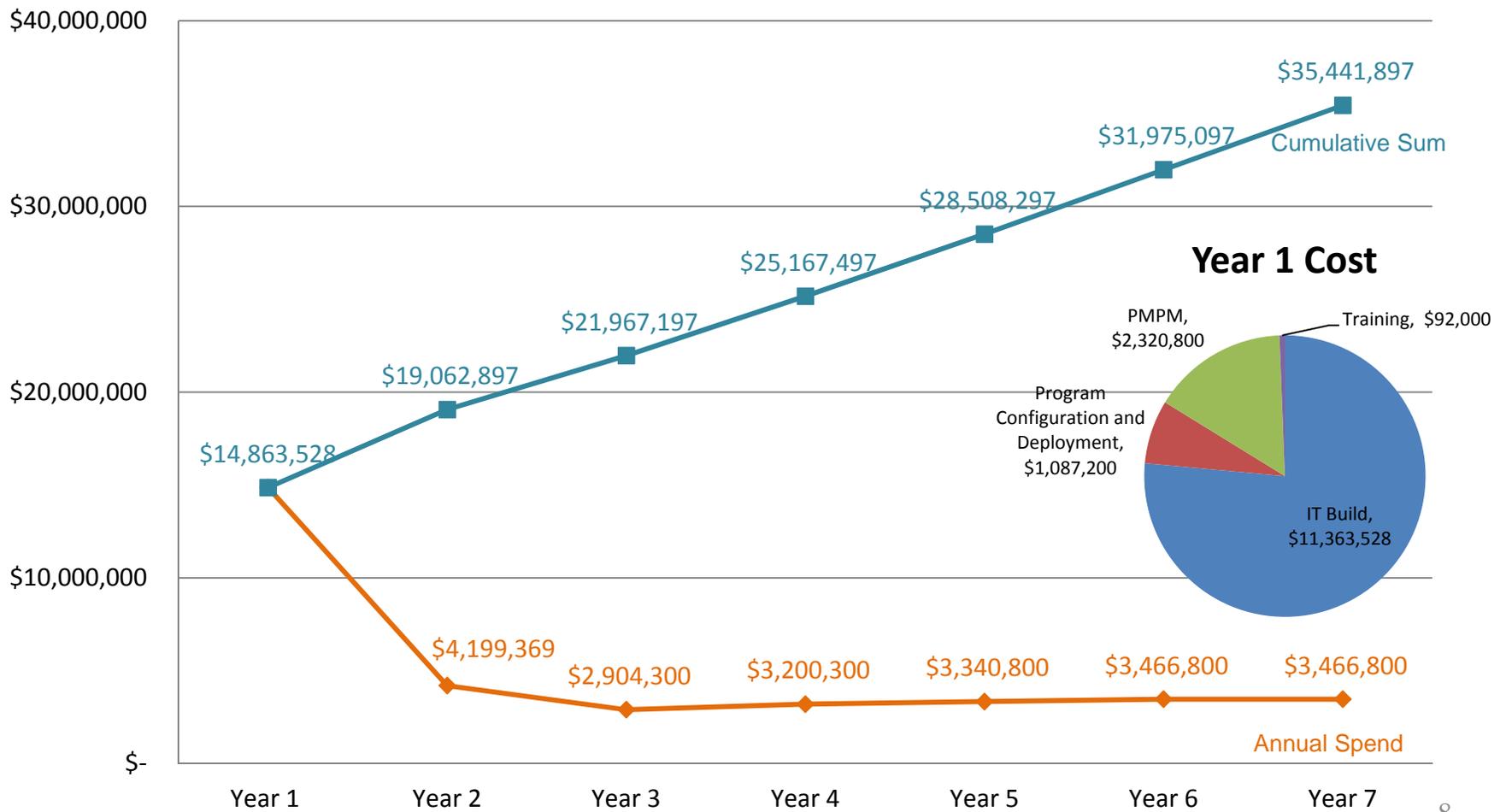
Projected Patient Volumes





Total Cost of Ownership

7 Year Cost Projection





Funding Sources

- Hospital Medical Home Grant
 - Health Home Revenue
 - DSRIP funds
-
- ❖ The previously shown IT Planned Expenditure document does NOT include this proposal. This is an externally driven new need, with a new source of funding.



NEW YORK CITY
HEALTH AND
HOSPITALS
CORPORATION

How NYC takes care of its own.



-
- Thank you

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a one-year revocable license agreement with SST, Inc. (the "Licensee") for its use and occupancy of approximately one square foot of exterior space for the operation of acoustical equipment at a single pilot facility of the Corporation with the occupancy fee waived and with the President holding an option to extend the license for up to four additional years to match the length of the Licensee's agreement with the New York City Police Department (the "NYPD") if such agreement is extended and with the President having the authority to designate the location included in the license.

