AGENDA

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE

Meeting Date: April 11, 2013
Time: 9:30 AM
Location: 125 Worth Street, Room 532

BOARD OF DIRECTORS

CALL TO ORDER — **DR. STOCKER**

ADOPTION OF MINUTES
-February 14, 2013

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

METROPLUS HEALTH PLAN — **DR. SAPERSTEIN**

INFORMATION ITEMS:

1. **Soarian Project Update** — **MS. ZURACK/ MS. KATZ**
2. **Care Coordination Demo** — **MS. KAUFMAN/ MR. CONTINO**

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

MINUTES

MEDICAL AND PROFESSIONAL AFFAIRS/ INFORMATION TECHNOLOGY COMMITTEE BOARD OF DIRECTORS

Meeting Date: March 14, 2013

ATTENDEES

COMMITTEE MEMBERS:

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

HHC CENTRAL OFFICE STAFF:

Deborah Cates, Chief of Staff, Board Affairs
Paul Contino, Chief Technology Officer
Shawn Davie, Senior Director, Office of Healthcare Improvement
John Delalio, Senior Director, EITS
Juliet Gaengan, Senior Director, Clinical Affairs
Marisa Salamone-Greason, Assistant Vice President, EITS
Sal Guido, Interim Assistant Vice President, Infrastructure Services
Evelyn Hernandez, Director, Media Relations
Caroline Jacobs, Senior Vice President, Safety and Human Development
Christina Jenkins, MD, Assistant Vice President, Primary Care Services
Lauren Johnston, Senior Assistant Vice President/Chief Nursing Officer, Patient Centered Care
Michael Keil, Assistant Vice President, IT Service Management
Mei Kong, Assistant Vice President, Patient Safety
Patricia Lockhart, Secretary to the Corporation
Ana Marengo, Senior Vice President, Communications & Marketing
Antonio D. Martin, Executive Vice President/Corporate Chief Operating Officer
Kathleen McGrath, Senior Director, Communications & Marketing
Susan Meehan, Assistant Vice President, HHC Office of Emergency Management
Angela Minielli, Director, EITS
Krista Olson, Senior Director, Corporate Budget
Bert Robles, Senior Vice President, Chief Information Officer
Salvatore Russo, Senior Vice President & General Counsel, Legal Affairs
Aleksandra Sas, Associate Director, Center for Culturally and Linguistically Appropriate Services (CLAS)
Pat Slesarchik, Assistant Vice President, Labor Relations
David Stevens, MD, Senior Director, Office of Healthcare Improvement
Azfshan Syed, Manager, EITS
Steven Van Schultz, Director, IT Audits
Joyce Wale, Senior Assistant Vice President, Office of Behavioral Health
Manasses Williams, Assistant Vice President, Office of Affirmative Action/EEO
Ross Wilson, MD, Senior Vice President/Corporate Chief Medical Officer
Marlene Zurack, Senior Vice President & Chief Financial Officer

FACILITY STAFF:

Lynda D. Curtis, Senior Vice President, South Manhattan Network
John Maese, MD, Medical Director, Coney Island Hospital Center
George Proctor, Senior Vice President, Central/Northern Brooklyn Network
Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan

OTHERS PRESENT:

Dwayne Breining, MD, Vice Chair, Laboratory Operations, North Shore LIJ Laboratories
James Crawford, MD, PhD, Senior Vice President, Chairman of Pathology and Laboratory Medicine, North Shore LIJ Laboratories
Moira Dolan, Senior Assistant Director, DC 37, Research & Negotiations Department
Scott Hill, Account Executive, QuadraMed
Richard McIntyre, Key Account Executive, Siemens
Stephen McNeil, Vice President of Sales, CyraCom International, Inc.
Megan Meagher, Analyst, Office of Management and Budget
Fred Moyle, VP and General Manager of Healthcare Sales, Language Line Services
David Porter, President, Pacific Interpreters, Inc.
Bob Stallone, Vice President, North Shore LIJ Laboratories

**MEDICAL AND PROFESSIONAL AFFAIRS/
INFORMATION TECHNOLOGY COMMITTEE
Thursday, March 14, 2013**

Michael A. Stocker, MD, Chairman of the Board, called the meeting to order at 12:05 P.M. The minutes of the February 14, 2013 Medical & Professional Affairs/IT Committee meeting were adopted.

CHIEF MEDICAL OFFICER REPORT:

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

1. Integrating depression care into Primary Care ("Collaborative Care")

HHC will contract for Collaborative Care Training with the University of Washington as part of the NYS Hospital Medical Home Demonstration Program. The contracted services will provide adult primary care clinics at all HHC Hospitals and D&TCs with comprehensive training, coaching and quality oversight services so that they can implement best-practices for integrated care management of depression in primary care. Collaborative care for depression in primary care is a requirement of the NYS Hospital Medical Home Demonstration and aligns with NCQA PCMH standards."

2. New York Safe Act

This new NYS Secure Ammunition and Firearms Enforcement Act has reporting requirements/provisions that the behavioral health community is concerned will deter people from seeking treatment. The Act requires that Mental Health licensed professionals report to DOHMH in the exercise of "reasonable professional judgment" when they determine a client/patient is likely to engage in conduct that would result in serious harm to self or others. We are awaiting further guidance from the State and the city about the implementation which is to take effect in March.

3. Behavioral Health Visioning Workshop Held

The Office of Behavioral Health together with the Breakthrough Office held a Visioning event to address the changes in models of behavioral health care, as we move into a fully managed care environment for mental health and chemical dependency services. The event held over a day and a half was enterprise-wide with interdisciplinary, facility and central office participants. The Reason for Action frankly addressed dissatisfaction from all stakeholders with current practices, and expressed strong concern about the financial consequences of continuing as we are. The group discussed how to achieve the triple aim while maintaining the HHC mission. The event proposed some strategic questions for HHC leadership, as well as a corporate-wide breakthrough event to reduce inpatient length-of-stay which should commence late in April.

4. Blood Transfusion Guidelines

New HHC guidelines for the use of red cell transfusions are about to be released, to address the appropriate use blood. This follows more than one year of work by a multi-disciplinary group led by Dr. Fishkin and supported by the Office of Healthcare Improvement. The guidelines are now being pilot tested at Woodhull.

5. Credentialing

A contract is being finalized to streamline current credentialing and privileging processes. This new program will standardize a corporate-wide approach, as well as incorporating OPPE and FPPE requirements. It will also facilitate the credentialing of providers at more than one HHC facility, to assist when they provide services at more than one site or need to move sites in circumstances like Hurricane Sandy.

6. Christina Jenkins MD

Dr. Jenkins has stepped down from membership of the HHC Board (and Chair of its QA committee) to join the division of Medical & Professional Affairs as Assistant Vice President for Primary Care Services. In this new role, she will oversee the McKinsey project to improve primary care access, as well as coordinate new efforts to better incorporate technology and social networking in our care delivery.

CHIEF INFORMATION OFFICER REPORT

Bert Robles, Senior Vice President/Chief Information Officer provided the Committee with updates on the following initiatives:

1. HHC's Response to the February 21st Cyber-Attacks

On Thursday, February 21st, China, according to "*The Washington Post*" hacked computers of virtually every institute in Washington. Additionally on the same day, Froedhert Hospital in Milwaukee, Wisconsin announced that it encountered one massive security hack that caused 43,000 patient records to be exposed. It was estimated that this security breach could cost Froedhert hospital close to $8.3m in damages.

Following these developments, the EITS Security Team became extra vigilant in monitoring intrusion attempts on our corporate assets especially from outside HHC. On February 22nd, the EITS Security Team proactively engaged the "*US Computer Emergency Readiness Team"* (US-CERT) and received specific IP addresses and websites that were involved in attacks against US government and private entities. This was non-public information and was received over a secure channel. In addition, the Security Team engaged and alerted its security partners/vendors and sister agencies. Based on historical institutional knowledge and information received from the Department of Homeland Security, the FBI and other entities contacted, the EITS Security Team elevated HHC's security status which included re-calibrating our perimeter security devices (Intrusion Prevention Systems, Anti-Virus, DNS, Firewalls etc.,) within a matter of 4 hours to cover all known as well as unknown but expected intrusions. In addition, the monitoring which is usually from 8am-6pm was extended to 24 by 7 from Friday, February 22nd through Monday, February 25th.

As a result of these proactive measures and collaboration with internal and external entities, HHC managed to block all malicious attempts. At this point, there is no reported or detected compromise of any HHC asset due to the alleged Chinese cyber-attacks. We continue to operate our security devices at increased sensitivity but have resumed normal security monitoring.

2. ICIS Electronic Health Record (EHR) Program Update:

Since Mr. Robles last update to the Committee at the January meeting, he is pleased to report that their planning phase for the Epic implementation is well underway.

<u>Staffing:</u>
The first major deadline with the project was to have identified 80% of the project team members by March 1st in order for HHC to begin the first wave of Epic training on March 25th. Depending on their identified

roles, EHR staff may need to attend multiple trainings at the Epic campus in order to receive their certification on specific application modules. It was critical for the program team to recruit and identify those key staff members who would be attending the first trainings scheduled for the week of March 25th. Mr. Robles is happy to report that the team has met this challenge and they will be sending their first wave of trainees to EPIC in late March.

Current Program Activities:
The Infrastructure and Operations team has ordered the necessary hardware for the program and it is being staged for initial review of the EPIC application.