WHEREAS, the Licensee installs and operates acoustical equipment in cooperation with the NYPD; and

WHEREAS, the Licensee participates in a pilot program operated by the NYPD; and

WHEREAS, the NYPD has asked the Corporation to house the Licensee's acoustical equipment at one of its facilities; and

WHEREAS, the Licensee's acoustical equipment complies with all regulatory guidelines, poses no health risk and will not compromise or interfere with the operations of the Corporation's facilities.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and is hereby authorized to execute a one-year revocable license agreement with SST, Inc. for its use and occupancy of approximately one square foot of exterior space for the operation of acoustical equipment at a single pilot facility of the Corporation with the occupancy fee waived and with the President holding an option to extend the license for up to four additional years to match the length of the Licensee's agreement with the New York City Police Department if such agreement is extended and with the President having the authority to designate the locations included in the license.

EXECUTIVE SUMMARY

LICENSE AGREEMENT SST, INC.

A SINGLE FACILITY OF THE CORPORATION TO BE DETERMINED

The President of the New York City Health and Hospitals Corporation seeks authorization to execute a revocable license with SST, Inc. ("SST") for its use and occupancy of approximately one square foot of exterior space for the operation of acoustical equipment at a single pilot facility of the Corporation.

SST, based in California, operates acoustical equipment potentially useful to the New York City Police Department (the "NYPD"). SST's system has been deployed in over sixty cities in the United States and abroad. SST will install and operate the equipment at its own expense. SST's equipment complies with all regulatory guidelines and poses no health risk and will not compromise or interfere with Facility operations. The occupancy fee will be waived.

Once installed, the acoustical equipment requires no on-site maintenance or operation. The Corporate facility will supply the necessary electricity.

SST is party to an agreement with the NYPD that provides for a pilot study of the usefulness of the acoustical equipment. The pilot agreement is one-year in length. The proposed resolution will enable the President to negotiate and execute a license agreement with SST that will be for one year but that may be extended to match the length of SST's agreement with the NYPD if, and to the extent, that the same is extended, but not longer than five years.

The President shall have the authority to designate the facility of the Corporation that will be the single pilot facility to be the location of the license.

The Licensee will 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 will not exceed five years without further authorization by the Board of Directors of the Corporation and shall be revocable by either party upon ninety days' written notice.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a Customer Installation Commitment ("CIC") with the New York City Department of Citywide Administrative Services ("DCAS") and the New York Power Authority ("NYPA") for an amount not-to-exceed \$9,462,886 for the planning, pre-construction, design, construction, procurement, construction management and project management services necessary for the Energy Conservation Measures upgrade project (the "Project") at Woodhull Medical and Mental Health Center (the "Facility").

WHEREAS, in March 2005, the Corporation, the City University of New York, the New York City Board of Education, and the City of New York, through the Department of Citywide Administrative Services (collectively, the "Customers"), entered into an Energy Efficiency-Clean Energy Technology Program Agreement ("ENCORE Agreement") with NYPA; and

WHEREAS, in September 2014, the City mandated a 80% reduction in greenhouse gas emissions in City-owned properties by 2050, managed by Division of Energy Management within Department of Citywide Administrative Services ("DCAS"); and

WHEREAS, in December 2009, as part of PlaNYC 2030, the City passed major legislation known as the "Greener, Greater Buildings Plan" that included more stringent code requirements; required installation of lighting upgrades and tenant meters in non-residential spaces; and required all buildings over 50,000 square feet to undertake benchmarking and audits; and implement retro-commissioning measures. Local Law 87 mandated Comprehensive Energy Audits be completed within a 10 year time frame (2013 – 2023); and

WHEREAS, the City, through DCAS, has allocated funding under the Accelerated Conservation and Efficiency ("ACE") program for improvements and upgrades to increase energy efficiency and energy cost savings at City-owned facilities in line with the PlaNYC initiative to reduce energy and greenhouse gas emissions of municipal operations 80% by 2050; and

WHEREAS, a component of the project will make the Corporation compliant with fuel combustion standards through elimination of No. 6 fuel oil; and

WHEREAS, the Corporation has determined that it is necessary to address the proposed energy conservation measures at the Facility by undertaking the project at a not-to-exceed cost of \$9,462,886 (see Exhibit A – Executive Project Summary), to enhance the reliability of its systems, as well as increase the comfort and safety of the building occupants; and

WHEREAS, DCAS has deemed this ACE project to be eligible under the PlaNYC initiative and has allocated \$7,897,840 in the PlaNYC capital budget; and

WHEREAS, NYPA demonstrates that the project will produce total annual cost savings to the Facility estimated at \$541,679; and

WHEREAS, the overall management of the construction contract will be under the direction of the Assistant Vice President - Facilities Development.