The program team continues to work on and prioritize workflows for standardization across the enterprise. They are in the process of developing a plan for application review sessions which will start in late June of this year and go through August. They anticipate some 200+ sessions for this review by HHC clinical and non-clinical staff over a 6-8 week period. Planning for this large scale event is underway and the team is currently exploring venues where this event could be held.

Mr. Robles reported that they are also in the process of finalizing the program plan which includes establishing a governance model, refining baseline timelines and milestones, as well as creating a risk plan. With Epic, they are also in the process of looking at key criteria that will be used in discussions with Senior HHC leadership to identify which facility/network will be the initial site for our implementation strategy.

Going forward, Mr. Robles will continue to provide a monthly update to the Committee members on their progress.

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 as of February 28, 2013 was 440,352. Breakdown of plan enrollment by line of business is as follows:

Medicaid	376,316
Child Health Plus	13,090
Family Health Plus	35,650
MetroPlus Gold	3,184
Partnership in Care (HIV/SNP)	5,604
Medicare	6,485
MLTC	23

Dr. Saperstein informed the Committee that this month, they had a net loss of 4,339 members and experienced a positive gain in Medicare, gaining 346 enrollees.

Dr. Saperstein provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

This month, MetroPlus analyzed disenrollments from their plan. In February, MetroPlus had 19,978 disenrollments from MetroPlus, and 15,639 new applications. The majority of the losses were due to loss of Medicaid eligibility, likely a catch-up after Superstorm Sandy.

MetroPlus membership losses to Health First and Fidelis continue to be a significant part of their monthly losses. In February, MetroPlus lost 899 members to Health First and lost 783 members to Fidelis Care. As Dr. Saperstein has reported in the past, approximately 80% of the members that transfer from MetroPlus to

Health First leave the HHC system as well. This trend began this summer, after their dental transition to Healthplex. MetroPlus has completed further disenrollment surveys beyond the dental transition period and the overwhelming number of members surveyed stated that they wish to see doctors that are not a part of the MetroPlus network.

This month, MetroPlus successfully completed the submission of the initial Centers for Medicaid and Medicare Services (CMS) Fully Integrated Duals Advantage (FIDA) application on February 21, 2013. The FIDA program is a demonstration project between CMS and the State of New York and is focused on long term care. MetroPlus is currently waiting for guidance from the State on any next steps that may be required.

In February, MetroPlus implemented an authorization program for outpatient high tech radiology services (PT, MRI, MRA, CT) and nuclear cardiology services. Due to the volume of requests, and expertise required, MetroPlus will be partnering with MedSolutions to issue the authorizations for these services. All HHC facilities are excluded from this authorization requirement.

The HHC Health Home initiative has entered into its second phase of enrollment. At the end of January, the State sent HHC a new list of members for outreach to join the HHC Health Home. The current outreach strategy includes a target outreach population of 50% of HHC Fee-for-Service (FFS) patients and 50% MetroPlus members. A mailing of 1,300 letters was sent this month and the response is favorable. The current enrollment in the HHC Health Home is 640 patients, 348 of which are MetroPlus members. In addition, the New York State Department of Health (NYSDOH) notified health plans that the plans must diversify their contracts beyond HHC. MetroPlus has entered into negotiations with other Health Homes that are not considered direct competitors.

This month, the State has announced the Phase II Medicaid Redesign Team rate adjustments for health plans. There will be an overall increase of 0.6% to Medicaid rates and 0.7% to Family Health Plus rates. In the future, there will also be a rate increase for our Managed Long Term product line. The calculation for reimbursement was made on the assumption that 80% of members in the program would be nursing home certifiable. The actual number has proven to be 98% of members that are nursing home certifiable-generating the rate increase.

There will be a .7% shift in dollars due to the transportation carve-out; these dollars will be used to support the primary care rate increase required by the Affordable Care Act. For dates of service starting January 1, 2013, the statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. In order to be eligible for higher payment physicians must first self-attest to a covered specialty or subspecialty designation. It was recently announced that the State will collect attestations from providers and will provide plans with an eligibility file to aid in the reimbursement process.

As the New York State Medicaid Redesign Team continues their work to cut costs, the focus is now on the Behavioral Health population. The latest recommendation for NYC will be full benefit integrated SNPs (affiliated with existing plan or freestanding) for high need populations to be called Health and Recovery Plans (HARPs). HARPs eligibility criteria and specialized benefits will be developed by NYS DOH, OASAS, OMH and NYC with stakeholder input. The State has issued a draft BH benefit redesign proposal timeline which shows that applicants will need to be prepared to respond to serve as a HARP in the Summer of 2013 with a 30-day response time to an RFP. HARPs will begin operation in Fall/Winter 2014.

ACTION ITEMS:

1. Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate a contract with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone-medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853, 396.

Presenting to the Committee was Caroline Jacobs, Senior Vice President, Safety & Human Development and Aleksandra Sas, Associate Director, Center for Culturally and Linguistically Appropriate Services (CLAS); Stephen McNeil, Vice President of Sales, CyraCom International, Inc.; Fred Moyle, VP and General Manager of Healthcare Sales, Language Line Services; and David Porter, President, Pacific Interpreters, Inc.

Over-the-phone medical interpreter (OPI) services is a technique that uses telephones to connect professional human interpreters to individuals who need to speak to each other but who do not share a common language. OPI connects remotely via telephone to professionals who are proficient in the languages of both the speaker and receiver and who may also have some knowledge or familiarity with both cultures. In the healthcare environment, medical OPI services facilitate and support patient's ability to converse with their health care providers and health care provider's the ability to converse with patients and their family.

In FY 12, over 25% of HHC's patient population was deemed limited English proficient. Medical OPI services are critical to patient safety and the provision of culturally competent, patient-centered care. Medical OPI services: clearly and concisely transfers complex, sensitive medical information in a manner understood by patients; increases patient satisfaction; and may reduce length of stay and, potentially readmissions. OPI services enables compliance with external review agency requirements and federal laws and mandates for the provision of healthcare in a manner understood by patients (e.g., the Centers for Medicare and Medicaid Services, The Joint Commission, NYS Department of Health, Title VI of the Federal Civil Rights Act, local executive directives).

In FY 12, OPI services were utilized enterprise-wide for approximately 700,000 interpretation requests in over 190 different languages and dialects ranging from 0ver 450,000 requests for Spanish to 1 request for Kanjobal (Mayan dialect), for a total of more than 7 million minutes of medical OPI services at a cost of $6,670,000 to the HHC acute hospitals, long term care facilities, diagnostic and treatment centers, community health clinics, and certified home health agency. The need for OPI services will not diminish.

CyraCom, Language Line, and Pacific have been providing OPI services at the HHC facilities since 2002, 2006 and 2009, respectively. The existing agreements with the three (3) Vendors were entered into in 2009. The contracts with the three Vendors expire in the Spring of 2013. The current negotiated flat rate per minute of medical interpreting is $0 .90. It was determined that we needed to scan the medical OPI market to assure the Corporation was receiving the best value and quality for the expenditure

Consistent with HHC Operating Procedure 100-5, a request for proposals for OPI services was issued on October 12, 2012. Ten (10) proposals were received of which three (3) vendors were selected as presented here. The selected vendor(s) have the capacity to meet HHC's current and potential increasing demand for OPI services. The proposed term of the new contracts with each of the three vendors will be for a period of three years, with two additional one-year options to renew, solely exercisable by the Corporation. The anticipated total cost of the contract over 5 years is $30,853,396.00 which includes a 10% contingency of $2,804,854.00.

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Key contract deliverables include: provision of services by exclusively qualified medical interpreters for 100% of requests; a 24/7 live operator to respond to HHC interpretation requests and connect each call within an average of 40 seconds, including lesser diffusion languages; a 24/7 live operator to address HHC customer service concerns and an efficient complaint resolution process; monthly and on-demand reports of vendor performance; and equipment (e.g., corded dual handset and cordless phones).

The proposed term of the contracts is three years with two-one year options to renew solely exercisable by the Corporation at a flat fee of $0.75 per minute of interpretation, irrespective of language, day of week, or time of day at an amount not to exceed $ 30, 853,396 for the five years. The new rate is a $0.15 per minute decrease over the current rate of $0.90 per minute of interpretation. Facilities will determine the vendor they wish to receive services from; facilities may choose to receive services from more than one vendor.

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

2. Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and enter into a sole source contract with Microsoft Corporation to purchase software licenses and related maintenance and support on an on-going basis in an amount not to exceed $34,500,000 for a three year period.

Presenting to the Committee was Michael Keil, Assistant Vice President, IT Service Management and John Delalio, Senior Director, EITS.

HHC's current Enterprise Agreement with Microsoft expires on March 31, 2013, requiring HHC to negotiate a new agreement for the next three years. The Microsoft agreement allowed HHC to centralize purchasing of Microsoft products and support. The agreement provides high levels of discount and software upgrade rights for all products covered by the agreement. In addition, the agreement provides payments for the software in a predictable annual payment schedule.

The new enterprise agreement will include the licensing and support rights for all the Microsoft products used by the Corporation today such as Microsoft Office (including Word, Excel, and PowerPoint), Windows, SharePoint, System Center, and SQL-Server (Jacobi only). Additionally the new agreement contains the Microsoft hosting service Office 365 which includes online access to Microsoft Exchange (email), SharePoint (collaboration web sites), and Lync (video conferencing and instant messaging).

Since FY2010, HHC has spent $31.5 million with Microsoft (including an upcoming true up payment). $27.6 million was with the previous Enterprise Agreement with the remaining $3.9 million being spent on other ancillary licensing and services agreements. EITS is proposing consolidating all licensing under a single agreement for a total spend of $34.5 million over a 3 year period allocated as follows:

- $30 million Enterprise Agreement
- $1.5 million contingency (5%) to allow for possible expanded software use related to significant increases in user counts or additional projects which may require Microsoft Software.
- $2 million EMR/Epic Project - Capital
- $1 million Health Homes Project (Heal17 Grant)

The total spend with Microsoft with the new agreement would be decreased by approximately 5% from $31.5 million to $30 million, excluding the contingency, EMR/Epic and Health Homes projects. The EMR/Epic and Health Homes projects are separate initiatives where the cost of the Microsoft software is included in the budget for these projects.

Microsoft has changed the structure of licensing for several products including SQL-Server, System Center, and Windows Server. Enrollment programs allow HHC to convert products licensed under the previous structure to the new without having to repurchase the software. Programs allow for discount levels on future purchases (15% to 40% depending on product).Microsoft provides software that does not have a feasible substitute in the market. A Direct agreement provides the lowest pricing and the most favorable terms to HHC. After researching several means of procurement it was determined that the best pricing and terms can be obtained by negotiating directly with Microsoft. In addition, Gartner and IBM were engaged to assist with reviewing pricing. Both confirmed HHC's approach as providing the most favorable pricing and terms.

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

3. Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a contract and related agreements with North Shore-Long Island Jewish Health Systems, Inc. ("NSLIJ) (i) to establish a jointly controlled not-for-profit hospitals cooperative ("CoOpLab") that will provide laboratory services at cost to NSLIJ's and the Corporation's respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services to have NSLIJ's existing not-for-profit corporation, which operates its core laboratory perform the Corporation's reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab's cooperative business.
   AND
   Authorizing the President of the Corporation to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described below consistent with these Resolutions.

Presenting to the Committee was Marlene Zurack, Senior Vice President & Chief Financial Officer and George Proctor, Senior Vice President, Central/Northern Brooklyn Network; James Crawford, MD, PhD, Senior Vice President, Chairman of Pathology and Laboratory Medicine, Bob Stallone, Vice President, and Dwayne Breining, MD, Vice Chair, Laboratory Operations, North Shore LIJ Laboratories.

HHC's current lab operations consist of four core labs serving entire system with rapid response labs at each of the hospitals. HHC's restructuring project reviewed efforts and savings to date; options for restructuring; and identified the opportunity to achieve greater efficiencies through a shared core lab with another large health system. Thus initiated a process to identify potential partners for which it was determined to develop a cooperative arrangement with North Shore Long Island Jewish (NSLIJ).

The vision of the cooperative included: sstandard test menus for local hospital clinical tests; hospital labs will continue to provide clinical lab results needed in less than four hours on behalf of emergency departments and inpatient units, surgical and anatomical pathology and blood bank. NSLIJ and HHC will cooperate to create one shared core lab to process: clinical lab work on behalf of nursing homes, diagnostic and treatment centres and hospital clinics; micro and molecular biology tests; and tests on behalf of community physicians and/or other outside business. Through collaboration will achieve economies of scale, better pricing, savings for both entities, improved quality and data sharing of best practices

The CoOpLab structure of the cooperative is:: it will be a not-for-profit corporation; NSLIJ and HHC will have joint membership and operate the shared core lab; the CoOpLab Board of Directors will have representation from NSLIJ and HHC; CEO and management; and will maintain NSLIJ outreach business and

support HHC commercial insurance collection (which HHC has not been able to do so in the past). NSLIJ and HHC will collaborate on lab methods but independently operate hospital rapid response labs; will share information technology, same test menus and group purchasing of equipment, reagents, and blood products.

The governance structure will be: NSLIJ will have majority seats on the Board of Directors of "CoOpLab"; NSLIJ will be providing all of the initial capital; given the phase in of HHC over four years and NSLIJ test growth rate it is almost certain that NSLIJ will always have the plurality of test volume; HHC receives founding member status, which guarantees that if new members join, HHC's rights and benefits shall not be diminished; and critical decisions will require HHC's consent as a founding member. Critical decisions requiring HHC's consent as a founding member include: sale, closing, or relocation of core lab; requirement that HHC contribute capital; the addition of any new member with the same rights as HHC; termination of HHC's membership; increases to the level of reserves of CoOpLab requiring increases to the cost per test; and any action taken to benefit NSLIJ at the expense of HHC.

The business model for HHC, the CoOpLab and NSLIJ is as follows: HHC - staff and operate hospital labs, provide staff to CoOpLab and pay CoOpLab per test; CoOpLab - sell tests to HHC and NSLIJ at actual cost, pay HHC and NSLIJ for staff, pay NSLIJ rent, bill commercial Insurers, group purchasing, and methods best practice sharing; NSLIJ - staff and operate hospital labs, provide staff to CoOpLab and pay CoOpLab per test.

Staffing changes and five year projections were presented and attached hereto.

The implementation plan is: NSLIJ may immediately offer membership to HHC in its existing 501 C-3 which will allow HHC to send reference tests to the lab at cost for a savings of $1.7 million; NSLIJ would enter into a real estate lease and pay build out costs and pass actual rental and debt service costs down to the core lab; NSLIJ and HHC must agree to the allowable costs for the build out; and HHC and NSLIJ shall seek 501 C-3 status. If it is not awarded within nine months HHC will ask the IRS for 501 E status.

NSLIJ provided the Committee with the history of their existing Centralized Laboratory Network, system rapid response labs, goals for the CoOpLab, performance metrics and core lab key indicators goals and current performance.

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

INFORMATION ITEM:

1. Chronic Illness Improvement at HHC: Hypertension

David Stevens, MD, Senior Director, Office of Health Care Improvement presented to the Committee. Dr. Steven's informed the Committee that Hypertension is the number two health threat to the US population (smoking is the number one threat). HHC treats 120,000 patients with hypertension of which 43% are controlled (national average is 46%). Seventy-five to eighty percent (75% -80%) is the benchmark for a national system. That seems unattainable, but these benchmark organizations started out where we are 10 years ago. Meeting this target would mean 38,400 additional patients controlled, resulting in 1,920 fewer health attacks every year and 768 fewer strokes every year. Each 1% improvement across HHC prevents 60 myocardial infarctions and 24 strokes.

Dr. Steven's provided the Committee with a slide that illustrated the percentage of primary care patients with blood pressure (BP) controlled at 140/90 in January 2013 which ranged from 38% to 55% which shows no major improvement from prior years (January 2010=44%; January 2011, 2012 & 2013 at 43%).

The factors contributing to uncontrolled hypertension are: Physician barriers – accepting 'close enough', ineffective counseling by primary care physician (PCP) in not getting the message of importance to patients, and unaware of own performance compared to other physician's success rates; Patient barriers – insufficient engagement (awareness, commitment) and time/cost involved in keeping appointments; and System barrier is access to primary care appointments. A chart review study we did at Gouverneur showed that the most common feature of patients with chronic poor BP control was *very few PCP visits*. Multiple studies show that patients with hypertension are approximately 50% of patients with hypertension take their pills all the time, or almost all the time.

The following are HHC's strategies for hypertension improvement: feedback to primary care patients on performance; identify uncontrolled patients in the registry; and engage patients as partners in their care with methods such as home BP monitors, collaborative goal setting and close relationship with RN care manager.

The essential elements of the registered nurse (RN) Treat-to-Target Pathways program are: 1) the PCP determines & negotiates goal with the patient and directs RN in BP target and medication adjustments; 2) the RN evaluates the patient frequently to see if they are reaching their target and adhering to treatment plan, counsels and adjusts treatment plan as needed and consults with the PCP as needed, documents discussion/changes in treatment plan which the PCP cosigns; and 3) review program performance and provide feedback to both the PCP and the RN.

The RN led Treat-to-Target Pathway was implemented in six (6) facilities beginning May 2012 [Elmhurst Hospital Center; Harlem Hospital Center; Jacobi Medical Center; North Central Bronx Hospital; Cumberland D&TC; East New York D&TC; and Gouverneur Healthcare Services]. There are three key strategies to this program: 1) focused - patients seen frequently by RN until BP is at target and the patient "get the message– this is about controlling BP"; 2) Supportive – patients build a relationship with RN, patients talk about their concerns about treatments, and patients feel they have a team caring for them; and 3) Convenient - "In and out" – patients appreciate minimal wait time.

The next steps are to: spread the Treat-to-Target model to all HHC facilities; integrate new conditions - phase 2 hyperlipidemia and depression in hypertensive patients will be integrated, phase 3 integrate diabetes; innovations to promote engagement will include community-based self-management groups, pedometers and other devices and digital social networks; payment models that align with better outcomes; and develop a registry that integrates all population health concerns.

There being no further business the meeting adjourned at 1:24 P.M.