**PAGE TWO – RESOLUTION
CIC – DCAS/NYPA/HHC**

NOW THEREFORE, be it

RESOLVED, the President of the New York City Health and Hospitals Corporation (the “Corporation”) to execute a Customer Installation Commitment (“CIC”) with the New York City Department of Citywide Administrative Services (“DCAS”) and the New York Power Authority (“NYPA”) for an amount not-to-exceed \$9,462,886 for the planning, pre-construction, design, construction, procurement, construction management and project management services necessary for the Energy Conservation Measures upgrade project (the “Project”) at Woodhull Medical and Mental Health Center (the “Facility”).

EXECUTIVE SUMMARY

WOODHULL MEDICAL AND MENTAL HEALTH CENTER NEW YORK POWER AUTHORITY (NYPA) - ENERGY CONSERVATION MEASURES UPGRADE

OVERVIEW: The Corporation is seeking to undertake an energy efficiency project, which addresses mandated energy reduction use while complying with elimination in the combustion of No. 6 (six) fuel oil, which will be no longer be used in most New York City buildings.

In addition, to comply with environmental combustion standards relating to No. 6 fuel oil, this project will incorporate a number of energy efficiency recommendations that arose from a comprehensive energy audit funded by the Department of Citywide Administrative Services (DCAS). The project is fully design, estimated, and completely bid under NYPA. The project cost is not-to-exceed \$9,462,886.

NEED: During the Comprehensive Energy Efficiency Audit of the Facility managed by NYPA, it was determined that several energy conservation measures (ECMs) of the audit be implemented. ECMs such as lighting upgrades, energy management systems upgrades, replacement of boilers burners (including fuel tanks upgrades), and other energy consumption measures be implemented to enhance the reliability of the facility systems, as well as increase the comfort and safety of building occupants. The facility currently operates three (3) medium pressure boilers installed in the 1970's, which have dual fuel burners and have the ability to operate No. 6 residual fuel. By February 2016, the facility cannot use No. 6 residual fuel. Since the existing boilers are in good condition and expected to provide reliable service for years to come, this measure proposes the installation of new burners and conversion to No. 2 fuel oil. If the boilers are not upgraded by February 2016, they would be deemed inoperable.

In 2013, the City of New York, through the Department of Citywide Administrative Services ("DCAS") allocated funding for improvements and upgrades to increase energy efficiency and energy cost savings at City-owned facilities in line with the PlaNYC initiative to reduce energy costs and greenhouse gas emissions ("GHG") of municipal operations 30% by 2017¹. DCAS developed the Accelerated Conservation and Efficiency ("ACE") Program to fund capital-eligible energy efficiency and clean energy projects. DCAS approved PlaNYC funding for the following ECMs at the Facility:

- ECM – 1: Lighting Upgrades;
- ECM – 2: Vacancy sensors upgrades;
- ECM – 3a: Boiler Burner Replacement;
- ECM – 3b: Fuel Tank Upgrades;
- ECM – 4: Steam Trap Upgrades;
- ECM – 5: Energy Management Systems (EMS) Upgrades; and
- ECM – 6: Fan Coil Unit Variable Speed Controller.

SCOPE: The scope of work corresponds to the ECMs approved by DCAS:

- ❖ ECM – 1: Replace the remaining T-12 lamp fixtures with high performance T-8 lamps at the Facility;
- ❖ ECM – 2: Install wireless vacancy sensors in offices and conference rooms throughout the Facility;

PAGE TWO – EXECUTIVE SUMMARY
CIC – DCAS/NYPA/HHC

- ❖ ECM – 3a: Replace existing burners with dual fuel modulating burners which will use natural gas and No. 2 fuel oil;
- ❖ ECM – 3b: Convert the existing No. 6 residual oil storage tanks to No. 2 fuel oil storage tank;
- ❖ ECM – 4: Replace eighty-nine (89) failed steam traps;
- ❖ ECM – 5: Install new direct digital control panels on selected number of air handling units that are not currently tied into the energy management systems; and
- ❖ ECM – 6: Install variable speed Opto Generic Devices on each fan coil unit motor.

TERMS: NYPA has competitively bid this project and has submitted a final total project cost to the Corporation.

COSTS: \$9,642,886

SAVINGS: Electrical:
Electrical Energy Consumption Savings: 2.1 kilowatts
Monthly Demand Decrease: 33.65 kilowatts
Annual Electrical Energy Savings: \$290,285

Fuel:
Gas / Oil Savings: 217,850 therms
Gas / Oil Energy Savings: \$251,394
CO2 Reductions: 1,913.5 tons

Total Annual Estimated Savings: \$541,679

FINANCING: PlaNYC Capital - \$7,897,840 (no cost); and General Obligations Bonds- \$1,565,046. The Corporation expects to proceed with this project upon the approval of this resolution, and the execution of the Customer Installation Commitment ("CIC") (see Exhibit B).