Staffing Changes

Staff at HHC facilities	Base	FY2014	FY2015	FY2016	FY2017	FY2018
Clinical*	636	591	545	487	455	446
Microbiology**	162	162	132	71	0	0
Pathology and Blood Bank	607	607	607	607	607	607
HHC staff at HHC	1405	1360	1285	1165	1062	1053
HHC staff at the Core**	0	0	30	91	162	162
Total	**1405**	**1360**	**1315**	**1256**	**1224**	**1215**

*Clinical staff will not be replaced as they leave and will be redeployed across HHC
**Microbiology staff move to the core as we transition our hospitals

Five Year Cost Savings Projections ($s in millions)

Change	Base	FY2014	FY2015	FY2016	FY2017	FY2018
Total Cost Current State	$ 233.3	$ 242.9	$252.5	$255.3	$260.5	$ 265.9
Total Cost Future State	$ 233.3	$ 231.8	$238.7	$240.9	$245.9	$ 247.4
Savings		**$ 11.1**	**$ 13.9**	**$ 14.4**	**$ 14.6**	**$ 18.5**
Additional Revenue			**$ 0.3**	**$ 1.9**	**$ 2.6**	**$ 4.6**
Total Benefit		**$ 11.1**	**$ 14.1**	**$ 16.3**	**$ 17.1**	**$ 23.1**

MetroPlus Health Plan, Inc.
Report to the
HHC Medical and Professional Affairs Committee
April 11th, 2013

Total plan enrollment as of March 29th, 2013 was 430,545. Breakdown of plan enrollment by line of business is as follows:

Medicaid	367,932
Child Health Plus	12,928
Family Health Plus	34,264
MetroPlus Gold	3,193
Partnership in Care (HIV/SNP)	5,557
Medicare	6,617
MLTC	54

This month, we had a net loss of 11,484 members. We experienced a positive gain in Medicare, gaining 132 enrollees.

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

This month, we experienced a loss of over 20,000 involuntary disenrollments as a result of retroactive adjustments due to Hurricane Sandy. HRA offered a two month extension for the recertification of members, yet the recertification packages were sent out just around the date of the storm. A very large percentage of these recertifications were not returned leading to loss of Medicaid. We are working very closely with HRA to address these losses as well as outreaching to these members to assist them in reapplying.

This month, MetroPlus successfully completed the submission of the initial Centers for Medicaid and Medicare Services (CMS) FIDA application on February 21st, 2013. The FIDA program is a demonstration project between CMS and the State of New York and is focused on long term care. MetroPlus is currently waiting for guidance from the State on any next steps that may be required.

In February, MetroPlus implemented an authorization program for outpatient high tech radiology services (PT, MRI, MRA, CT) and nuclear cardiology services. Due to the volume of requests, and expertise required, MetroPlus will be partnering with MedSolutions to issue the authorizations for these services. All HHC facilities are excluded from this authorization requirement.

The HHC Health Home initiative has entered into its second phase of enrollment. At the end of January, the State sent HHC a new list of members for outreach to join the HHC Health Home. The current outreach strategy includes a target outreach population of 50% of HHC FFS patients and 50% MetroPlus members. A mailing of 1,300 letters was sent this month and the response is favorable. The current enrollment in the HHC Health Home is 640 patients, 348 of which are MetroPlus members. In addition, the NYSDOH notified health plans that the plans must

diversify their contracts beyond HHC. MetroPlus has entered into negotiations with other Health Homes that are not considered direct competitors.

This month, the state has announced the Phase II Medicaid Redesign Team rate adjustments for health plans. There will be an overall increase of 0.6% to Medicaid rates and 0.7% to Family Health Plus rates. In the future, there will also be a rate increase for our Managed Long Term product line. The calculation for reimbursement was made on the assumption that 80% of members in the program would be nursing home certifiable. The actual number has proven to be 98% of members that are nursing home certifiable- generating the rate increase.

There will be a .7% shift in dollars due to the transportation carve-out; these dollars will be used to support the primary care rate increase required by the Affordable Care Act. For dates of service starting January 1st, 2013, the statute specifies that higher payment applies to primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation specifies that specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment. In order to be eligible for higher payment physicians must first self-attest to a covered specialty or subspecialty designation. It was recently announced that the State will collect attestations from providers and will provide plans with an eligibility file to aid in the reimbursement process.

As the New York State Medicaid Redesign Team continues their work to cut costs, the focus is now on the Behavioral Health population. The latest recommendation for NYC will be full benefit integrated SNPs (affiliated with existing plan or freestanding) for high need populations to be called Health and Recovery Plans (HARPs). HARPs eligibility criteria and specialized benefits will be developed by DOH, OASAS, OMH and NYC with stakeholder input. The state has issued a draft BH benefit redesign proposal timeline which shows that applicants will need to be prepared to respond to serve as a HARP in the Summer of 2013 with a 30-day response time to an RFP. HARPs will begin operation in Fall/Winter 2014.

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2013

Other Plan Name	Category	2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	INVOLUNTARY	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	0	2	0	0	6
	VOLUNTARY	7	130	14	128	13	117	12	112	14	114	11	133	11	93	21	152	7	88	9	85	24	122	13	153	1,583
	TOTAL	7	130	14	129	13	117	12	113	14	114	11	133	11	93	21	152	8	88	9	86	24	124	13	153	1,589
Amerigroup/ Health Plus/CarePlus	INVOLUNTARY	0	3	0	2	1	4	0	1	0	2	2	1	0	1	0	0	0	2	0	2	0	1	0	0	22
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
	VOLUNTARY	20	198	33	188	23	267	11	243	18	241	11	236	14	180	18	209	11	167	22	164	25	207	18	192	2,716
	TOTAL	20	201	33	190	24	271	11	244	18	243	13	237	14	181	18	209	11	169	22	167	25	208	18	192	2,739
Fidelis Care	INVOLUNTARY	0	1	0	1	0	1	0	3	0	2	0	0	0	2	0	1	0	6	1	2	0	0	1	0	21
	VOLUNTARY	21	265	28	274	26	239	76	562	149	990	98	792	89	652	79	874	40	549	84	634	73	709	64	652	8,019
	TOTAL	21	266	28	275	26	240	76	565	149	992	98	792	89	654	79	875	40	555	85	636	73	709	65	652	8,040
Health First	INVOLUNTARY	1	3	0	3	0	3	0	5	0	4	0	0	0	5	0	0	1	5	0	9	0	0	0	0	39
	UNKNOWN	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	2
	VOLUNTARY	52	480	62	636	46	600	77	780	114	996	69	910	60	833	75	935	63	662	55	769	60	841	63	853	10,091
	TOTAL	53	483	62	639	46	603	77	786	114	1,000	69	910	60	838	75	935	64	667	55	778	60	842	63	853	10,132
HIP/NYC	INVOLUNTARY	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	1	4
	VOLUNTARY	15	113	14	98	16	84	10	84	5	85	10	91	12	53	17	89	6	68	5	82	13	80	4	84	1,138
	TOTAL	15	114	14	98	16	84	10	84	5	85	10	92	12	53	17	89	6	69	5	82	13	80	4	85	1,142
Neighborhood Health Provider PHPS	INVOLUNTARY	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	1	0	0	0	2	0	0	0	0	6
	VOLUNTARY	14	94	13	138	17	106	8	118	23	140	13	133	10	122	14	170	5	60	4	113	17	121	0	33	1,486
	TOTAL	14	95	13	138	17	106	8	118	23	141	14	133	10	122	14	171	5	60	4	115	17	121	0	33	1,492

MetroPlus Health Plan

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2013

		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
United Healthcare of NY	INVOLUNTARY	0	1	0	0	0	0	0	1	0	2	0	0	0	0	0	0	0	1	0	0	0	2	0	0	7
	VOLUNTARY	8	68	13	102	11	69	13	110	18	129	11	92	7	84	21	143	12	73	17	84	12	138	17	112	1,364
	TOTAL	8	69	13	102	11	69	13	111	18	131	11	92	7	84	21	143	12	74	17	84	12	140	17	112	1,371
Wellcare of NY	INVOLUNTARY	0	1	2	5	0	0	0	2	0	1	0	0	0	1	0	1	0	0	0	0	0	0	0	0	13
	VOLUNTARY	1	17	3	27	1	30	4	15	2	38	3	30	3	31	3	45	2	24	5	27	3	38	3	21	376
	TOTAL	1	18	5	32	1	30	4	17	2	39	3	30	3	32	3	46	2	24	5	27	3	38	3	21	389
Disenrolled Plan Transfers	INVOLUNTARY	1	11	2	12	1	8	0	13	0	12	3	2	0	9	0	3	2	15	1	16	0	5	1	1	118
	UNKNOWN	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	3
	VOLUNTARY	138	1,365	180	1,591	153	1,512	211	2,024	343	2,733	226	2,417	206	2,048	248	2,617	146	1,691	201	1,958	227	2,256	182	2,100	26,773
	TOTAL	139	1,376	182	1,603	154	1,520	211	2,038	343	2,745	229	2,419	206	2,057	248	2,620	148	1,706	202	1,975	227	2,262	183	2,101	26,894
Disenrolled Unknown Plan Transfers	INVOLUNTARY	7	84	8	59	3	33	11	35	2	33	4	20	1	93	5	32	0	84	4	55	11	39	1	43	667
	UNKNOWN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	2
	VOLUNTARY	28	71	4	40	31	103	9	73	23	102	17	101	9	87	12	132	5	83	4	63	12	104	10	102	1,225
	TOTAL	35	155	12	99	34	136	20	108	25	135	21	121	10	180	17	164	5	167	8	118	24	144	11	145	1,894
Non-Transfer Disenroll Total	INVOLUNTARY	1,062	9,786	1,077	9,304	1,270	10,972	971	9,738	1,191	9,733	1,194	10,142	888	8,885	1,227	10,555	156	5,511	131	3,790	1,640	12,445	1,968	16,904	130,540
	UNKNOWN	2	15	3	9	5	5	8	6	5	2	2	4	4	15	2	1	0	4	0	2	0	6	0	1	101
	VOLUNTARY	2	98	7	133	0	92	0	76	0	69	0	81	0	55	0	81	0	53	0	48	0	79	0	47	921
	TOTAL	1,066	9,899	1,087	9,446	1,275	11,069	979	9,820	1,196	9,804	1,196	10,227	892	8,955	1,229	10,637	156	5,568	131	3,840	1,640	12,530	1,968	16,952	131,562
Total MetroPlus	INVOLUNTARY	1,070	9,881	1,087	9,375	1,274	11,013	982	9,786	1,193	9,778	1,201	10,164	889	8,987	1,232	10,590	158	5,610	136	3,861	1,651	12,489	1,970	16,948	131,325
	UNKNOWN	2	15	3	9	5	5	8	7	5	2	2	4	4	15	2	1	0	4	0	3	1	8	0	1	106

Disenrolled Member Plan Transfer Distribution

Last Data Refresh Date: 03/14/2013

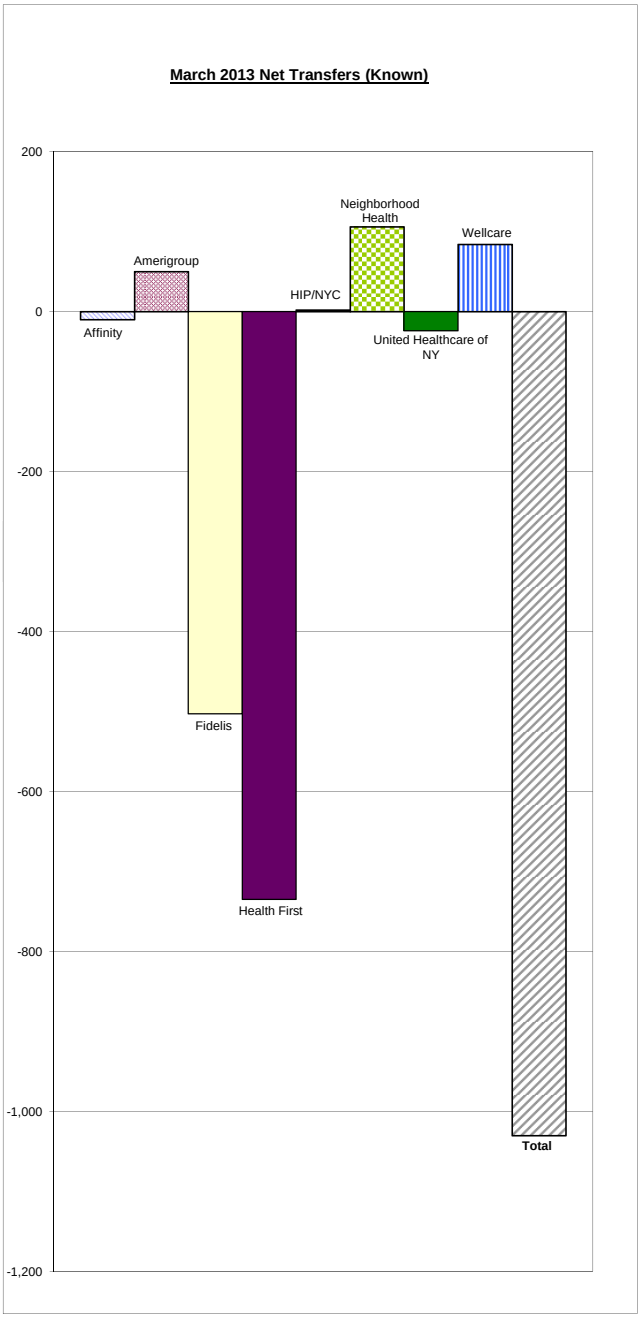
		2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		TOTAL
		FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Total MetroPlus Disenrollmen	VOLUNTARY	168	1,534	191	1,764	184	1,707	220	2,173	366	2,904	243	2,599	215	2,190	260	2,830	151	1,827	205	2,069	239	2,439	192	2,249	28,919
	TOTAL	1,240	11,430	1,281	11,148	1,463	12,725	1,210	11,966	1,564	12,684	1,446	12,767	1,108	11,192	1,494	13,421	309	7,441	341	5,933	1,891	14,936	2,162	19,198	160,350

Disenrollments TO Other Plans		Mar-13			Apr-12 to Mar-13		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOL.	0	0	0	1	5	6
	VOL.	13	153	166	156	1,427	1,583
Affinity Health Plan	TOTAL	13	153	166	157	1,432	1,589
	INVOL.	0	0	0	3	19	22
	VOL.	18	192	210	224	2,492	2,716
Amerigroup/Health Plus/CarePlus	TOTAL	18	192	210	227	2,512	2,739
	INVOL.	1	0	1	2	19	21
	VOL.	64	652	716	827	7,192	8,019
Fidelis Care	TOTAL	65	652	717	829	7,211	8,040
	INVOL.	0	0	0	2	37	39
	VOL.	63	853	916	796	9,295	10,091
Health First	TOTAL	63	853	916	798	9,334	10,132
	INVOL.	0	1	1	0	4	4
	VOL.	4	84	88	127	1,011	1,138
HIP/NYC	TOTAL	4	85	89	127	1,015	1,142
	INVOL.	0	0	0	1	5	6
	VOL.	0	33	33	138	1,348	1,486
Neighborhood Health	TOTAL	0	33	33	139	1,353	1,492
	INVOL.	0	0	0	0	7	7
	VOL.	17	112	129	160	1,204	1,364
United Healthcare of NY	TOTAL	17	112	129	160	1,211	1,371
	INVOL.	0	0	0	2	11	13
	VOL.	3	21	24	33	343	376
Wellcare of NY	TOTAL	3	21	24	35	354	389
	INVOL.	1	1	2	11	107	118
	VOL.	182	2,100	2,282	2,461	24,312	26,773
Disenrolled Plan Transfers:	TOTAL	183	2,101	2,284	2,472	24,422	26,894
	INVOL.	1	43	44	57	610	667
	VOL.	10	102	112	164	1,061	1,225
Disenrolled Unknown Plan Transfers:	TOTAL	11	145	156	222	1,672	1,894
	INVOL.	1,968	16,904	18,872	12,775	117,765	130,540
	UNK.	0	1	1	31	70	101
	VOL.	0	47	47	9	912	921
Non-Transfer Disenroll Total:	TOTAL	1,968	16,952	18,920	12,815	118,747	131,562
	INVOL.	1,970	16,948	18,918	12,843	118,482	131,325
	UNK.	0	1	1	32	74	106
	VOL.	192	2,249	2,441	2,634	26,285	28,919
Total MetroPlus Disenrollment:	**TOTAL**	**2,162**	**19,198**	**21,360**	**15,509**	**144,841**	**160,350**

Disenrollments FROM Other Plans	Mar-13			Apr-12 to Mar-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	15	141	156	249	2,320	2,569
Amerigroup/Health Plus/CarePlus	22	238	260	480	4,090	4,570
Fidelis Care	15	199	214	175	2,411	2,586
Health First	18	163	181	198	2,246	2,444
HIP/NYC	7	84	91	74	1,223	1,297
Neighborhood Health	11	128	139	219	2,015	2,234
United Healthcare of NY	12	93	105	104	1,234	1,338
Wellcare of NY	18	90	108	210	1,312	1,522
Total	118	1,136	1,254	1,709	16,851	18,560
Unknown (not in total)	1,381	8,789	10,170	21,277	133,525	154,802

Data Source: RDS Report 1268a&c Updated 03/18/2013

Net Difference	Mar-13			Apr-12 to Mar-13		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan	2	-12	-10	92	888	980
Amerigroup/Health Plus/CarePlus	4	46	50	253	1,578	1,831
Fidelis Care	-50	-453	-503	-654	-4,800	-5,454
Health First	-45	-690	-735	-600	-7,088	-7,688
HIP/NYC	3	-1	2	-53	208	155
Neighborhood Health	11	95	106	80	662	742
United Healthcare of NY	-5	-19	-24	-56	23	-33
Wellcare of NY	15	69	84	175	958	1,133
Total	-65	-965	-1,030	-763	-7,571	-8,334



MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

March-2013

		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Total Members	Prior Month	438,851	437,964	437,460	439,054	440,749	445,268	442,029
	New Member	15,920	14,301	19,160	11,270	14,023	16,174	12,141
	Voluntary Disenroll	3,073	2,576	3,263	2,139	2,526	2,976	2,630
	Involuntary Disenroll	13,734	12,229	14,303	7,436	6,978	16,437	20,995
	Adjusted	-19	-17	-20	-17	576	1,676	0
	Net Change	-887	-504	1,594	1,695	4,519	-3,239	-11,484
	Current Month	437,964	437,460	439,054	440,749	445,268	442,029	430,545
Medicaid	Prior Month	371,610	371,441	371,411	373,717	375,155	379,967	377,894
	New Member	13,322	11,869	16,407	9,444	11,464	13,554	9,919
	Voluntary Disenroll	2,600	2,190	2,830	1,826	2,069	2,440	2,247
	Involuntary Disenroll	10,891	9,709	11,271	6,180	4,583	13,187	17,634
	Adjusted	-13	-11	-13	-10	567	1,578	0
	Net Change	-169	-30	2,306	1,438	4,812	-2,073	-9,962
	Current Month	371,441	371,411	373,717	375,155	379,967	377,894	367,932
Child Health Plus	Prior Month	15,691	15,366	15,116	14,663	14,473	13,463	13,096
	New Member	434	467	454	216	334	387	399
	Voluntary Disenroll	33	35	39	21	38	30	57
	Involuntary Disenroll	726	682	868	385	1,306	724	510
	Adjusted	-4	-4	-5	-6	-6	6	0
	Net Change	-325	-250	-453	-190	-1,010	-367	-168
	Current Month	15,366	15,116	14,663	14,473	13,463	13,096	12,928
Family Health Plus	Prior Month	36,668	36,302	36,022	35,671	36,106	36,471	35,715
	New Member	1,817	1,603	1,917	1,279	1,496	1,826	1,464
	Voluntary Disenroll	243	215	260	151	205	239	192
	Involuntary Disenroll	1,940	1,668	2,008	693	926	2,343	2,723
	Adjusted	0	1	-1	-2	3	65	0
	Net Change	-366	-280	-351	435	365	-756	-1,451
	Current Month	36,302	36,022	35,671	36,106	36,471	35,715	34,264