SCHEDULE: HHC expects NYPA to complete this project by June 2016.

¹ In September 2014, New York City released a comprehensive, 10-year plan called "*One City: Built to Last-Transforming New York City's Buildings for a Low Carbon Future*" to address the energy used in our buildings. The plan has an overall target of reducing greenhouse gas (GHG) 80% below 2005 levels by 2050, with an interim target to reduce building-based GHG emissions by 35% from 2005 levels by 2025.

**Woodhull Medical & Mental Health Center
Energy Conservation Measures Upgrade Project
Table 1: Total Project Summary**

Line #	Item	Percentage Rates	Costs
1	Construction Material Costs ⁽¹⁾		\$2,885,351
2	Construction Labor Costs ⁽¹⁾⁽²⁾		\$2,960,393
3	Asbestos Abatement		\$31,200
4	Subtotal Construction Cost (total of lines 1 thru 3)		\$5,876,944
5	Construction Contingency ⁽³⁾	10.0%	\$587,695
6	Allowance ⁽⁴⁾		\$300,000
7	Subtotal Construction Cost plus Construction Contingency & Allowance (lines 4 thru 6)		\$6,764,639
8	Payment and Performance Bond		\$164,704
9	Hazardous Waste Disposal Cost		\$72,800
10	Reduce Scope fees		\$158,338
11	Environmental Waste Management Fees		\$5,149
12	Expeditor Fee		\$10,000
13	Architect/Engineering & Construction Management Fees ⁽⁵⁾	17.0%	\$1,144,154
14	NYPA Project Management & Administrative Fees ⁽⁶⁾	11.0%	\$744,110
15	NYPA Lighting Material Handling Fees		\$2,672
16	Subtotal Construction Costs and Fees (total of lines 7 thru 15)		\$9,066,566
17	Interest During Construction (IDC) ⁽⁷⁾		\$396,320
18	Total Project Cost (total of lines 16 & 17)		\$9,462,886

- Notes:
- (1) Construction costs based on selected contractors bid reviewed and approved by NYPA.
 - (2) Construction labor costs includes fees for general conditions, controlled inspections and environmental permit services.
 - (3) Construction Contingency is 10% of the construction cost.
 - (4) Allocated amount for asbestos abatement and underground storage tank repairs if required.
 - (5) Architect/Engineering and Construction Management fees is 17% of construction cost and contingency (total \$6,730,319).
 - (6) NYPA fees is 11% of construction cost, contingency and allowance - Line 7 (\$6,764,639).
 - (7) Interest during construction is based on 24 months at 4%.

NYC & NYPA ENCORE II: INITIAL CIC REPORT CIC APPROVAL
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Date: 29-Dec-14

Project No.: ES-GSN-0721

Project: HHC Woodhull Hospital

CUSTOMER REPAYMENT OBLIGATION

Total Installed Cost of Project	\$9,462,885.50
NYPA Incentive Payment	\$0.00
Energy Grant	\$0.00
CUSTOMER Repayment Obligation	\$9,462,885.50

METHOD OF PAYMENT

Progress Payments, payable upon receipt of AUTHORITY invoices after completion of each milestone \$9,462,885.50

Outstanding Balance financed by Authority	\$0.00
Estimated Authority Cost of Money	4.00%
Number of Monthly Payments	120
Monthly Bill Surcharge	\$0.00
Annual Bill Surcharge	\$0.00

ESTIMATED ANNUAL COST REDUCTION

Annual Energy Cost Savings	\$541,679.09
Annual Other Cost Savings	\$0.00
Total Annual Cost Savings	\$541,679.09

AUTHORIZATIONS

Signatures in the spaces below signify that the parties have reviewed and agree to the CIC Design and specifications presented to them by the AUTHORITY.

Authorized CUSTOMER Representative:

Agency NYC Health and Hospitals Corporation

Signature _____

Name Dr. Ramanathan Raju

Title President & CEO

Date _____

Agency North Brooklyn Healthcare Network

Signature _____

Name George Proctor

Title Network Senior VP

Date _____

Authorized CITY Representative:

Agency Dept. of Citywide Admin. Services

Signature _____

Name Richard Badillo

Title Chief - DFMO

Date _____

Agency Dept. of Citywide Admin. Services

Signature _____

Name Ozgem Ornektekin

Title Deputy Commissioner

Date _____

Authorized AUTHORITY Representative:

Agency NYPA

Signature _____

Name Gil Quiniones

Title President & CEO

Date _____

Agency _____

Signature _____

Name _____

Title _____

Date _____