MetroPlus Health Plan

Membership Summary by LOB Last 7 Months

March-2013

		Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
HHC	Prior Month	3,127	3,130	3,133	3,119	3,119	3,335	3,206
	New Member	26	25	19	25	248	18	0
	Voluntary Disenroll	2	0	0	0	0	114	0
	Involuntary Disenroll	21	22	33	25	32	33	13
	Adjusted	-1	-2	0	5	17	22	0
	Net Change	3	3	-14	0	216	-129	-13
	Current Month	3,130	3,133	3,119	3,119	3,335	3,206	3,193
SNP	Prior Month	5,789	5,772	5,753	5,747	5,707	5,673	5,611
	New Member	107	94	102	74	73	90	66
	Voluntary Disenroll	43	33	33	30	34	50	28
	Involuntary Disenroll	81	80	75	84	73	102	92
	Adjusted	-1	-1	-1	-4	-4	7	0
	Net Change	-17	-19	-6	-40	-34	-62	-54
	Current Month	5,772	5,753	5,747	5,707	5,673	5,611	5,557
Medicare	Prior Month	5,966	5,953	6,025	6,137	6,189	6,353	6,485
	New Member	214	243	261	232	402	282	261
	Voluntary Disenroll	152	103	101	111	180	102	106
	Involuntary Disenroll	75	68	48	69	58	48	23
	Adjusted	0	0	0	0	-1	-1	0
	Net Change	-13	72	112	52	164	132	132
	Current Month	5,953	6,025	6,137	6,189	6,353	6,485	6,617
Managed Long Term Care	Prior Month	0	0	0	0	0	6	22
	New Member	0	0	0	0	6	17	32
	Voluntary Disenroll	0	0	0	0	0	1	0
	Involuntary Disenroll	0	0	0	0	0	0	0
	Adjusted	0	0	0	0	0	-1	0
	Net Change	0	0	0	0	6	16	32
	Current Month	0	0	0	0	6	22	54

MetroPlus Health Plan

New Member Transfer From Other Plans

	2012_04		2012_05		2012_06		2012_07		2012_08		2012_09		2012_10		2012_11		2012_12		2013_01		2013_02		2013_03		TOTAL
	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	FHP	MCAD	
Affinity Health Plan	30	242	38	296	26	239	21	180	23	199	21	212	15	202	15	190	7	128	19	152	19	139	15	141	2,569
Amerigroup/Health Plus/CarePlus	63	494	77	614	74	549	44	372	47	342	30	333	20	263	36	281	22	188	24	211	21	205	22	238	4,570
Fidelis Care	17	190	27	224	11	199	5	159	22	220	14	215	11	206	24	285	12	158	6	164	11	192	15	199	2,586
Health First	20	213	19	253	25	212	13	212	20	244	22	177	13	165	18	191	5	117	14	147	11	152	18	163	2,444
HIP/NYC	7	117	5	130	7	130	9	95	7	112	8	128	4	96	4	106	5	53	6	78	5	94	7	84	1,297
Neighborhood Health Provider PHPS	22	190	29	250	32	200	15	140	16	184	12	186	13	144	19	195	13	110	18	131	19	157	11	128	2,234
United Healthcare of NY	10	89	11	161	10	144	10	96	6	95	13	92	9	98	5	115	4	90	5	80	9	81	12	93	1,338
Unknown PLan	1,913	10,656	2,476	14,769	2,180	12,020	1,950	11,514	2,029	13,344	1,695	10,659	1,524	9,375	1,788	13,737	1,201	7,360	1,408	9,293	1,732	12,009	1,381	8,789	154,802
Wellcare of NY	23	144	15	185	27	146	19	84	32	137	13	91	16	79	18	86	8	70	5	91	16	109	18	90	1,522
TOTAL	2,105	12,335	2,697	16,882	2,392	13,839	2,086	12,852	2,202	14,877	1,828	12,093	1,625	10,628	1,927	15,186	1,277	8,274	1,505	10,347	1,843	13,138	1,499	9,925	173,362

Report ID: MHP1268C
Report Run Date: 3/15/2013

SOARIAN
REVENUE CYCLE MANAGEMENT SYSTEM
PROJECT UPDATE-
MPA / IT BOARD COMMITTEE

Maxine Katz

April 11,2013

Agenda

- Background
- Deliverables
- Schedule
- Experience to date

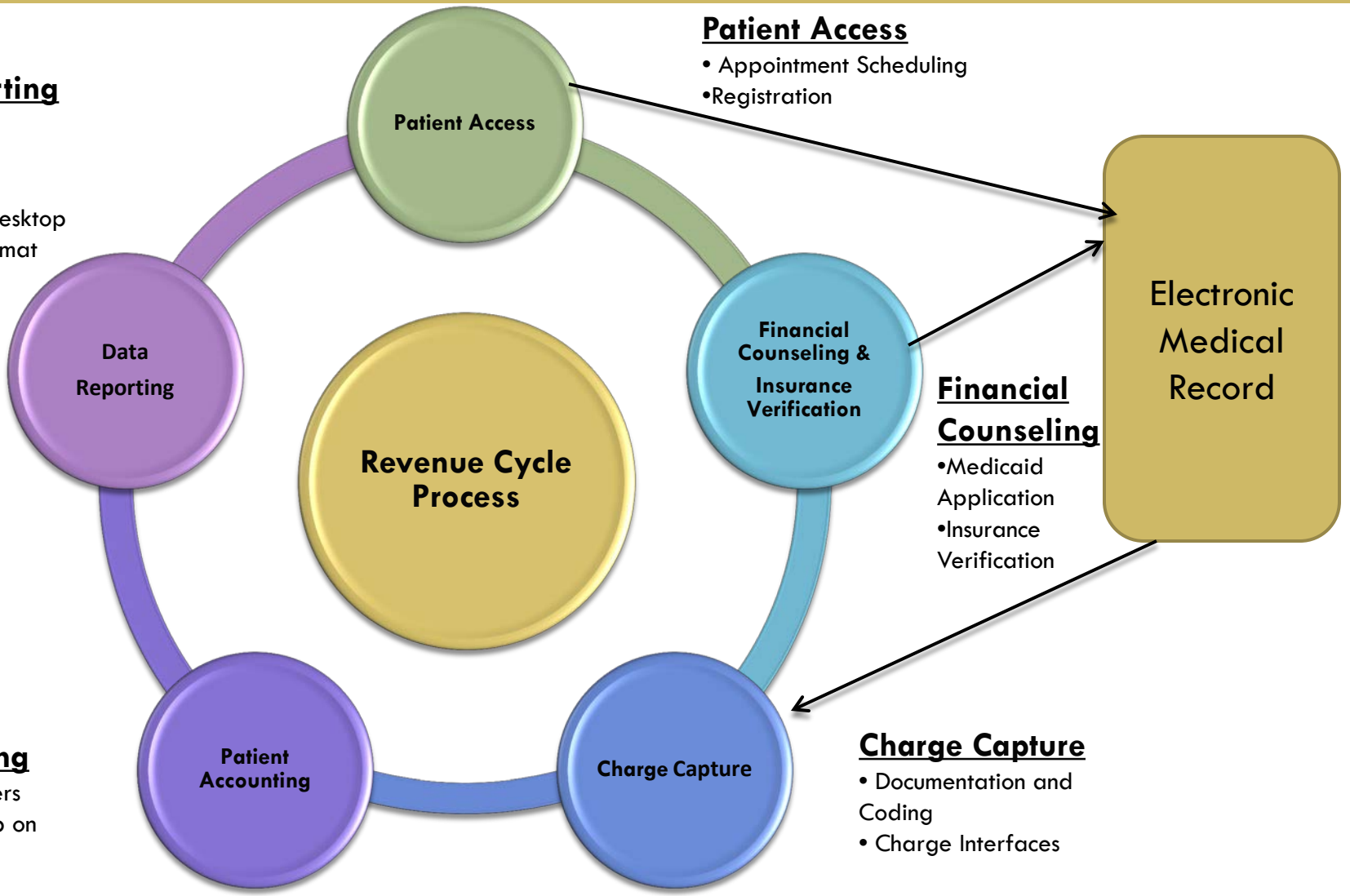
Background

- Why Migrate to a Revenue Cycle Management System?
- What's different in the new system?
- New Features

Why Migrate to a Revenue Cycle Management System?

- Improve Collections
- Make Work Easier For Staff
- Allow Patients Easier Access to HHC

Revenue Cycle Management



Patient Access
- Appointment Scheduling
- Registration

Data Reporting
- Statistics
- Payments and Charges
- Available at desktop in Excel-like format

Financial Counseling
- Medicaid Application
- Insurance Verification

Charge Capture
- Documentation and Coding
- Charge Interfaces

Patient Accounting
- Billing Insurers
- Following up on receivables

What's different in the new system?

Soarian is a web based system that:

- Integrates:
  - Scheduling and Registration
  - Billing and Follow-up
  - Management Support
- Combines twenty-one facility databases into one
- Supports operational work flows
- Adds features

New Features

- Enterprise Document Management
- Easy to use Management Decision Reporting
- Single Corporate Patient Directory

New Features-- continued

- Single Corporate Scheduling System
- Decision support for patient account staff
- Denials Management Tools
- Automated Work Listing and Workflow throughout the entire process

Deliverables

	Completion Date
Enterprise Document Imaging	November 2010 
Data Reporting	June 2012 
Revenue Cycle Management	December 2014 20 % complete

Updated Schedule

Completion Dates	2010	2011	2012	2013	2014
Document Imaging	Nov				
Data Reporting			June		
Revenue Cycle Management					
Scheduling and enterprise master patient index development and testing			July		
Installation first 2 sites			Sept		
Remaining sites				Jul/Aug	
Financials development and testing				Sept	
Installation long term care				Oct	
First 2 acute hospitals					Jan
Remaining sites					Dec

Initial Schedule

Completion Dates	2010	2011	2012	2013	2014
Document Imaging	Nov				
Data Reporting					
Communication		July			
Training		Dec			
Installation in all sites			March		
Assessment			June		
Revenue Cycle Management					
Scheduling and enterprise master patient index development and testing			April		
Installation first 4 sites			July		
Second 4 sites			Oct		
Third 4 sites			Dec		
Remaining sites				March	
Financials development and testing			Nov		
Installation of First 4 sites				March	
Second 4 sites				July	
Third 5 sites				Nov	
Remaining sites					March

Experience to date

- What Went well
  - Using Breakthrough to develop Business Needs
  - Overcoming conflict between Siemen's implementation strategy and HHC vision
  - Hospital Teams Worked Collaboratively

- Challenges
  - Existing variation in practices between facilities
  - Complexity of designing, developing and implementing
  - Difficult to roll-out process improvement in all facilities
  - Vendor underestimated the level of development required
  - Coordination throughout all facilities and departments

HHC's Care Plan Management System – Training and Launch Summary

Medical and Professional Affairs Board

April 2013

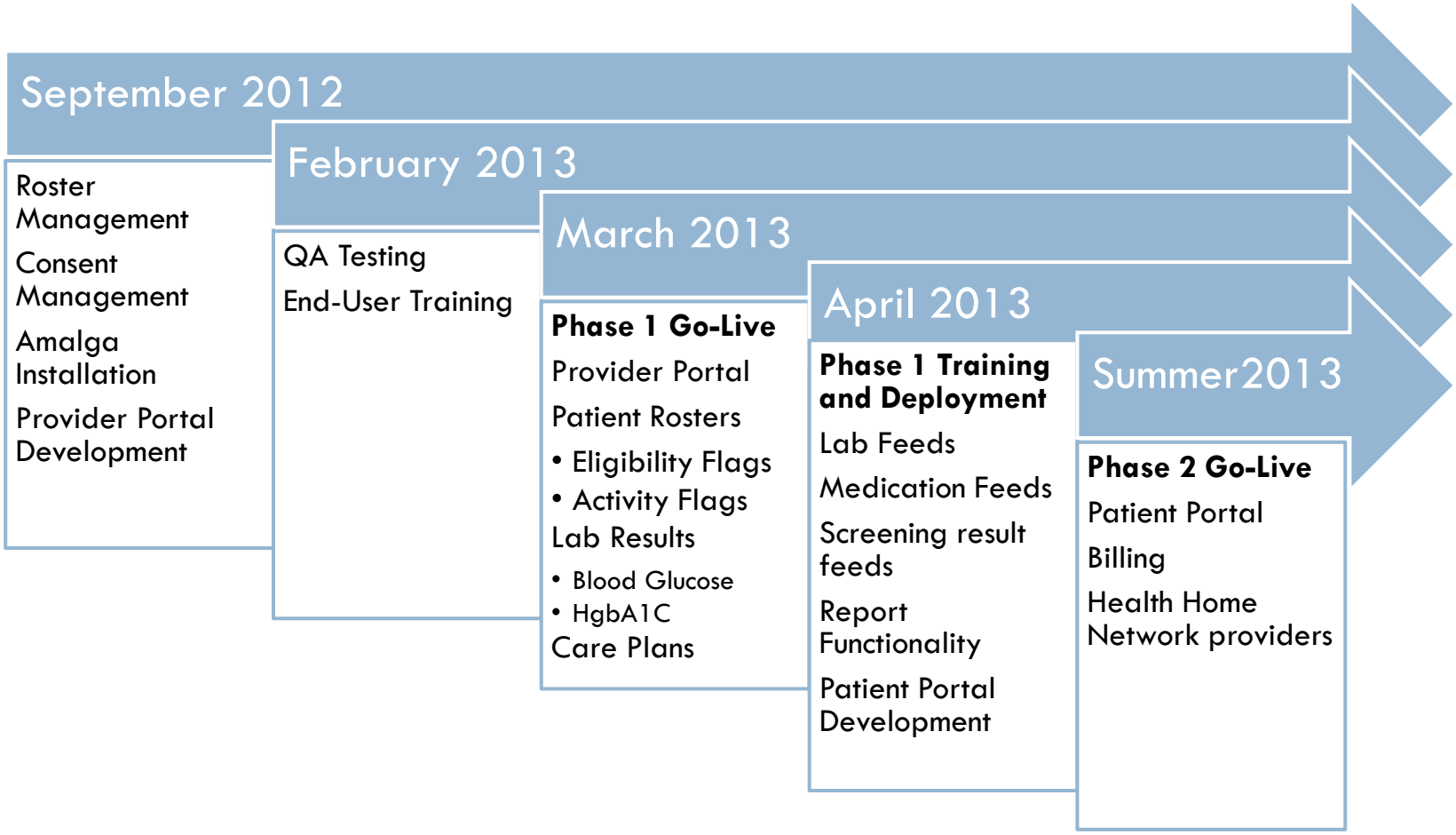
Irene Kaufmann
Sr. AVP, Office of Ambulatory Care Transformation
Paul Contino
Chief Technology Officer
Brian Maxey, LMSW
Assoc. Director, HHC Health Homes

Care Coordination Program

Care Plan Management System (CPMS)

- Functionality Targeted
  - Create, update and store patient care plans
  - Automatic alerts & flags
  - Provider Portal & Patient Portal - Personal Health Record (PHR)
  - Patient Roster, Panel and Consent Management
  - Care Transitions Tracking
  - Population based reports with drill-down to individual panels

Implementation Time Line



Training and Deployment Process

- Training Process
  - 1 week on-site training
    - Hands on exercises to simulate program processes, end to end
  - Enhancements Training:
    - online update and release notes to users identifying changes
  - Remedial Training: via super-users
  - New Employees – CO Health Home

- CPMS Deployment Support Schedule
  - 1st week - onsite support by integrated project team and trainers
  - 2nd week – onsite support by project team
  - 3rd week – remote support by project team and trainers

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PHASE II

- Additional features to include
  - Alerts
  - Expanded reporting
  - Patient portals
  - Expanded Quadramed feeds
  - Medications feed
  - Billing
- Care Plan screens and functionality supporting
  - Collaborative Care - TEAMCare
  - PCMH
  - Transitions in Care
  - CBO's

Selected Screen Shots

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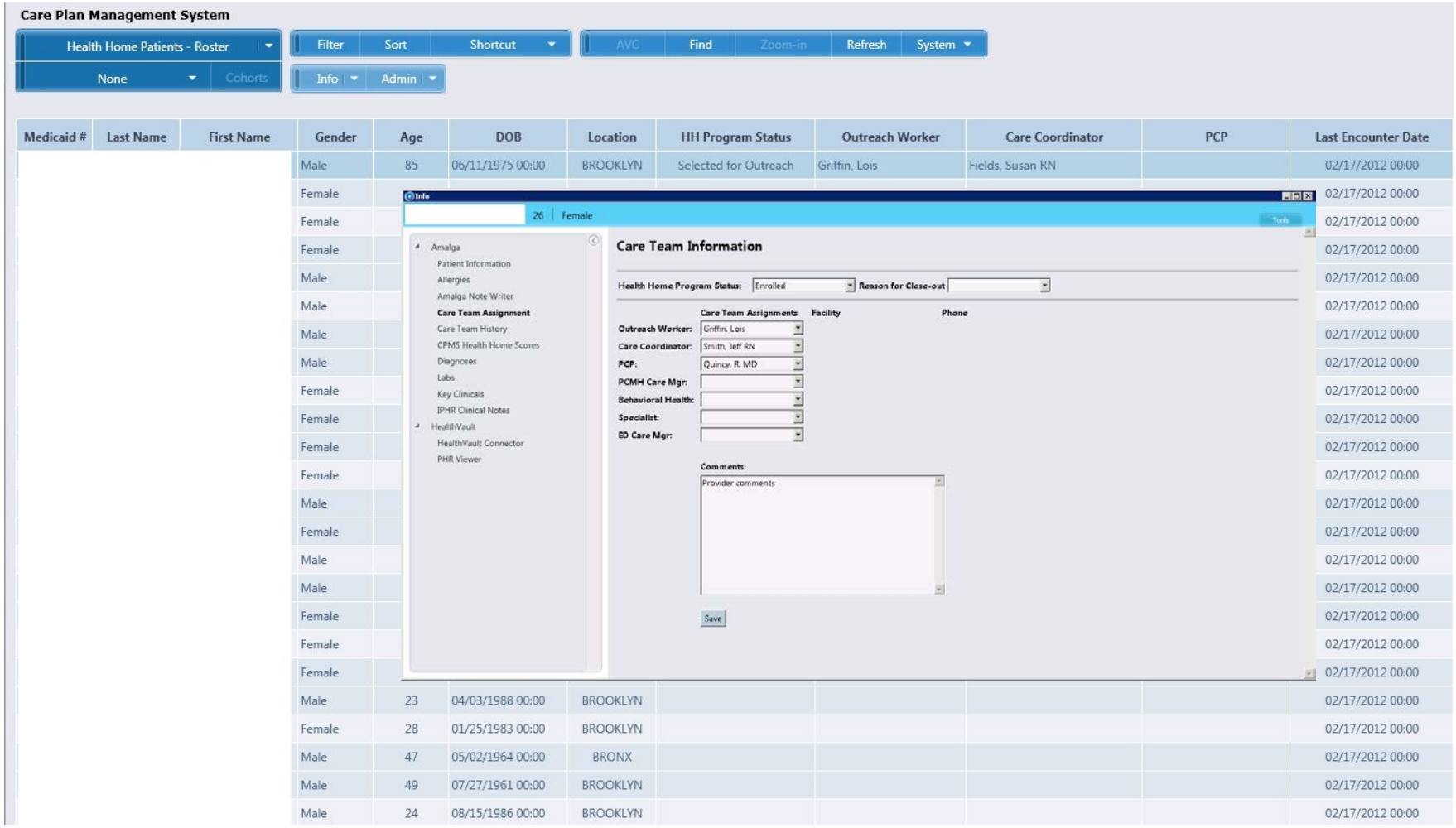
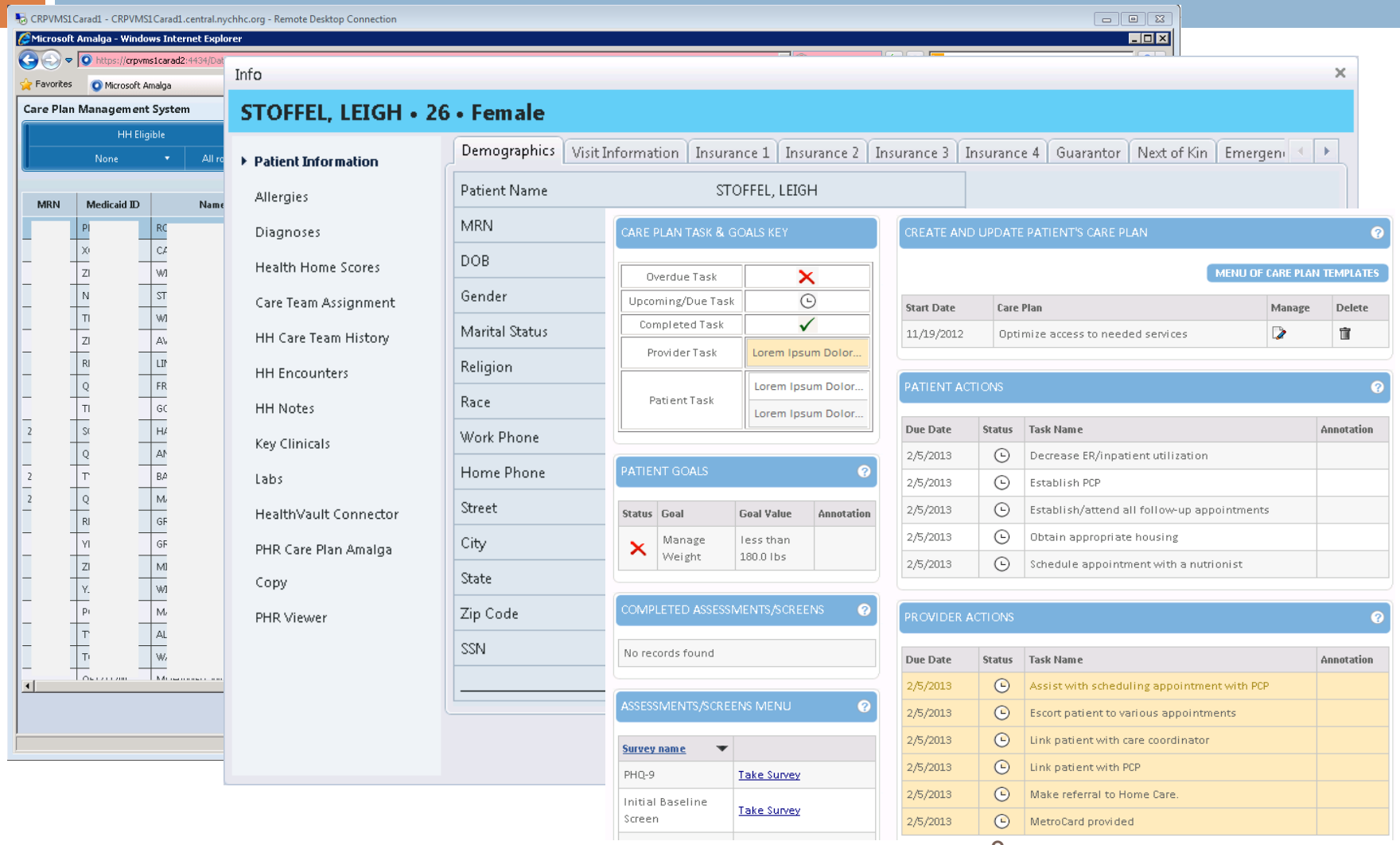
Patient Roster Management



Care Plan Management System (CPMS)



Care Plan Modules – Provider View

MY CARE TEAM

ADD NEW ITEM

Name	Specialty	Phone Number	Email	Notes
Abdul Munim, MD	Primary Care Provider	718-802-3452	abdul.munim@nychhc.org	
George Watson	Health Home Care Coordinator	718-903-9055	george.watson@nychhc.org	
Alfred Chahine, MD	Behavioral Health Specialist	718-222-6600	alfred.chahine@nychhc.org	
Abbas Motazedi	Health Home Outreach Worker	718-674-3042	abbas.motazedi@nychhc.org	

HEALTH STATUS

A color-coded summary of your patient's most recent key health measures indicating whether the values are within the target range.

HIGH

Blood Pressure
Systolic: 150 mmHg
Diastolic: 95 mmHg
Last Taken: 1/23/2013

NORMAL

LDL Cholesterol
LDL ("bad cholesterol"): 90 mg/dL
Last Taken: 10/29/2012

NORMAL

A1C
A1C: 5.7%
Last Taken: 12/19/2012

Care Plan Modules – Provider View

PATIENT GOALS

Status	Goal	Goal Value	Annotation
✗	Blood Pressure less than 140/80	less than 140	This tracks the first number.
✗	Blood Pressure less than 140/80	less than 80	This tracks the second number.
✗	Increase physical activity/exercise	0 out of 1 task(s) completed	
✓	Quit Smoking	1 out of 1 task(s) completed	

PATIENT ACTIONS

Due Date	Status	Task Name	Annotation
1/2/2013	✗	Start My Mood Log	Assigned: 12/28/2012
1/23/2013	🕒	Call my Care Coordinator if I think I need to go to the emergency room (1-855-602-4663)	Assigned: 1/18/2013
1/23/2013	✓	I agree to try Nicotine patches or gum (nicotine replacement therapy)	Assigned: 1/18/2013
1/23/2013	✓	Identify Health Care Proxy	Assigned: 1/2/2013
1/23/2013	🕒	Walk 30 minutes a day	Assigned: 1/18/2013

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Care Plan Modules – Provider View

CURRENT MEDICATIONS

Show : Medications I currently take

ADD NEW ITEM

Medication Name	Date Started	Dosage	Frequency	Prescribed By	Source	Notes
Metformin / pioglitazone Oral Tablet [Actoplus Met 15/500]	1/2/2013	1 Tablets	Once a day	Dr. Abdul Munim	George Watson via InstantPHR provider portal	
WELLBUTRIN 100MG SR TABLET	1/2/2013	1 Tablets	Once a day	Dr. Abdul Munim	George Watson via InstantPHR provider portal	
LOPRESOR 100MG TABLET	1/2/2013	1 Tablets	Once a day	Dr. Abdul Munim	George Watson via InstantPHR provider portal	
Ginkgo biloba	3/8/2008	2 capsules	once a day		Self-Entered	

DISCONTINUED MEDICATIONS

Show : Medications I no longer take

Medication Name	Date Started	Dosage	Frequency	Date Discontinued	Source	Notes
WELLBUTRIN 50MG SR TABLET	12/3/2012	1 Tablets	Once a day	1/2/2013	George Watson via InstantPHR provider portal	
Vicks 44 Cold, Flu and Cough	3/1/2012	6 Tablespoons (tbsp)	Once a day	3/26/2012		
Cough Medicine	2/1/2010	2 TBS	morning and night	2/21/2010	Self-Entered	

ALLERGIES

ADD NEW ITEM

Allergy	Reaction	Date Of First Reaction	What To Do	Notes
TRAMADOL	URINARY RETENTION	3/11/2011		
Peanuts	(Moderate) Hives	8/3/1980		

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Care Plan Management System - Demonstration

Brian Maxey, CSW

Associate Director, HHC Health Homes